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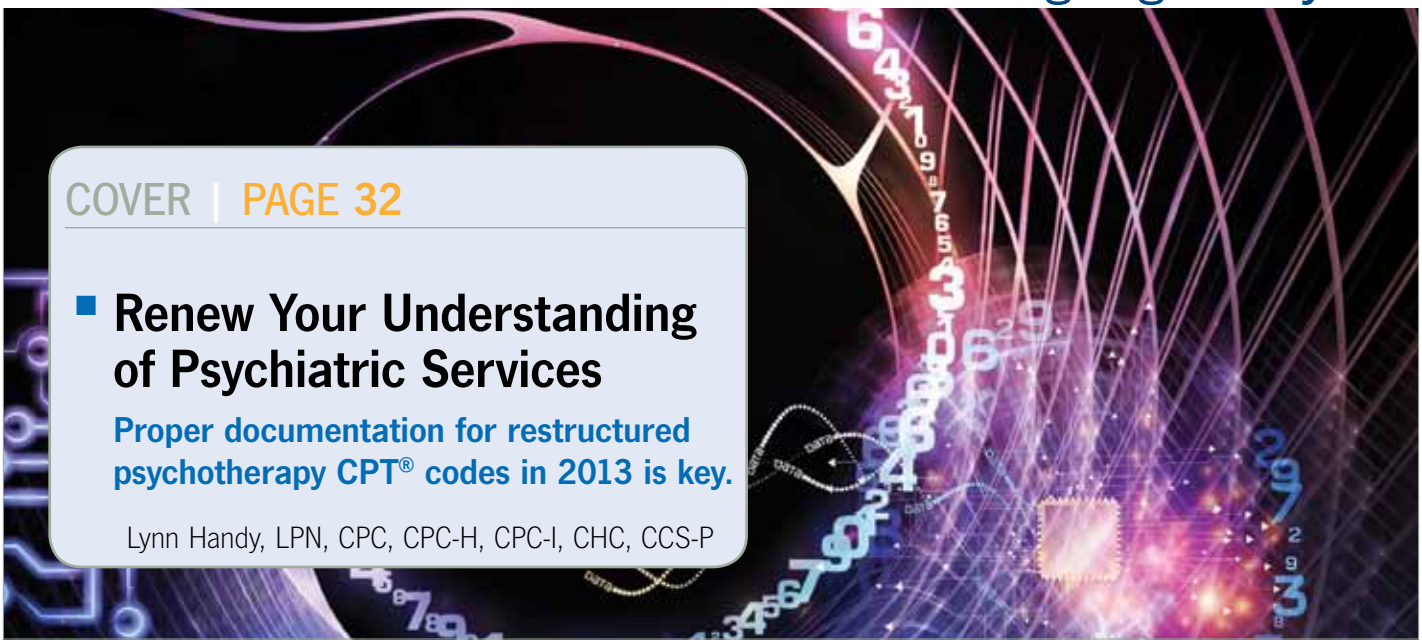

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Renew Your Understanding of Psychiatric Services

Proper documentation for restructured psychotherapy CPT® codes in 2013 is key.

Lynn Handy, LPN, CPC, CPC-H, CPC-I, CHC, CCS-P

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On the Cover: *Lynn Handy, LPN, CPC, CPC-H, CPC-I, CHC, CCS-P, gives you a glimpse of the documentation providers must include in the medical record to ensure proper coding and reimbursement of restructured psychotherapy services in 2013. Cover design by Tina Smith.*

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AAPC CUTTING EDGE
Healthcare Business Monthly
July 2013

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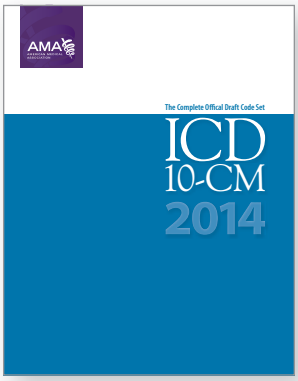
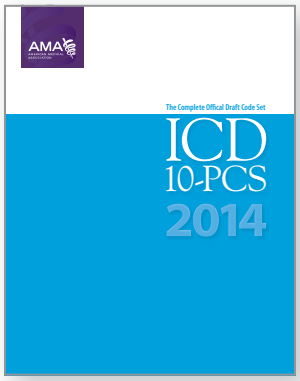
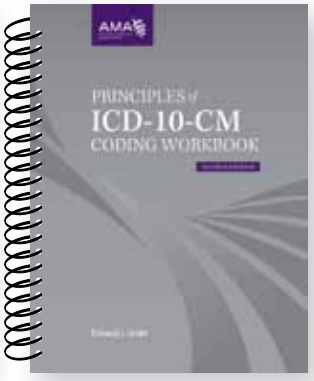
Volume 24 Number 7 July 1, 2013

AAPC Cutting Edge (ISSN: 2326-2575) is published monthly by AAPC, 2480 South 3850 West, Suite B, Salt Lake City UT 84120-7208, for its paid members. Periodicals Postage Paid at Salt Lake City UT and at additional mailing office. POSTMASTER: Send address changes to: Cutting Edge c/o AAPC, 2480 South 3850 West, Suite B, Salt Lake City UT 84120-7208.







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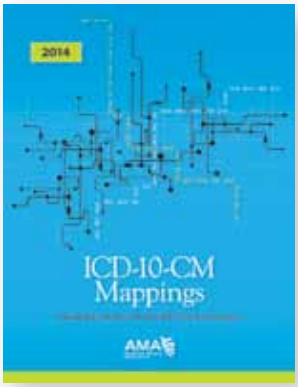

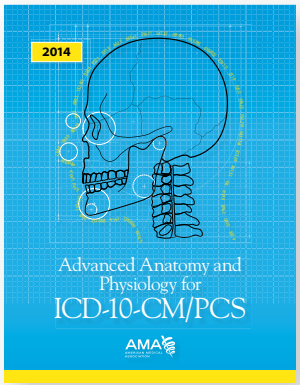

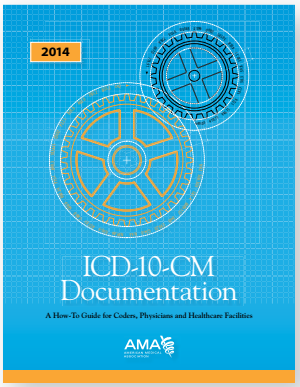

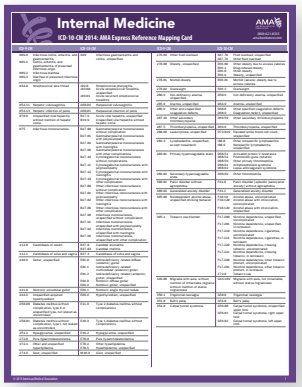

Now is the time to make the transition from ICD-9-CM to ICD-10-CM.

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Letters to the Editor

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

Identify Information on Every Page of the Patient Record

I love when standards of medical record documentation are discussed in *AAPC Cutting Edge*. Your recent article, "Deliver Constructive Criticism the Thoughtful Way," (June 2013, p. 30-31) brought this scenario to mind:

As an auditor, I receive chart notes to review daily. One thing often missed is the need for patient identifying information on *each* page of the record. A patient record may start out as an electronic file or a front/back copy, but by the time it's printed down or copied and faxed, it's a multiple page document—and patient identifying information is still a necessary element on every page. Using an electronic health record or a front/back page system doesn't override this need; I often have to send records back to have this information added.

Sarah Hobson, CPC, CPC-H, CPC-P, CPMA, CANPC

Thank you, Sarah, for reminding us all of how important this is.

AAPC Cutting Edge

Extreme Coding = Extreme Education

Whatever happened to the "Extreme Coding" articles that appeared in past editions of *Coding Edge [AAPC Cutting Edge]*? I liked those and found them quite educational. Would you consider reinstating them?

Ken Camilleis, CPC, CPC-I, CMRS, CCS-P

For members who are unfamiliar with this column, it was a feature in **AAPC Coding Edge** *from August 2007 through June 2009. It included difficult-to-code medical scenarios submitted by our members. These records often presented jaw-dropping cases that required a great deal of imagination and research to code the services properly. We'll look at bringing it back.*

AAPC Cutting Edge

Use 33983 when VAD Involves Bypass

In June's "Learn VAD Management to Help Failing Coding," there is a typo in the second example (page 24):

You should report 33983 *Replacement of ventricular assist device pump(s); implantable intracorporeal, single ventricle, with cardiopulmonary bypass* for the replacement of intracorporeal ventricular assist device (VAD) pump with bypass, **not** 33982 *Replacement of ventricular assist device pump(s); implantable intracorporeal, single ventricle, without cardiopulmonary bypass.*

Kudos

CPC® Unleashes Her Dark Side

You may recognize the name **Belinda S. Frisch, CPC**, as an author of killer coding content. She has contributed articles for *AAPC Cutting Edge* and has written 2006 and 2007 editions of *Correct Coding for Medicare: Compliance and Reimbursement* for educational publisher Cengage. If you're wondering why you haven't seen her talents in *AAPC Cutting Edge* for a while, it's because she retired from non-fiction writing and crossed over to the dark side of fiction. Frisch has written a number of novels, including "Crisis Hospital: Dark Tales from the Ward, the World, and the Bedside," "Dead Spell," "City of Hell Chronicles," "Payback," "Cure," and "Afterbirth."

AAPC Cutting Edge asked Frisch why she made the switch from coding to horror. Her tongue-in-cheek response was that she switched because of "the real life impending horror that is ICD-10. After 15 years in the business, many of them spent in compliance, I just didn't want to start over with the new code set." The truth is Frisch has always written horror stories, and she made the switch for personal reasons. "Real life made it hard to continue with a demanding day job," said Frisch. "I spent a good deal of time over the past two and a half years helping my grandfather with chemo for the late-onset mesothelioma that took him last September."

Frisch's horror stories are medicine-influenced and her clinical writing experience has influenced her latest writing projects. The textbook writing for Cengage, according to Frisch, "really sharpened my prose and put me through the necessary editorial paces. I call on those lessons when I'm writing fiction. So far, all of my fictional stories have at least a bit of medicine in them, so writing about coding and medicine influenced my fiction, too."

The first book, "Cure," in Frisch's Strandville series "was the culmination of years working with an infectious diseases department—the real life horror of difficult-to-cure illnesses and outbreaks—and my grandfather's can-

July Update to ASC Pay Rates Released

It's July, and that means changes to the Ambulatory Surgical Center Payment System (ASCPS) have been released. Among the latest changes, effective July 1, 2013, HCPCS Level II code C9736 *Laparoscopy, surgical, radiofrequency ablation of uterine fibroid(s), including intraoperative guidance and monitoring, when performed* is assigned for payment under the ASCPS (ASC payment indicator G2).

Also of note, the following two Category III CPT® codes are now separately payable under the ASCPS:

- 0331T *Myocardial sympathetic innervation imaging, planar qualitative and quantitative assessment* (ASC payment indicator Z2)
- 0332T *Myocardial sympathetic innervation imaging, planar qualitative and quantitative assessment; with tomographic SPECT* (ASC payment indicator Z2)

Two drug and biological codes have been granted OPPS pass-through status:

- C9131 *Injection, ado-trastuzumab emtansine, 1 mg* (ASC payment indicator K2)
- Q4122 *Dermacell, per square centimeter* (ASC payment indicator K2)

And there are two new HCPCS Level II codes:

- Q2050 *Injection, doxorubicin hydrochloride, liposomal, not otherwise specified, 10 mg* (ASC payment indicator K2)
- Q2051 *Injection, zoledronic acid, not otherwise specified, 1 mg* (ASC payment indicator K2)

You should also note that code J9002 *Injection, doxorubicin hydrochloride, liposomal, doxil, 10 mg* is replaced with code Q2050.

And ASC payment indicators for HCPCS Level II codes Q4126 *Memoderm, dermaspan, tranzgraft or integuply, per sq cm* and Q4134 *Hmatrix, per sq cm* will change from Y5 to K2.

Lastly, HCPCS Level II code C9297 *Omacetaxine mepesuccinate* has a corrected payment rate of $2.53 and C9298 *Injection, ocriplasmin* has a corrected payment rate of $1,046.75. Both codes have an ASC payment indicator of K2.

See CMS transmittal 2717 (www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2013-Transmittals-Items/R2717CP.html), issued May 31, for complete details of this ASCPS update.

Please send your KUDOS to:
kudos@aapc.com

Belinda Frisch

cer treatment," she said. The book, Frisch explains, "is a different take on a worldwide viral outbreak … The zombie element is in the background and it could be any easily transmitted, lethal virus."

Frisch still uses her clinical expertise as a Certified Professional Coder (CPC®) for occasional healthcare consulting, and she plans to expand her writing genre to medical mysteries (http://belindaf.blogspot.com/).

Congratulations and kudos to Frisch for taking her clinical expertise and creativity in a unique direction!

CMS Pays for Three New DME Codes

The Centers for Medicare & Medicaid Services (CMS) added three new customized durable medical equipment (DME) HCPCS Level II codes for payment effective July 1.

K0008 Custom manual wheelchair/base

K0013 Custom motorized/power wheelchair base

K0900 Custom durable medical equipment, other than wheelchairs

To use these codes, your DME must meet Medicare's regulatory definition of a "customized item." Medicare claims with these codes will be manually processed and evaluated by payers to ensure the items meet this definition.

A customized DME item, per 42 Code of Federal Regulations (CFR) Section 414.224(a), is a covered item (including a wheelchair) that must be:

1. Uniquely constructed or substantially modified for a specific beneficiary according to a physician's description and orders; and
2. So different from another item used for the same purpose that the two items cannot be grouped together for pricing purposes.

Medicare's example of a customized item:

"For example, a wheelchair that is custom fabricated, or substantially modified, so that it can meet the needs of wheelchair-confined, conjoined twins facing each other is unique and cannot be grouped with any other wheelchair used for the same purpose. It is a one-of-a-kind item, fabricated to meet specific needs."

According to CFR section 414.224(b), "The lump-sum payment made for purchase of the customized item is based on the Medicare contractor's individual consideration and judgment of a reasonable payment amount for each item."

For a full explanation of "customized item" requirements and what is factored into the "contractor's individual consideration," see CMS transmittal 1239 (www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1239OTN.pdf), issued May 21.

By Angela Jordan, CPC

Privileges Abound for AAPC Members

Advance your career, save money, and broaden your network of peers.

Being a member of the nation's largest association of medical coders, billers, auditors, regulatory compliance experts, and physician practice managers has its privileges. When was the last time you explored all AAPC membership has to offer? You might be surprised by the variety of benefits membership affords you.

Education

AAPC offers a wide range of competitively-priced online courses in medical coding, billing, auditing, compliance, and practice management—including supplemental classes and study guides for anatomy, medical terminology, and evaluation and management (E/M).

AAPC also offers:

- Preparation courses for those getting ready to sit for a certification exam.
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- AAPC national and regional conferences.
- Free or low-priced education and continuing education units (CEUs) made available through AAPC local chapters.

Jobs

AAPC provides an employment database containing thousands of job listings from across the country for coding, billing, auditing, compliance, and practice management positions. There is also an externship program, Project Xtern, which offers real-world experience to participating members. Local chapter meetings and AAPC discussion forums provide members with additional avenues to locate new employment opportunities.

Networking

AAPC provides unmatched networking opportunities through local chapters, offering a support system with other like-minded professionals. Some local chapters even have a new mentoring program set up to help you further your career.

Forums are also a great way to network. AAPC forums contain thousands of posts from members across the country on just about every specialty and topic you can imagine. It's an easy way for members to post questions and learn from experts in various specialties and backgrounds.

Another great networking opportunity can be realized by attending workshops and conferences. Take plenty of business cards to share with friends and colleagues.

Recognition

With more than 90,000 healthcare professionals across the country holding an AAPC certification, AAPC members are recognized for excellence. AAPC membership and certifications carry weight in the healthcare industry and are backed by a lobbyist in Washington, D.C., who represents our common interests on matters affecting healthcare.

Resources

Let's start with the obvious: *AAPC Cutting Edge* magazine is a valuable resource that arrives in your mailbox each month. Did you know that AAPC also publishes several electronic newsletters? If you haven't been receiving them, check out your member settings when you log in to the AAPC website. Speaking of which: The member area on AAPC's website is another valuable resource worth exploring. You'll find great research tools and other resources free of charge in your customized member area.

Savings

You can save on coding books, as well as other medical books, when you purchase them through the AAPC Vendor Bookstore. The savings doesn't stop there, however. Take the time to visit the "Savings" link under the "Resources" tab on the AAPC website. A link to "Member Perks" will show you where you can save on shopping, travel and hotels, insurance and services, and entertainment. You can find offers for almost anything you need, from major retailers and service providers such as car rentals, telephone services, and even prescriptions. There is also a Medical Coding Buyer's Guide to assist members with additional information on the companies found in the Vendor Bookstore.

Now that you know the benefits of your membership, use them to your advantage to fully appreciate what it means to be a part of AAPC.

Angela Jordan, CPC, is managing consultant at Medical Revenue Solutions, LLC. She has more than 10 years of experience in healthcare, including working as a coding and compliance manager for a large physician network and HCA. Jordan is well versed in many areas of healthcare. She served as AAPCCA Board of Directors chair from 2012-2013, and is a past-president of the Kansas City chapter.

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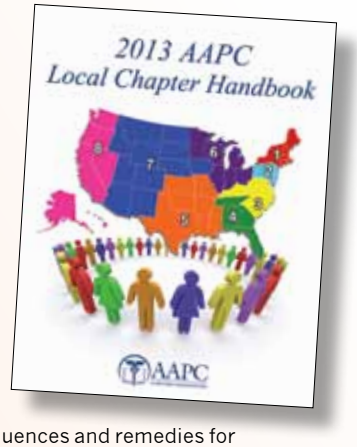
By Melissa Corral, CPC, AAPCCA Local Chapter Handbook Committee chair

Look What's Changing in the Appendices



Not many of us can say we've read through the *Local Chapter Handbook*, page by page, cover to cover. It's too bad because the handbook (available for download at **www.aapc.com/memberarea/chapters/index.aspx**) is filled with valuable information that's continually updated—especially the appendices. The handbook is easily accessible online, and you can save it to your desktop for quick reference. At the very least, chapter secretaries should review the handbook in its entirety and keep the rest of their chapter up to date.

Here is a sample of the type of information in the appendices:

Appendix A—Submitting Information/Seeking Approval for Events. In the electronic format of the *Local Chapter Handbook* there are hyperlinks to areas of the website where information can be uploaded for online submission to the Local Chapter Department such as attendance sheets, meeting minutes, and the quarterly meeting/financial report. Reviewing this list of required information at least once a year is a great way to know what is expected of local chapter officers.

Appendix B—Summary of Infractions/Consequences. Although this is one area that no one wants to talk about (guess that's why it's in the back of the book, right?), you'll find some of the most frequent infractions reported by the Local Chapter Department in this section, as well as explanations of the related consequences, and actions needed to be taken by the local chapter, officer, or member, depending on the situation. This section was recently reviewed and edited by the AAPCCA Local Chapter Handbook Committee. Some edits include:

- Making consequences consistent for infractions with similar caliber;
- Clarifying statements that may have been unclear or vague; and
- Adding the summary of consequences and remedies for mishandling the election process at the local chapter level.

Appendix C—AAPC and AAPCCA Contacts. There is a list of AAPC local chapter staff and AAPCCA board contacts by region. The AAPCCA board term begins and ends at the annual AAPC National Conference. The new board is announced on the last day of conference for the upcoming year. Use Appendix C to find your chapter's current representatives.

Every member should be familiar with the handbook. Know what region you live in and its color (helpful at AAPC conferences), and who the AAPCCA and the National Advisory Board representatives are for your region. Knowing who to contact is essential when you have questions or suggestions for AAPC or the Local Chapter Department.

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Quick Tip

By Jonnie Massey, CPC, CPC-P, CPC-I, CPMA, AHFI

Coding/Billing

Who Is an "Other Qualified Health Care Professional"?

Staying within scope-of-practice requirements will require an understanding of this new term.

The annual update of the CPT® codebook includes many hundreds of changes, but what especially caught my attention for 2013 was the revision of many code descriptors to replace the word "physician" with "physician or *other qualified health care professional*" or "*individual.*"

Define the New Term

Within the context of coding for services, a qualified healthcare professional is an individual who is qualified by education, training, and licensure/regulation and/or facility privileges (when applicable) who performs a professional service within his or her scope of practice, and independently reports that professional service. Scope of practice will vary by provider type and state regulation. Individual payers may also specify guidelines, which you should review and follow.

Physicians—such as doctors of medicine, doctors of osteopathic medicine, and doctors of chiropractic—certainly are qualified healthcare professionals. A licensed practicing physician has successfully obtained and maintained a degree after completing extensive education and residencies, and has passed the requirements exams. Other qualified healthcare professionals include registered nurses, physician assistants, nurse practitioners, certified registered nurse anesthetists, and physical, speech, occupational, and massage therapists. All have demonstrated skill and expertise in their field of study to complete the education and regulatory requirements, to obtain licensure, and to remain in good standing with the respective licensing boards.

Qualified healthcare professionals are separate from "clinical staff." *Clinical staff* is defined as someone working under the supervision of the physician or other qualified healthcare professional, who is allowed by the law, regulation, and facility policies to perform (and/or, to assist in the performance of) a specific service, but who does not separately report that professional service.

Scope of Practice for Clinicians Hasn't Changed

The CPT® definition of modifier 25 has expanded to "Significant separately identifiable evaluation and management by the same physician or *other qualified health care professional* on the same day of the procedure or other service."

Although the definition is expanded to include other qualified healthcare professionals, those professionals must still practice according to regulations. In other words, the requirements for scope of practice have not changed.

Evaluation and management (E/M) guidelines in CPT® 2013 further clarify the changes. A Coding Tip states, "*Solely for the purpose of distinguishing between new and established patients, professional services are those face-to-face services rendered by physician or other qualified health care professional* **who may report** *evaluation and management services reported by a specific CPT® code(s)*" [emphasis added]. Notice the inclusion of "who may report." The language may be subtle, but it has significant meaning. The "other qualified health care professional" must be the one who provides the service within his or her own scope of practice, and who may rightfully bill independently for that service.

When in Doubt, Find Out

Throughout CPT® "physician," "other qualified health care professional," and "individual" are used interchangeably. The use of these terms does not indicate that other (unspecified) individuals cannot report the service. When in doubt, review the instructions for specific services to be clear whether the service is limited to a specific professional or other entity (e.g., home health or hospital).

Bottom line: When deciding who may bill for what, make certain to follow scope-of-practice and all other regulatory requirements. CE

Jonnie Massey, CPC, CPC-P, CPC-I, CPMA, AHFI, is a senior investigator with Blue Shield of California. She is an accredited healthcare fraud investigator, served on AAPC's National Advisory Board from 2007-2009, and is a frequent presenter at conferences and workshops for numerous organizations.

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By Yvonne Dailey, CPC, CPC-I, CPB

Auditing/Compliance

Troubleshoot and Fix Possible ICD-10-CM Revenue Cycle Issues

The "new" code set will bring back end workflow changes; prepare now to save money later.

The Centers for Medicare & Medicaid Services (CMS) is holding firm on the ICD-10-CM implementation date of Oct. 1, 2014. Although we don't know exactly what affect the code set change will have on the revenue cycle, we do know the best way to face the unknown is to prepare early. To get the ball rolling, consider ICD-10-CM implementation issues that may affect your billing system.

Assign the Right Person for the Job

Assign a lead person to address all of your claim submissions to ensure things don't fall through the cracks. Once you find that person, begin by reviewing your current workflow for claim submissions. This will enable you to see what areas will be affected and how it should be handled.

Regardless of whether you are on a paper system (charge tickets) or an electronic health record (EHR) system, the office needs to run a frequency report for the most commonly used diagnosis codes. Create a crosswalk between the current ICD-9-CM codes and the equivalent ICD-10-CM codes. This will enable you to see whether the level of specificity has changed and how the changes will affect documentation and code selection. For example, you may need to add "laterality" as a component of a code.

Because of ICD-10-CM code specificity, carriers are saying they may not cover unspecified codes. Eliminating those codes from your system, wherever possible, is an easy solution.

Spot Shortfalls in Documentation

Offices should begin now to perform mini chart assessments for ICD-10-CM documentation to be sure providers are recording enough detail to choose codes accurately and effectively. Addressing this issue now will eliminate having to go back to query your

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Because of ICD-10-CM code specificity, carriers are saying they may not cover unspecified codes.

providers after Oct. 1, 2014. Even though you may not be using "laterality," for instance, it's simple enough for providers to begin documenting that information now.

Providers, billers, and coders need to work closely together to make everything run smoothly and reduce the time required to go back and forth with inquiries. Without the proper documentation, coders and billers will not be able to process claims. They can help assist providers by informing them of what is necessary to get claims paid. For example, they can alert them as to the necessary information for coding and billing laboratory procedures and/or radiology. Working together will help ensure success.

Make Sure Your EHR Is Online

If you use an EHR or practice management system, you'll need to ask your vendor how your system will be updated with the new codes. Often, updates are tied to the support contract. If you haven't been keeping up to date on support, you may have to pay extra for these changes.

Keep in mind: Generally, when these updates are performed, your system will get all of the codes available at the time of the update. Often, if a code needs to be extended, it doesn't happen automatically. Ask how these updates will be handled. For example, will the codes be updated already, or will your staff have to enter them manually after Oct. 1, 2014?

Review Carrier Contracts

Now is also a good time to review your carrier contracts; some contracts are tied to specific diagnosis codes. Contact your carrier and ask how those codes will crosswalk to ICD-10-CM codes, as this will greatly affect billing and reimbursement.

Get on Board 5010

In preparation for ICD-10-CM, your practice management system was supposed to be converted from version 4010 to 5010 as of Jan. 1, 2012. Version 5010 is the latest Health Insurance Portability and Accountability Act (HIPAA) electronic administrative transactions standard—which, in layman's terms, means the way your claims are sent and received electronically by clearinghouses and carriers.

Although the implementation deadline has come and gone, there are still some systems that have not made the transition. It's important to ask your vendor, billing agency, and clearinghouse if the system being used to process your claims is in compliance. Some clearinghouses are able to take your 4010 claims and convert them to 5010; however, when the new code system goes live, they may not be able to do this any longer.

CMS has a great side-by-side comparison to understand the difference between 4010 and 5010. One change is the need to have the correct National Provider Identifier (NPI), not only for your staff, but for your referring providers, as well. Carriers will read the NPI in combination with the tax identification or Social Security number to identify the rendering physician. This is something billing agencies must keep up to date because providers don't include referring providers' NPIs. Review your system and make sure you have all of your referring providers' information in your system now.

Another thing to watch out for: Version 5010 allows for an increase in the number of diagnoses that can be submitted with a claim; however, some carriers have stated that although they are able to accept up to 25 diagnosis codes for an 837I file (UB-04) and up to 12 diagnosis codes for an 837P file (CMS-1500), for billing purposes, only four codes can be linked on a specific service line level. Check with your payers to make sure you are entering and linking procedure and diagnosis codes correctly.

When Paper Claims Are Still in the Picture

Often a carrier cannot accept claims electronically. Instead, the practice submits all of their claims electronically to the clearinghouse, and the clearinghouse drops and mails the paper claims to the carrier on behalf of the practice. If you have a similar setup, inquire whether the clearinghouse will continue this practice after the conversion and how it will be handled.

Not All Contractors Will Make the Change

Another area to review is your current workers' compensation and auto claims contracts. These payers are not required to convert to the new coding system; the option will vary from state to state and from carrier to carrier. If you process many of these claims, ask carriers what their plans are. This will greatly affect chiropractic and physical therapy facilities, for instance, and may require you to maintain duel systems.

Now is also a good time to review your carrier contracts; some contracts are tied to specific diagnosis codes.

Learn the Reports Inside Out

Vendor, clearinghouse, and carrier electronic data interchange (EDI) departments all speak in terms of numbers for set reports. For example, 837I claims are for institutions that file claims on a UB-04; 837P claims are submitted by physicians; 835 are remittance advice forms; and 997/999 are acknowledgement reports. Familiarize yourself with all of the reports and their correspondent numbers, as you may need to work with your vendors to fix any issues (e.g., if you are appealing timely filing, the carriers may request a specific report).

If your system has made the changeover to 5010, review your EDI reports to familiarize yourself with the changes.

Monitor Payments and Denials

Assign someone to track and manage any denials. Because of uncertainties associated with ICD-10-CM, have someone stay on top of denials, appeals, improper payments, and other issues the code set change will bring. To offset payment delays and other unexpected costs that may initially occur, you may want to set up a cash reserve, too.

Many practice management systems can track whether you receive improper payments based on fee schedules. For that feature to work, the fee schedule must be entered into your system. This may seem like a lot of work, but it will greatly assist you during the transition. There are clearinghouses that offer this service, as well.

Testing, One, Two, Three

Finally, ask your vendors and carriers when they will test the new code set with your system. Allow plenty of time for testing between your system, the clearinghouse, and the carrier—or you and the carrier, if that's the case. This transition is vendor dependant. There may be backlogs with the transition, so procrastination is not your friend.

ICD-10-CM is not just a code set change; it will bring many changes to your backend workflow. The time to prepare is now.

Yvonne Dailey, CPC, CPC-I, CPB, is owner of Dailey Billing Services Inc., founded in 2001 to provide electronic medical billing services. With more than 10 years experience in the medical billing and coding field, she teaches her clients the "key role" for correct coding and documentation and its affect on the reimbursement process. Dailey has experience as an adjunct instructor for business schools in her area and is a PMCC instructor providing seminars for physicians, staff, and new coders. She serves on the 2013-2015 NAB and has served as president for the Monmouth Ocean and Toms River local chapters and on the 2007-2009 NAB.

A&P QUIZ

By Rhonda Buckholtz, CPC, CPMA, CPC-I, CENTC, CGSC, COBGC, CPEDC

Think You Know A&P? Let's See …

Pneumonia is an infection that inflames the air sacs in one or both lungs, causing the air sacs to fill with fluid or pus. The signs and symptoms of pneumonia vary from mild to severe, depending upon factors such as the type of germ causing the infection—a variety of organisms can cause pneumonia—and the patient's age and overall health. Mild signs and symptoms often are similar to those of cold or flu, but last longer.

Pneumonia is classified according to the type of germ that caused it, and where the patient acquired the infection:

Community-acquired pneumonia is the most common type of pneumonia. It occurs outside of hospitals and other healthcare facilities, and is caused by:

- Bacteria, such as Streptococcus pneumoniae
- Bacteria-like organisms, mycoplasma pneumoniae
- Viruses and fungi

Hospital-acquired pneumonia is a bacterial infection that occurs in people 48 hours or more after being hospitalized for another condition. Patients who are on a breathing machine (ventilator), often used in intensive care units, are at higher risk of this type of pneumonia.

Healthcare-acquired pneumonia is a bacterial infection that occurs in people who are living in long-term care facilities or have been treated in outpatient clinics, including kidney dialysis centers.

Aspiration pneumonia occurs when inhaling food, drink, vomit, or saliva into the lungs. This aspiration may happen if something disturbs the normal gag reflex, such as a brain injury, swallowing problem, or excessive use of alcohol or drugs.

Antibiotics and antiviral medications can be used to treat many common forms of pneumonia; however, hospital-acquired pneumonia tends to be more resistant.

Test yourself to find out where your A&P skills rank:

Routine signs and symptoms of pneumonia *do not* include:

A. Fever, sweating, and shaking chills

B. Lower than normal body temperature in people older than age 65, and in people with poor overall health or weakened immune systems

C. Cough, which may produce thick, sticky fluid

D. Vertigo

Check your answer on page 65.

Rhonda Buckholtz, CPC, CPMA, CPC-I, CENTC, CGSC, COBGC, CPEDC, is vice president of ICD-10 Training and Education at AAPC.

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By G.J. Verhovshek, MA, CPC

7 Essential Rules for Medicare Telehealth Services

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Provide healthcare at remote locations and, with careful reporting, get paid.

Telehealth services allow patients to receive healthcare from providers at remote locations. The Centers for Medicare & Medicaid Services (CMS) provides payment for telehealth services, but only under carefully defined conditions. Here are the seven essential rules for reporting telehealth services provided to Medicare patients.

Rule 1: Target Underserved Areas

Per Medicare rules, "beneficiaries are eligible for telehealth services only if they are presented from an originating site located in a rural Health Professional Shortage Area (HPSA) or in a county outside of a Metropolitan Statistical Area" (see *Medicare Learning Network*, "Rural Health Fact Sheet Series: Telehealth Services," available at www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/telehealthsrvcsfctsht.pdf). An originating site is defined as, "the location of an eligible Medicare beneficiary at the time the service being furnished via a telecommunications system occurs."

In other words, telehealth services aren't available to patients in just any location. The patient receiving the service must be in an underserved area.

A list of HPSAs by state and county can be

... telehealth services aren't available to patients in just any location. The patient receiving the service must be in an underserved area.

found on the U.S. Department of Health & Human Services (HHS) Health Resources and Services Administration (HRSA) website (http://hpsafind.hrsa.gov); and the U.S. Census Bureau maintains a list of metropolitan statistical areas on its website (www.census.gov/population/metro/).

Exception: Entities that participated in a federal telemedicine demonstration project prior to Jan. 1, 2001 qualify as originating sites, regardless of geographic location.

Rule 2: The Patient Must Be in a Medical Facility or Office

An originating site (where the patient is), in addition to being within an HPSA or in a county outside of a metropolitan statistical area, must be a type authorized by law. Originating sites include:

- Physician or practitioner office
- Hospitals
- Critical access hospitals (CAH)
- Rural health clinics (RHC)
- Federally qualified health centers (FQHC)
- Skilled nursing facilities (SNF)
- Community mental health centers (CMHC)
- Hospital-based or CAH-based renal dialysis centers (including satellites) (Independent renal dialysis facilities are not eligible originating sites.)

The originating site must be a medical facility (not, for instance, the patient's home). There are no specific rules regarding the location from which the telehealth services are delivered (i.e., the "distant" site or where the provider is).

Rule 3: Providers Must Be Approved

Practitioners who may provide and bill for Medicare telehealth services include:

- Physicians
- Nurse practitioners (NP)
- Physician assistants (PA)
- Nurse midwives
- Clinical nurse specialists (CNS)
- Registered dietitians or nutrition professionals (RD)
- Clinical psychologists (CP) and clinical social workers (CSW)

Per CMS rules, CPs and CSWs cannot bill for psychiatric diagnostic interview examinations with medical services or medical evaluation and management (E/M) services under Medicare, and may not bill or receive payment for codes:

90792 *Psychiatric diagnostic evaluation with medical service*

+90833 *Psychotherapy, 30 minutes with patient and/or family member when performed with an evaluation and management service (List separately in addition to the code for primary procedure)*

+90836 *Psychotherapy, 45 minutes with patient and/or family member when performed with an evaluation and management service (List separately in addition to the code for primary procedure)*

+90838 *Psychotherapy, 60 minutes with patient and/or family member when performed with an evaluation and management service (List separately in addition to the code for primary procedure)*

Payment for telehealth services is the same as for services furnished without the use of a telecommunications system, but billed services must be within a practitioner's scope of practice under applicable state law.

Rule 4: Services Must Be Interactive

Medicare pays only for interactive video consultation services, which mimic face-to-face interactions between patients and providers. CMS stipulates that a video telecommunications system must permit "real-time communication between … the physician or practitioner at the distant site, and the beneficiary, at the originating site."

In other words, telehealth has to be delivered in such a way that the patient and provider are in constant, two-way communication during the service.

What CMS defines as "asynchronous 'store and forward' technology" (e.g., video clips, still images, X-rays, magnetic resonance images, electrocardiograms, and electroencephalogram, laboratory results, audio clips, and text) is covered only in federal telemedicine demonstration programs in Alaska or Hawaii. In all other cases, as a condition of payment, the patient must be present and participating in the telehealth visit.

Rule 5: Report Covered Services Using Approved Codes

Medicare pays for a wide range of telehealth services, including consultations, office visits, subsequent hospital care, and behavioral assessments. **Table A** (on the next page) provides a list of Medicare telehealth services and associated codes for 2013.

All of the above-mentioned services must be delivered in accordance with specific, applicable coding and documentation guidelines.

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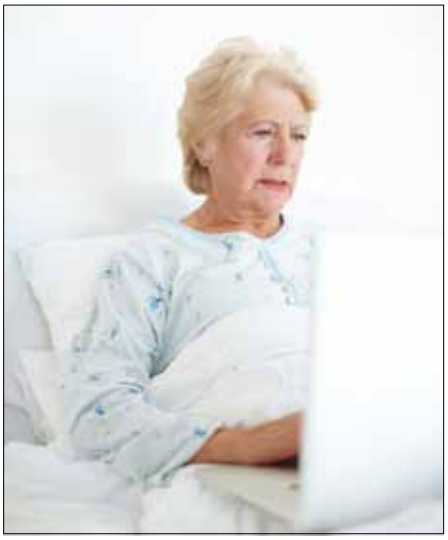
... telehealth has to be delivered in such a way that the patient and provider are in constant, two-way communication during the service.

Table A: Covered telehealth services and their codes

Service	CPT®/HCPCS Code
Telehealth consultations, emergency department or initial inpatient*	G0425-G0427
Follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals or SNFs*	G0406-G0408
Office or other outpatient visits	99201-99215
Subsequent hospital care services**	99231-99233
Subsequent nursing facility care services***	99307-99310
Individual and group kidney disease education services	G0420, G0421
Individual and group diabetes self-management training services, with a minimum of 1 hour of in-person instruction to be furnished in the initial year training period to ensure effective injection training	G0108, G0109
Individual and group health and behavior assessment and intervention	96150-96154
Individual psychotherapy	90832-90834, 90836-90838
Psychiatric diagnostic interview examination	90791, 90792
End-stage renal disease (ESRD)-related services included in the monthly capitation payment: For ESRD-related services, at least one "hands on" visit (not telehealth) must be furnished each month to examine the vascular access site by a physician, NP, PA, or CNS.	90951, 90952, 90954, 90955, 90957, 90958, 90960, 90961
Individual and group medical nutrition therapy	G0270; 97802-97804
Neurobehavioral status examination	96116
Smoking cessation services	G0436, G0437; 99406, 99407
Alcohol and/or substance (other than tobacco) abuse structured assessment and intervention services	G0396, G0397
Annual alcohol misuse screening, 15 minutes	G0442
Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes	G0443
Annual depression screening, 15 minutes	G0444
High-intensity behavioral counseling to prevent sexually transmitted infection; face-to-face, individual, includes: education, skills training and guidance on how to change sexual behavior; performed semi-annually, 30 minutes	G0445
Annual, face-to-face intensive behavioral therapy for cardiovascular disease, individual, 15 minutes	G0446
Face-to-face behavioral counseling for obesity, 15 minutes	G0447

** Initial and follow-up inpatient telehealth consultations are subject to the criteria for inpatient telehealth consultation services, as described in pub. 100-04,* Medicare Claims Processing Manual, *chapter 12, section 190.3.*
*** Subsequent hospital care services are limited to one telehealth visit every three days.*
**** Subsequent nursing facility care services are limited to one telehealth visit every 30 days.*



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Rule 6: Append Modifier GT

When reporting an approved telehealth service, you must append modifier GT *Via interactive audio and video telecommunication systems* to the appropriate service code(s). For example, to report a level III established patient office visit provided by telehealth, report 99213-GT. The modifier tells your Medicare contractor the beneficiary was present at an eligible originating site when the telehealth service was furnished.

Special circumstance: When appending modifier GT with a covered ESRD-related service telehealth code, you are further certifying that one visit per month was furnished "hands on" to examine the vascular access site.

In those rare cases (limited to Alaska and Hawaii) when you may bill Medicare for non-face-to-face telehealth services, you should report the appropriate code for the professional service with modifier GQ *Via asynchronous telecommunications system.*

Rule 7: Originating Sites Get to Bill, Too

The practitioner providing the telehealth service bills for his or her professional service following rules 1-6 above. The facility serving as the originating site may also report Q3014 *Telehealth originating site facility fee to* receive a separate Part B payment. See the *Medicare Benefit Policy Manual*, chapter 15, section 270.5 for complete details.

G.J. Verhovshek, MA, CPC, is managing editor at AAPC.

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By G.J. Verhovshek, MA, CPC

How to Get Medicare to Pay for Consults

CMS says to use E/M codes to report these services, but you'll have to play by their rules to get paid.

Takeaways:

- In lieu of consultation codes (99241-99245, 99251-99255), Medicare requires you to report an appropriate E/M code.
- Physicians need to include a request, reason, and report in their documentation.
- Append modifiers and report telehealth services when appropriate.

Medicare stopped accepting claims for outpatient (99241-99245) and inpatient (99251-99255) consultations as of Jan. 1, 2010, but physicians haven't stopped providing these services. How are they getting paid? After the 2010 Physician Fee Schedule (PFS) final rule was published, the Centers for Medicare & Medicaid Services (CMS) instructed physicians billing under the PFS to use other "applicable" evaluation and management (E/M) codes to report these services. Three years later, identifying which E/M code is most applicable is still a source of confusion for many. Let's clear up that confusion here and now.

Follow "Regular" E/M Guidelines for Outpatient Services

Report outpatient E/M services with the appropriate Outpatient Services code (e.g., 99201-99215 for office outpatients). The service must be supported by the key components of history, exam, and medical decision-making (MDM)—or time, if counseling and/or coordination of care dominates the encounter.

For example, a surgeon sees a new Medicare patient in the office for a consultation for another provider in the area. The surgeon will bill the consultation visit as a new patient visit at the appropriate level using 99201-99205. For instance, to report 99203 *Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 components; A detailed history; A detailed examination; Medical decision making of low complexity,* the physician would need to document, at a minimum, a detailed history, a detailed examination, and low-complexity MDM. Alternatively, the physician may report 99203 if counseling and/or coordination of care comprise 50 percent or more of a visit lasting 30-44 minutes, and the content of the visit is properly documented.

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Report outpatient E/M services with the appropriate Outpatient Services code ... supported by the key components of history, exam, and medical decision-making (MDM)—or time, if counseling and/or coordination of care dominates the encounter.

Don't Forget the "Three Rs"

Although you cannot report CPT® consultation codes (99241-99245 or 99251-99255) to Medicare payers, the Centers for Medicare & Medicaid Services (CMS) instructs providers to continue to document the request, reason, and report for consistency and improved patient care.

Per *MLN Matters*® MM6740 revised, "Revisions to Consultation Services Payment Policy," Dec. 14, 2009:

> *"Conventional medical practice is that physicians making a referral and physicians accepting a referral would document the request to provide an evaluation for the patient. In order to promote proper coordination of care, these physicians should continue to follow appropriate medical documentation standards and communicate the results of an evaluation to the requesting physician. This is not to be confused with the specific documentation requirements that previously applied to the use of the consultation codes."*

Inpatient Services

Inpatient consultations should be reported using the appropriate Initial Hospital Care code (99221-99223) for the initial evaluation and a Subsequent Hospital Care code (99231-99233) for subsequent visits.

In some cases, the service the physician provides may not meet the documentation requirements for the lowest level initial hospital visit (99221). According to CMS guidance found in *MLN Matters*® SE1010 (revised), "Questions and Answers on Reporting Physician Consultation Services," you may report subsequent hospital care codes (99231-99233) in these cases:

Q. *"How should providers bill for services that could be described by CPT inpatient consultation code 99251 or 99252, the lowest two of five levels of the inpatient consultation CPT codes, when the minimum key component work and/or medical necessity requirements for the initial hospital care codes 99221 through 99223 are not met?"*

A. "There is not an exact match of the code descriptors of the low-level inpatient consultation CPT codes to those of the initial hospital care CPT codes. For example, one element of inpatient consultation CPT codes 99251 and 99252, respectively, requires 'a problem focused history' and 'an expanded problem focused history.' In contrast, initial hospital care CPT code 99221 requires 'a detailed or comprehensive history.' Providers should consider the following two points in reporting these services. First, CMS reminds providers that CPT code 99221 may be reported for an E/M service if the requirements for billing that code, which are greater than CPT consultation codes 99251 and 99252, are met by the service furnished to the patient. Second, CMS notes that subsequent hospital care CPT codes 99231 and 99232, respectively, require 'a problem focused interval history' and 'an expanded problem focused interval history' and could potentially meet the component work and medical necessity requirements to be reported for an E/M service that could be described by CPT consultation code 99251 or 99252."

The same article assures providers that Medicare payers will pay for initial visits reported using subsequent care codes:

Q. *"How will Medicare contractors handle claims for subsequent hospital care CPT codes that report the provider's first E/M service furnished to a patient during the hospital stay?"*

A. "While CMS expects that the CPT code reported accurately reflects the service provided, CMS has instructed Medicare contractors to not find fault with providers who report a subsequent hospital care CPT code in cases where the medical record appropriately demonstrates that the work and medical necessity requirements are met for reporting a subsequent hospital care code (under the level selected), even though the reported code is for the provider's first E/M service to the inpatient during the hospital stay."

Read More on the Three Rs

See the article, "Remember the 'Three Rs' for Payers Accepting Consults," June 2013, pages 26-29, for more information on the three Rs: request, reason, and report. The article reviews CPT® documentation and reporting requirements for outpatient and inpatient consultations for (non-government) payers who still accept E/M service codes 99241-99245 and 99251-99255.

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When a Medicare patient is admitted, and another physician provides a consultation for that patient, a situation may arise in which both the admitting physician and consulting physician report an initial inpatient service ...

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Consults CMS Will Recognize

By law, telehealth services must include "professional consultations" and, as such, Medicare does recognize codes to describe telehealth consult services.

Telehealth consultations codes G0425-G0427 apply both to initial inpatient and emergency department services, while G0406-G0408 apply for follow-up telehealth consultation services provided to a beneficiary in an inpatient hospital or skilled nursing facility. These codes must be reported with the corresponding interactive telehealth modifier GT *Via interactive audio and video telecommunication systems* or GQ *Via asynchronous telecommunications system.*

For detailed information, look to *MLN Matters*® MM6705 ("Expansion of Medicare Telehealth Services for Calendar Year (CY) 2010"), updated Jan. 18, 2013. Also see the article on page 18.

Modifier AI Distinguishes Among Providers' Inpatient Services

When a Medicare patient is admitted, and another physician provides a consultation for that patient, a situation may arise in which both the admitting physician and consulting physician report an initial inpatient service (e.g., 99221-99223). To differentiate between the two physicians' services, and to prevent a claims denial for duplication of services, the admitting physician should append modifier AI *Principal physician of record* to the initial inpatient service code.

For example: A patient presents to the emergency department (ED) with chest pain. The ED physician evaluates the patient and codes an ED visit (99281-99285). He also requests a consult from a cardiologist. The cardiologist evaluates the patient and decides to admit him. The admitting cardiologist would report an initial hospital visit (99221-99223) with modifier AI appended.

If the patient also has uncontrolled diabetes, and the admitting physician (the cardiologist) requests a consult from an endocrinologist, the endocrinologist might also select an initial hospital visit code, depending on the level of service she provides, to report her consultation. But the endocrinologist would not append modifier AI because she is not the admitting physician overseeing the patient's overall care.

What if? Per CMS guidelines, "In all cases, physicians will bill the available code that most appropriately describes the level of the services provided." For instance, if the cardiologist had not admitted the patient in the scenario above, she would have reported an ED visit because 99281–99285 are the best (non-consultation) codes to describe the service. For patients receiving hospital outpatient observation services who are not subsequently admitted to the hospital as inpatients, physicians should report 99217–99220, etc.

You can find complete guidelines with extensive coding examples in *MLN Matters*® MM6740 (revised).

G.J. Verhovshek, MA, CPC, is managing editor at AAPC.

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OPTUM

By Uma Nachiappan, CPC, CCS

Calculate the Impact of MPPR

Cardiovascular and ophthalmology technical service providers will feel the penny pinch.

Effective Jan. 1, 2013, the Centers for Medicare & Medicaid Services (CMS) expanded its Multiple Procedure Payment Reduction (MPPR) policy to cover diagnostic cardiovascular and ophthalmology procedures. Providers rendering the technical component (TC) of such services can expect lower payments and should know how these payments are calculated.

Will MPPR Affect Your Practice?

Payers apply the MPPR when the same provider renders two or more procedures for the same patient during the same encounter, with the assumption that pre- and post-procedure services will overlap, and therefore shouldn't be reimbursed in full for each procedure. Per change request (CR) 7848 (which applies to all providers who are paid based on the Medicare Physician Fee Schedule (MPFS)), CMS has extended the concept of the MPPR to diagnostic cardiovascular and ophthalmology procedures.

Providers are now paid a reduced amount on additional TC services—or the TC of global services (the TC plus professional component (PC))—when multiple services are performed for the same patient:

- In the same session, on the same day of service;
- By the same physician or by multiple physicians in the same group practice (same group National Provider Identifier (NPI)); and
- For claims with dates of service on or after Jan. 1, 2013.

When multiple services meet the above criteria, the highest-valued TC reported would be allowed at 100 percent of the fee schedule amount. Subsequent procedures would be paid at reduced rates, as shown in **Table A**:

Table A: The effects of the MPPR policy on payments

Type of Service	TC % Reduction	TC % Payment	PC % Payment
Diagnostic cardiovascular	25%	75%	100%
Diagnostic ophthalmology	20%	80%	100%

Identify Services Subject to MPPR

You can identify specific services covered under MPPR using the "multiple procedure" column of the National Physician Fee Schedule Relative Value file. Diagnostic cardiovascular services subject to the MPPR are identified with a "6," while diagnostic ophthalmology services subject to the MPPR are identified with a "7." Such services are categorized as:

- Global services: codes for which both PC and TC may be submitted
- The TC of diagnostic cardiovascular and ophthalmology services
- The PC of diagnostic cardiovascular and ophthalmology services
- Standalone, TC-only codes (PC/TC indicator 3 in the physician relative value unit (RVU) file)
- Global-only codes: standalone codes for which there are associated codes that describe the PC of the test only and TC of the test only (PC/TC indicator 4 in the physician RVU file)

To determine which of the reported services qualifies as the "highest valued," follow **Table B**.

Table B: Determine the highest-valued service

Type of Service	Basis
Global services	Based on comparing the fee schedule of the TC of the global services
TC of diagnostic cardiovascular and ophthalmology services	Based on comparing the fee schedule of the technical fee schedule of the services billed
PC of diagnostic cardiovascular and ophthalmology services	Hierarchy is not necessary: MPPR reduction on PC is allowable at 100 percent, even for subsequent services
TC-only codes	Based on comparing the fee schedule of the billed services
Global test-only codes	Based on the fee schedule for the global test-only services' related technical codes

Examples Show the Way

The examples that follow illustrate how payments are made for each of these types of service.

Example 1: Global Services

Steps for arriving at the final allowable amounts shown in **Table C**:

Step 1: In **Table D**, notice that all of the codes have an indicator 6. This means they are subject to MPPR for diagnostic cardiovascular services.

Step 2: Identify the technical and professional code rates for the billed global codes.

Step 3: Order the TC of the billed services based on their allowable amount in the fee schedule and identify the primary and subsequent procedures (see **Table E**).

Step 4: Calculate the primary procedure allowable. The PC and TC portion is allowed at 100 percent (see **Table F**).

Step 5: Calculate the allowable for subsequent procedures. The PC portion is at 100 percent and the TC portion is at 75 percent (see **Table G**).

Table C: Billed services and the final allowable

Member Name	Date of Service	Procedure Code	Modifier	Charge	Final Allowable	Provider	NPI
John Smith	04/01/2013	75600	–	$212.00	$211.45	Francis, MD, Joe	1234567890
John Smith	04/01/2013	75625	–	$131.00	$130.68	Francis, MD, Joe	1234567890
John Smith	04/01/2013	75630	–	$160.00	$159.95	Francis, MD, Joe	1234567890

Table D: Fee schedule

CPT® Code	Modifier	PFS	OPPS Cap*	Multiple Procedure Indicator
75600	–	$211.45	$2,174.67	6
75600	26	$23.85	–	6
75600	TC	$187.60	$2,150.82	6
75625	–	$155.59	$2,209.27	6
75625	26	$55.93	–	6
75625	TC	$99.66	$2,153.34	6
75630	–	$184.62	$2,239.29	6
75630	26	$85.95	–	6
75630	TC	$98.67	$2,153.34	6

Table E: Services in order

CPT® Code	Modifier	PFS	Order
75600	TC	$187.60	1 – Primary
75625	TC	$99.66	2 – Subsequent
75630	TC	$98.67	3 – Subsequent

***OPPS Cap:** The MPFS will contain both the regular PFS amount and the Outpatient Prospective Payment System (OPPS) amount for the TC and global portion of imaging procedures. If the imaging procedure has an OPPS amount in addition to the regular PFS amount, then the lower of either PFS or OPPS for that service is normally the allowable for that imaging procedure. If the lowest amount is the OPPS allowed amount, then the service is subject to the OPPS cap.

Table F: Primary procedure allowable

CPT® Code	Global Rate – PFS (A)	PC Rate – PFS (B)	TC Rate – PFS (C)	Calculation (PC Rate x 100%) + (TC Rate x 100%) (D)	PFS After Reduction Calculation (E)	OPPS Cap (Global Rate) (F)	Minimum of PFS After Reduction vs. OPPS Cap (E vs. F)
75600	$211.45	$23.85	$187.60	= ($23.85 x 100%) + ($187.60 x 100%)	$211.45	$2,174.67	$211.45

Table G: Subsequent procedures allowable

CPT® Code	Global Rate – PFS (A)	PC Rate – PFS (B)	TC Rate – PFS (C)	Subsequent Procedure Calculation (PC Rate x 100%) + (TC Rate x 75%) (D)	PFS After Reduction Calculation (E)	OPPS Cap (Global Rate) (F)	Minimum of PFS After Reduction vs. OPPS Cap (E vs. F)
75625	$155.59	$55.93	$99.66	= ($55.93 x 100%) + ($99.66 x 75%)	$130.68	$2,209.27	$130.68
75630	$184.62	$85.95	$98.67	= ($85.95 x 100%) + ($98.67 x 75%)	$159.95	$2,239.29	$159.95

Example 2: TC of Diagnostic Cardiovascular and Ophthalmology

Steps for arriving at the final allowable amount shown in **Table H**:

Step 1: All of the codes have an indicator of 7, which means they are subject to MPPR - diagnostic ophthalmology services.

Step 2: Identify the rates for the billed services, as shown in **Table I**.

Step 3: Order the billed services based on their allowable amount in the fee schedule and identify the primary and subsequent procedures (see **Table J**).

Step 4: Calculate the allowable for the primary procedure, as shown in **Table K**.

Step 5: Calculate the allowable for subsequent procedures. The TC portion is 80 percent, as shown in **Table L**.

Table H: Billed services and the final allowable

Member Name	Date of Service	Procedure Code	Modifier	Charge	Final Allowable Amount	Provider	Group NPI
John Smith	04/02/2013	76510	TC	$84.00	$83.52	Francis, MD, Joe	1223344550
John Smith	04/02/2013	76511	TC	$40.00	$39.68	Francis, MD, Joe	1223344550
John Smith	04/02/2013	76512	TC	$33.00	$32.83	Alfred, MD, Joe	1223344550

Table I: Fee schedule

CPT® Code	Modifier	PFS	OPPS Cap	Multiple Procedure Indicator
76510	TC	$83.52	$140.70	7
76511	TC	$49.60	$96.57	7
76512	TC	$41.04	$96.57	7

Table J: Services in order

CPT® Code	Modifier	PFS	Order
76510	TC	$83.52	1 – Primary
76511	TC	$49.60	2 – Subsequent
76512	TC	$41.04	3 – Subsequent

Table K: Primary procedure allowable

CPT® Code	Modifier	Calculation (TC Rate x 100%) (A)	PFS After Reduction Calculation (B)	OPPS Cap (C)	Minimum of PFS After Reduction vs. OPPS Cap (B vs. C)
76510	TC	= ($83.52 x 100%)	$83.52	$140.70	$83.52

Table L: Subsequent procedures allowable

CPT® Code	Modifier	Calculation (TC Rate x 80%) (A)	PFS After Reduction Calculation (B)	OPPS Cap (C)	Minimum of PFS After Reduction vs. OPPS Cap (B vs. C)
76511	TC	= ($49.60 x 80%)	$39.68	$96.57	$39.68
76512	TC	= ($41.04 x 80%)	$32.83	$96.57	$32.83

Example 3: PC of Diagnostic Cardiovascular and Ophthalmology Services

Billed services and final allowable amounts are shown in **Table M**. The indicator for these codes is 7, which means they are subject to MPPR - diagnostic ophthalmology services. Per this MPPR, the PC of the diagnostic ophthalmology services for subsequent procedures is allowable at 100 percent of the fee schedule.

Table M: Billed services and the final allowable

Member Name	Date of Service	Procedure Code	Modifier	Charge	Final Allowable Amount	Provider	Group NPI
John Smith	04/03/2013	76510	26	$101.00	$100.07	Francis, MD, Joe	1223344550
John Smith	04/03/2013	76511	26	$52.00	$51.94	Francis, MD, Joe	1223344550
John Smith	04/03/2013	76512	26	$54.00	$53.85	Alfred, MD, Joe	1223344550

Example 4: TC-only Codes

Steps for arriving at the final allowable for each code shown in **Table N:**

Step 1: As shown in **Table O**, all of the codes have an indicator of 6, which means they are subject to MPPR – diagnostic cardiovascular services.

Step 2: Identify the rates for the billed services, as shown in **Table O**.

Step 3: Order the billed services based on their allowable amount in the fee schedule and identify the primary and subsequent procedures (see **Table P**).

Step 4: Calculate the allowable for the primary procedure (see **Table Q**).

Step 5: Calculate the allowable for subsequent procedures. The TC portion is 75 percent, as shown in **Table R**.

Table N: Billed services and the final allowable

Member Name	Date of Service	Procedure Code	Modifier	Charge	Final Allowable Amount	Provider	NPI
John Smith	04/04/2013	93005	–	$8.00	$7.56	Francis, MD, Joe	1234567890
John Smith	04/04/2013	93017	–	$43.00	$42.68	Francis, MD, Joe	1234567890
John Smith	04/04/2013	93041	–	$5.00	$4.60	Francis, MD, Joe	1234567890

Table O: Fee schedule

CPT® Code	Modifier	PFS	Multiple Procedure Indicator
93005	–	$10.08	6
93017	–	$42.68	6
93041	–	$6.13	6

Table P: Services in order

CPT® Code	Modifier	PFS	Order
93005	–	$10.08	2 – Subsequent
93017	–	$42.68	1 – Primary
93041	–	$6.13	3 – Subsequent

Table Q: Primary procedure allowable

CPT® Code	Modifier	Calculation (Fee Schedule x 100%)	PFS After Reduction
93017	–	= ($42.68 x 100%)	$42.68

Table R: Subsequent procedures allowable

CPT® Code	Modifier	Calculation (Fee Schedule x 75%)	PFS After Reduction
93005	–	= ($10.08 x 75%)	$7.56
93041	–	= ($6.13 x 75%)	$4.60

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Example 5: Global Test-only Codes

Steps for arriving at the final allowable amounts shown in **Table S**:

Step 1: All of the codes have an indicator of 6, as shown in **Table T**, which means they are subject to MPPR – diagnostic cardiovascular services.

Step 2: Billed codes are global codes; you must identify the related PC-only and TC-only codes for the services reported, as shown in **Table U**.

Step 3: Identify the allowable fee schedule amount for related PC and TC codes (see **Table V**).

Step 4: Billed codes are global codes. To find the highest and the subsequent procedures, use the values of the related TC-only codes (see **Table W**).

Step 5: Calculate the allowable for the primary procedure. The primary PC is allowed at 100 percent and the primary TC is allowed 100 percent, as shown in **Table X**.

Step 6: Calculate the allowable for subsequent procedures. The PC-related portion is 100 percent and TC-related portion is 75 percent (see **Table Y**).

Table S: Billed services and the final allowable

Member Name	Date of Service	Procedure Code	Modifier	Charge	Final Allowable Amount	Provider	NPI
John Smith	04/05/2013	93000	–	$16.00	$15.85	Francis, MD, Joe	1234567890
John Smith	04/05/2013	93015	–	$79.00	$78.48	Francis, MD, Joe	1234567890
John Smith	04/05/2013	93040	–	$12.00	$11.88	Francis, MD, Joe	1234567890

Table T: Fee schedule

CPT® Code	Modifier	PFS	Multiple Procedure Indicator
93000	–	$18.37	6
93015	–	$78.48	6
93040	–	$13.41	6

Table U: Identify the codes

Global Code	PC-only Code	TC-only Code
93000	93010	93005
93015	93016, 93018	93017
93040	93042	93041

Table V: Allowable fee schedule amounts

CPT® Code	Modifier	PFS
93005	–	$10.08
93010	–	$8.29
93016	–	$21.44
93017	–	$42.68
93018	–	$14.36
93041	–	$6.13
93042	–	$7.28

Table W: Services in order

CPT® Code	Related TC Code	PFS	Order
93000	93005	$10.08	2 – Subsequent
93015	93017	$42.68	1 – Primary
93040	93041	$6.13	3 – Subsequent

Table X: Primary procedure allowable

CPT® Code	Related PC-only Code	PC Code Rate (A)	Related TC-only Code	TC Code Rate (B)	Calculation (PC only Code x 100%) + (TC Only Code x 100%) (C)	PFS After Reduction
93015	93016 + 93018	$21.44 + 14.36	93017	$42.68	= (($21.44 + 14.36) x 100%) + ($42.68 x 100%)	$78.48

Table Y: Subsequent procedures allowable

CPT® Code	Related PC-only Code	PC Code Rate (A)	Related TC-only Code	TC Code Rate (B)	Calculation (PC-only Code x 100%) + (TC-only Code x 75%) (C)	PFS After Reduction
93000	93010	$8.29	93005	$10.08	= ($8.29 x 100%) + ($10.08 x 75%)	$15.85
93040	93042	$7.28	93041	$6.13	= ($7.28 x 100%) + ($6.13 x 75%)	$11.88

MPPR reductions for the TC of diagnostic cardiovascular and ophthalmology procedures do not apply to services provided prior to Jan. 1, 2013.

Points to Keep in Mind

Billers need to be aware of how the payments are made by payers. It's a good idea to remember the following items while considering payment for these services:

- MPPR reductions for the TC of diagnostic cardiovascular and ophthalmology procedures do not apply to services provided prior to Jan. 1, 2013.
- The highest priced TC is always allowed at 100 percent of the fee schedule.
- The PC of diagnostic cardiovascular and ophthalmology services is not subject to MPPR reduction.
- MPPR is independently applied to diagnostic cardiovascular and ophthalmology services.
- The reduction applies to the TC of global services alone.
- For services subject to the MPPR and the OPPS cap on imaging, the lower of either the MPPR-reduced payment or the OPPS cap is allowed.
- Services performed over multiple sessions and reported with modifier 59 *Distinct procedural service* are not subject to MPPR.
- Global procedure code rates are always the sum of the PC-only code rate and TC-only code rate.

References:

— CMS transmittal 1149 (www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1149OTN.pdf); MLN Matters® MM7848 (www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7848.pdf)

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By Lynn Handy, LPN, CPC, CPC-H, CPC-I, CHC, CCS-P

Renew Your Understanding of Psychiatric Services

Proper documentation for restructured psychotherapy CPT® codes in 2013 is key.

It's well into 2013, and you've been using the restructured psychotherapy codes (90832-90837) for some time. Now is a perfect time to review the new requirements for reporting these services. Are your physicians documenting their services appropriately to ensure proper reimbursement? Let's see.

Don't Worry About Where, Just When

For individual psychotherapy, there are no longer separate codes for inpatient and outpatient settings. These psychotherapy services are face-to-face services with the patient (and/or family member, with the patient present for some or all of the service), described by the following CPT® codes:

90832 Psychotherapy, 30 minutes with patient and/or family member

90834 Psychotherapy, 45 minutes with patient and/or family member

90837 Psychotherapy, 60 minutes with patient and/or family member

The specific time assigned to a code may differ from the actual time the practitioner provided psychotherapy. In general, select the code that *most closely* matches the actual time spent. CPT® provides flexibility by identifying time ranges that may be associated with each of the three codes:

90832: 16 to 37 minutes

90834: 38 to 52 minutes

90837: 53 minutes or longer

Do not bill psychotherapy codes for sessions lasting less than 16 minutes.

When psychotherapy and an evaluation and management (E/M) service are performed during the same encounter, you should instead report the appropriate add-on code in addition to the E/M service code. The add-on codes are:

+90833 Psychotherapy, 30 minutes with patient and/or family member when performed with an evaluation and management service (List separately in addition to the code for primary procedure)

+90836 Psychotherapy, 45 minutes with patient and/or family member when performed with an evaluation and management service (List separately in addition to the code for primary procedure)

+90838 Psychotherapy, 60 minutes with patient and/or family member when performed with an evaluation and management service (List separately in addition to the code for primary procedure)

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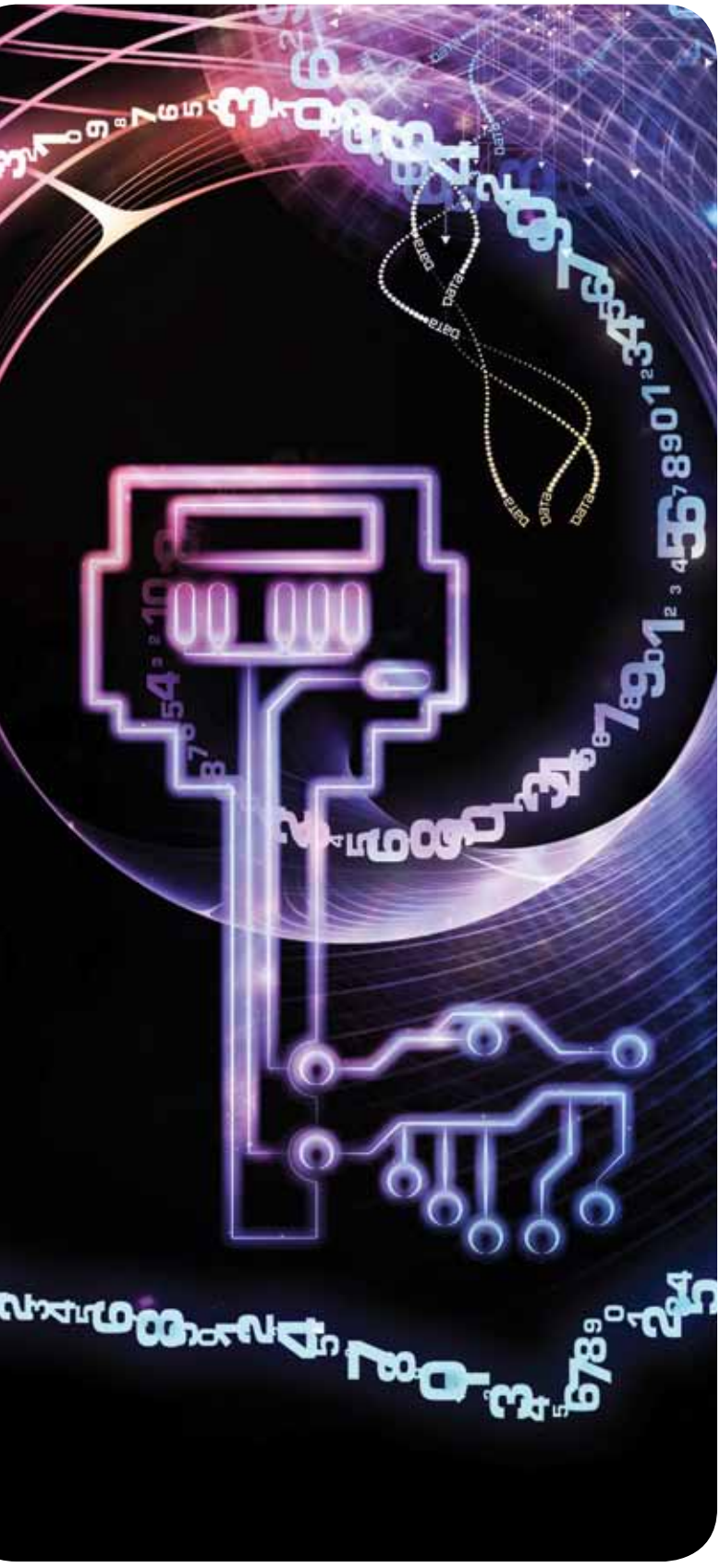

Coding E/M services by time is a common option for psychiatric providers, but should not be confused with psychotherapy time. Most E/M services may be billed by time if over 50 percent of the total time is spent counseling the patient and family and/or coordinating care. It's important to note, however, that if the new psychotherapy add-on codes are reported with an E/M service, the E/M level cannot be selected based on time.

Not All Services Are Billable Time

The time spent arranging for services, providing reports, and communicating with other healthcare professionals is not included in the length of the psychotherapy session. Such activity is considered post-service work, and is already "built into" the psychotherapy codes. This is not new for 2013; these activities were considered post-service work under the psychotherapy codes effective in 2012.

Minimum Documentation Guidelines

For claims payment of psychotherapy services, providers must document at a minimum:

- Date of service
- Time spent with the patient (length of session)
- Specific therapeutic maneuvers used (e.g., cognitive restructuring, behavior modification) to produce therapeutic change
- Clearly documented diagnosis: for each visit and related to treatment and therapy
- Periodic summary of goals, progress toward goals, and an updated treatment plan
- Progress or lack of progress toward the goals stipulated in the individual treatment plan
- Legible provider signature

E/M: No Longer Optional

Prior to 2013, when a medical evaluation was performed at the time of the psychotherapy, the E/M service was included in the psychotherapy service (that is, the E/M was not separately reported). With the introduction of 90832-90837, when an E/M service represents a portion of the work performed at the encounter, the E/M visit becomes the primary CPT® code reported. This requires the provider to determine the appropriate E/M code category and level of service rendered, as supported by documentation, in addition to the elements described above for psychotherapy.

The history of present illness (HPI) is a subjective description of findings from the patient and should not be confused with the psychiatric exam elements.

Because this concept may be less familiar to mental health professionals and their coders, let's explore the documentation requirements for E/M services as it pertains to psychiatric services. Although both the *1995* and *1997 Documentation Guidelines for Evaluation and Management Services* are an option, let's focus on the 1997 guidelines using the psychiatric single organ system exam.

History

There are a few challenges when trying to document the history requirements for psychiatric services. The history of present illness (HPI) is a subjective description of findings from the patient and should not be confused with the psychiatric exam elements.

Four HPI elements are required for a detailed and comprehensive history. Anything less would lower the history element to either problem-focused or expanded problem-focused. HPI must be documented by the provider (not the nursing or support staff) and would resemble something similar to this:

> *The patient complains of severe depression for the past 3 months with a lack of appetite, inability to stay focused at work, and frequent headaches. She has been taking Zoloft for the past 2 months with no improvement.*

The example statement provides at least four HPI elements: severity, duration, associated signs and symptoms, and modifying factors.

The review of systems (ROS) require a minimum of 10 systems for a comprehensive history, but only two systems are required for a detailed history that will support 99203 *Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; Medical decision making of low complexity*, or 99214 *Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity* (level III new patient or level IV established patient).

Don't forget: Patient history forms are a great timesaver and typically include all systems and an inventory of the patient's past, family, and social history (PFSH). To allow credit for the information included on the patient history form, the provider *must* document his or her review of the information. **Table A** is a snapshot of the history documentation requirements.

Table A: A chief complaint is required for all history levels.

History Level	HPI	ROS	PFSH
Problem Focused	1	None	None
Expanded Problem Focused	1	1	None
Detailed	4	2-9	1
Comprehensive	4	10	2 or 3

Exam: Psychiatric Single Organ System (1997 Guidelines)

Although you may use the 1995 or 1997 guidelines to determine the level of the E/M service documented, the examination many mental health providers perform resembles the psychiatric examination in the 1997 guidelines. Choose the guidelines that are most advantageous to the provider, which may differ from encounter to encounter.

Just remember: If the 1997 examination is used to score the exam portion of the visit, the remainder of the visit must also be scored using the 1997 guidelines. Likewise, if the 1995 guidelines are used, they must be used for the entire visit note.

See **Table B** for the number of elements required for each level of the 1997 psychiatric specialty examination.

Table B: The number of elements required for each level of the 1997 psychiatric exam.

Exam Level	Elements
Problem Focused	1-5 elements
Expanded Problem Focused	At least 6 elements
Detailed	At least 9 elements
Comprehensive	All elements from constitutional and psychiatric exam and one element from musculoskeletal

The elements of the "Documentation-psychiatric Exam 1997 Documentation Guidelines" include:

Constitutional

Measurement of any three of the following seven vital signs:

- Sitting or standing blood pressure
- Supine blood pressure
- Pulse rate and regularity

With the increased use of electronic health record systems, the history and exam can become over-documented and may not align with the level of service and medically necessary information to accurately assess the presenting problem.

- Respiration
- Temperature
- Height
- Weight (may be measured and recorded by ancillary staff)
- General appearance of patient (e.g., development, nutrition, body habitus, deformities, attention to grooming)

Musculoskeletal

- Assessment of muscle strength and tone (e.g., flaccid, cogwheel, spastic), with notation of any atrophy and abnormal movements
- Examination of gait and station

Psychiatric

- Description of speech, including: rate, volume, articulation, coherence, and spontaneity with notation of abnormalities (e.g., perseveration, paucity of language)
- Description of thought processes, including: rate of thoughts, content of thoughts (e.g., logical vs. illogical, tangential), abstract reasoning, and computation
- Description of associations (e.g., loose, tangential, circumstantial, intact)
- Description of abnormal or psychotic thoughts, including: hallucinations, delusions, preoccupation with violence, homicidal or suicidal ideation, and obsessions
- Description of the patient's judgment (e.g., concerning everyday activities and social situations) and insight (e.g., concerning psychiatric condition)
- Complete mental status examination including:
  - Orientation to time, place, and person
  - Recent and remote memory
  - Attention span and concentration
  - Language (e.g., naming objects, repeating phrases)
  - Fund of knowledge
  - Mood and affect

Medical Decision-making

Many articles have been written about the importance of medical decision-making (MDM) and the nature of the presenting problem as a driving factor when choosing the level of E/M services. With the increased use of electronic health record systems, the history and exam can become over-documented and may not align with the level of service and medically necessary information to accurately assess the presenting problem. As a result, the industry is seeing more medical necessity reviews initiated by the Centers for Medicare & Medicaid Services (CMS) and other payers.

The three elements of MDM are:

- Number of diagnosis/management options
- Amount of data reviewed/ordered
- Patient risk

For example: An established patient is seen for medication management by a psychiatrist with a history of anxiety disorder, depression, and attention-deficit/hyperactivity disorder (ADHD). The patient states he is doing well on the present medication with no episodes of anxiety or depression. The patient also states he is able to focus and complete tasks at work, and feels that the Ritalin dosage is working. The psychiatrist performs a detailed psychiatric exam. He determines the patient's three chronic conditions are stable, and refills all medications. This encounter supports 99214 (level IV established patient office visit) because the MDM is moderate, with three stable established conditions, and moderate risk (medication management).

Knowledge Is a Powerful Anecdote

The introduction of new psychotherapy CPT® codes and methodology for reporting therapy services as of Jan. 1, 2013 require a renewed understanding of the documentation required for selecting an E/M CPT® code. Over-coding the E/M portion of the service when rendered and not documenting appropriately may lead to increased risk while under-documenting the E/M portion would result in lost revenue. Providers and coders who do not fully understand these requirements should seek additional education to remain compliant when reporting services. CE

Lynn Handy, LPN, CPC, CPC-H, CPC-I, CHC, CCS-P, speaks at various national coding, compliance, and auditing associations. Handy is the senior director of professional coding services at Sinaiko Healthcare, a division of Altegra Health.

Takeaways:

- Codes 90382, 90834, and 90835 combine inpatient and outpatient settings for reporting psychiatric care.
- Assure the provider meets minimal documentation guidelines, remember that not all services are billable time.
- E/M codes are now the primary code reported with these services.

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By Angela Clements, CPC, COSC

Keep Coding Grounded for Gastrocnemius Recession

Check your state's scope-of-practice requirements for podiatrists allowed to treat gastrocnemius equinus.

A change in the scope of practice for podiatric physicians in Louisiana now allows for above-the-ankle treatment—making the Pelican State the 44th state to permit podiatrists to treat at or above the ankle. For patients, the wider scope of practice means not having to be referred to a surgeon for certain treatments, such as a gastrocnemius recession to correct a foot deformity. For podiatrists, it means expansion and growth, but also added responsibility. In particular, podiatrists must know how to document such treatments to ensure compliant coding.

Treating Gastrocnemius Equinus

A gastrocnemius recession is performed on a patient with gastrocnemius equinus (tightness of the calf muscle) to lengthen the calf muscle. The tightness in the gastrocnemius muscle causes the ankle to point downward, meaning the joint cannot dorsiflex (bend up) normally. Gastrocnemius recession lengthens the calf muscle to get the heel on the ground.

When a patient has gastrocnemius equinus, the physician checks the ankle's range of motion with the knee in the bent (flexed) and straight positions. If the patient can normally flex the ankle when in a bent position, a gastrocnemius recession would be indicated. If the patient cannot flex the ankle when the knee is either bent or straight, he or she will have to lengthen the Achilles tendon, 27685 *Lengthening or shortening of tendon, leg or ankle; single tendon (separate procedure)*, or look for a bony block (spur), 28120 *Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (eg, osteomyelitis or bossing); talus or calcaneus*.

The problem with lengthening the Achilles tendon is that it weakens the plantar flexion strength. Podiatrists prefer not to lengthen the Achilles if other options are available to maintain muscle strength.

Gastrocnemius Recession Techniques Advance

Gastrocnemius recession traditionally has been (and sometimes still is) performed as an "open" procedure using a T-shaped incision (some surgeons perform the procedure with a reverse T-shaped incision). Reporting an open gastrocnemius recession is straightforward: 27687 *Gastrocnemius recession (eg, Strayer procedure)* properly describes the procedure.

Photo by iStockphoto/© DKart

There isn't a specific CPT® code to report EGR, so you must report the procedure using 29999 *Unlisted procedure, arthroscopy*.

As medicine advances, so have treatment options for the gastrocnemius recession procedure. A scope similar to the one used for carpal tunnel endoscopic surgery was developed for an endoscopic gastrocnemius recession (EGR). This scope allows surgeons to perform the procedure endoscopically, with smaller incisions.

The surgeon cuts through the fascia to expose the underlying muscle. The gastrocnemius is separated from the soleus muscle and a gap is left in the fascial segments to lengthen it. Compared to an open procedure, endoscopic surgery is minimally invasive, which allows for a quicker recovery time. The patient can bear weight in a cast boot.

There isn't a specific CPT® code to report EGR, so you must report the procedure using 29999 *Unlisted procedure, arthroscopy*. Coders often hesitate to use this code because of the wording of its descriptor (i.e., the use of "arthroscopy" rather than "endoscopy"). The November 2008 *CPT® Assistant* clarified that this unlisted code is appropriate, however, stating:

> *"There is no specific CPT code to describe endoscopic gastrocnemius recession. This procedure should be reported using code 29999 ... While code 29999 uses the term 'arthroscopic' and the joint space is not entered, code 29999 is located in the section for arthroscopic or endoscopic procedures of the musculoskeletal system and is intended to include unlisted endoscopic services."*

Tip: To claim endoscopic plantar fasciotomy, another common podiatric endoscopic procedure, report 29893 *Endoscopic plantar fasciotomy*.

Although most states now allow podiatrists to treat above-the-ankle, some states do not. Be sure to consult your state's scope-of-practice requirements before making the leap into gastrocnemius recession.

Author's note: Special thanks to **Daniel Hake, DPM**, for assisting with the clinical information in this article.

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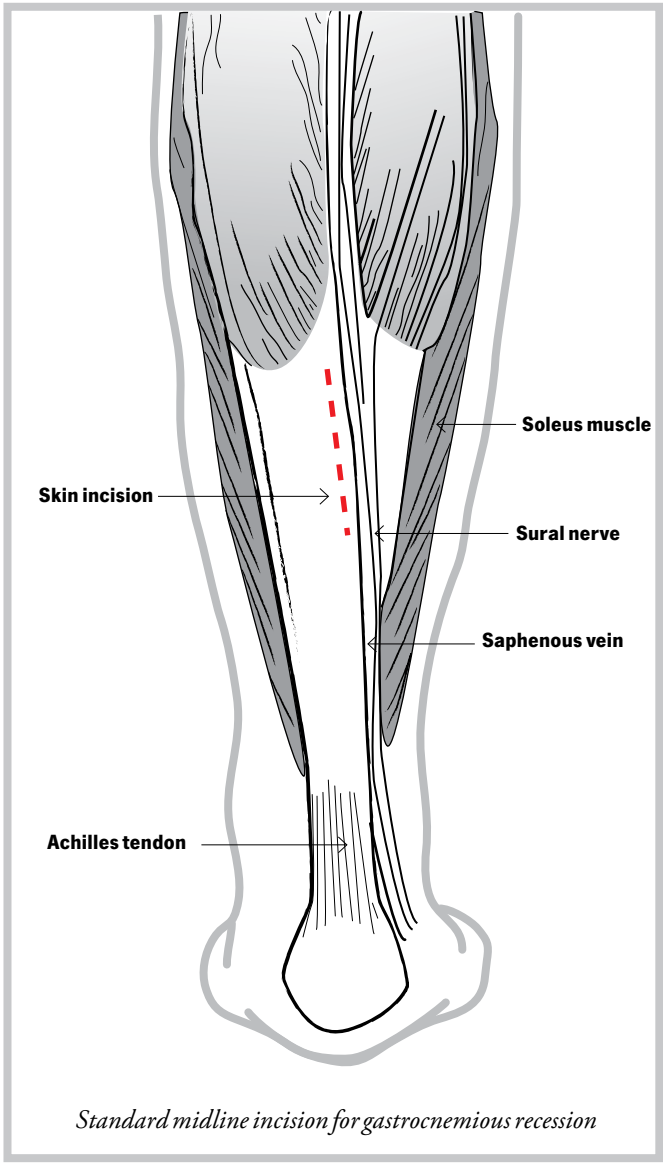

Standard midline incision for gastrocnemious recession

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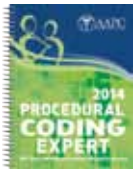

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By Marilyn Holley, CPC, CPC-I, CHISP, RHIT

Prompt Proper Assistant-at-surgery Payment

It's as easy, or as hard, as 1, 2, 3.

Successful coding and billing for surgical assistants depends on three principal factors:

1. Does the payer allow additional reimbursement for surgical assistance for the reported procedure?
2. Has the surgeon sufficiently documented the need for and role of the surgical assistant?
3. Has the proper modifier been appended to the claim?

Here are some tips and techniques for ensuring your assistant-at-surgery claims prompt proper payment.

Not All Surgeries Merit Assistance

Just because a surgeon recruits an extra pair of hands to help during a surgical procedure doesn't mean the payer will reimburse the assistant's efforts. Surgical assistance must be deemed *medically necessary* (per the payer's standards) to warrant additional payment.

Medicare specifies the procedures for which it allows additional payment for a surgical assistant, as identified by the "ASST SURG" column of the Medicare Physician Fee Schedule (MPFS) Relative Value File. If Medicare does not allow payment for an assistant at surgery, you cannot charge the patient, even if using an advanced beneficiary notice (ABN).

Indicators you might see in the ASST SURG column are:

2 - Medicare will pay for an assistant at surgery for that particular code.

0 - Medicare might pay for an assistant at surgery if documentation substantiates medical necessity.

1 - An assistant at surgery will not be paid.

9 - The concept of assisted surgery does not apply (i.e., Medicare will not pay for an assistant at surgery).

Table A (on the next page) shows several codes and their assistant-at-surgery indicators, which are from the most recent PFS Relative Value File.

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Just because a surgeon recruits an extra pair of hands to help during a surgical procedure doesn't mean the payer will reimburse the assistant's efforts.

Third-party payers designate their own guidelines, or may stipulate limitations on assistants at surgery by contract.

Table A

CPT®	Short Descriptor	ASST SURG Indicator
32609	Thoracoscopy w/bx pleura	0
48500	Surgery of pancreatic cyst	2
55000	Drainage of hydrocele	1
65760	Revision of cornea	9

Resource: You may download the PFS Relative Value File free from the Centers for Medicare & Medicaid Services (CMS) website: www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html. All files are dated. Be sure to choose the most recent file, and check back quarterly for updates.

Medicare has established straightforward criteria to determine which codes are eligible for assistant-at-surgery reimbursement. Per the Medicare *Claims Processing Manual*, chapter 12, section 20.4.3, "Contractors may not pay assistants-at-surgery for surgical procedures in which a physician is used as an assistant-at-surgery in fewer than five percent of the cases for that procedure nationally."

Third-party payers designate their own guidelines, or may stipulate limitations on assistants at surgery by contract. The best bet with these payers is to seek pre-authorization to ensure an assistant will be reimbursed for his or her effort in the operating room.

Don't Confuse Co-surgeons with Assistant Surgeons

If two or more surgeons work on the same patient during the same session, the second surgeon is not necessarily "assisting" the first. For example, when two surgeons work together as primary surgeons, each performing distinct parts of a procedure (e.g., co-surgeons), both surgeons should report the (same) appropriate CPT® code describing the procedure, and append modifier 62 *Two surgeons*. Each surgeon must document a separate operative report describing the work he or she performed. By contrast, an assistant at surgery does not document his or her own procedure note.

Documentation Must Support Medical Necessity

Documentation must establish medical necessity for all cases when a surgical assistant is used. Although a payer might not request documentation when a claim is filed, and might choose to pay a claim without review, you shouldn't file a claim without documentation to support it. An operative note detailing the need for services rendered is not just a coding and reimbursement requirement, but also a compliance and ethical requirement.

The surgeon should specify in the body of the operative report what the assistant actually did. It's insufficient to simply list the assistant's name. The surgeon should clearly explain in the "indications" paragraph of the note why an assistant was necessary, and that he or she was involved in the actual performance of the covered surgical procedure, and not simply there to perform other ancillary services.

Coders should inform physicians of the documentation requirements for reporting assistant-at-surgery services. It's not always easy communicating with physicians, but the alternative is lost reimbursement, which can occur again and again if not corrected.

Remember: When the surgeon signs an operative report, it becomes a legal document that cannot be altered. If necessary, however, the surgeon may dictate an addendum to his or her documentation, and the claim may be resubmitted.

Provider Type and Extent of Assistance Determines Modifier

You've determined the payer allows reimbursement for an assistant at surgery, and you've verified documentation establishes medical necessity for the same. The next factor to consider when preparing the claim is proper reporting. With three CPT® modifiers and a HCPCS Level II modifier to describe various assistant-at-surgery scenarios, this is where the real fun begins for most coders.

The first step is to know your payer. The instructions and examples below are based on national Medicare guidelines. For third-party payers, you may use the advice below as a general guideline, but be sure to check your contracts or inquire with the individual payer to determine which modifier you should use in a particular situation.

If two or more surgeons work on the same patient during the same session, the second surgeon is not necessarily "assisting" the first.

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Modifier 80 *Assistant surgeon*: Modifier 80 identifies services provided by a surgical assistant who is a medical doctor. Append this modifier only to the primary surgical service.

For example, an assistant surgeon frequently is used during arthrodesis surgery. The assistant helps to hold the vertebrae in place and assist in harvesting and placing the bone graft. In such a case, the primary surgeon might report 22610 *Arthrodesis, posterior or posterolateral technique, single level; thoracic (with or without transverse technique)*, while the assistant surgeon would report 22610-80.

For assistant-at-surgery services performed by physicians, the fee schedule amount equals 16 percent of the amount otherwise applicable for the surgical payment.

Modifier 82 *Assistant surgeon (when qualified resident surgeon not available)*: Append modifier 82 only in a teaching hospital setting and only if a qualified resident is not available to assist during surgery.

Per the *Claims Processing Manual* (chapter 12, section 100.1.7), Medicare does not pay for assistant-at-surgery services furnished in a teaching hospital that has a training program related to the medical specialty required for the surgical procedure, unless:

- A qualified resident surgeon was not available.
- Medical staff determined exceptional circumstances justified the services of an assistant at surgery, even though a qualified resident was available.
- The primary surgeon has an across-the-board policy of never involving residents in the preoperative, operative, or postoperative care of his or her patients.

For example, a lung hernia through the chest wall needs immediate repair in a teaching hospital setting. The residents on call are assisting in another procedure, and a second thoracic surgeon assists the primary surgeon. In this case, the primary surgeon reports 32800 *Repair lung hernia through chest wall*, while the assistant surgeon reports 32800-82.

The assistant surgeon should document clearly in the operative report why a resident was not involved in the case. You may also use Box 19 on the CMS-1500 form to indicate why a resident did not provide assistance during the surgery.

Modifier AS *Physician assistant, nurse practitioner, or clinical nurse specialist services for assistant at surgery:* Use this modifier for Medicare if a physician assistant (PA), nurse practitioner (NP), or clinical nurse specialist—rather than a medical doctor or doctor of osteopathic medicine—assists during a surgical procedure. Section 110.2 of the *Claims Processing Manual* stipulates:

> *"… when a PA actively assists a physician in performing a surgical procedure and furnishes more than just ancillary services, the PA's services are eligible for payment as assistant-at-surgery services … the actual payment amount that PAs receive for assistant-at-surgery services is 13.6 percent of the amount paid to physicians.… The AS modifier must be reported on the claim form when billing PA assistant-at-surgery services."*

Modifier 81 *Minimum assistant at surgery*: Modifier 81 describes minimal assistance during surgery by another physician. Payers may also allow modifier 81 to report a second physician in the operating room for a small, selective portion of a particular procedure (such as opening and closure only).

Medicare payers generally do not recognize modifier 81 for payment, and CMS does not include modifier 81 in the PFS Relative Value File. Whereas you should never use modifier 81 to indicate a non-physician (e.g., PA or NP) assisting at surgery for Medicare, some third-party payers (who don't recognize modifier AS) may accept modifier 81 for this purpose. CE

Marilyn Holley, CPC, CPC-I, RHIT, CHISP, is AAPC's director of education.

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

By Lanaya Sandberg, MBA, CPCO

PCPs in Line for Higher Medicaid Payments

A final rule puts Medicare and Medicaid on a level playing field for certain primary care.

The Centers for Medicare & Medicaid Services (CMS) published a final rule last fall mandating payers reimburse qualified healthcare providers for certain primary care services rendered to Medicaid enrollees at rates not less than the Medicare rates for 2013 and 2014, using the 2009 Medicare Physician Fee Schedule conversion factor. Fees for the administration of vaccines under the Vaccines for Children program have been updated, as well.

This rule is important because Medicaid reimbursement has always been significantly less than that for Medicare. Primary care physicians (PCP) may now benefit from an increase in Medicaid reimbursement.

PCPs Score

The accessibility of primary care is especially important for Medicaid enrollees. As the United States moves closer to Medicaid expansion in 2014, there must be an appropriate number of PCPs who accept Medicaid enrollees. A goal of this rule is to encourage PCPs to participate in Medicaid by increasing reimbursement. This rule provides the opportunity to improve clinical outcomes and quality while reducing overall healthcare costs through more efficient coordination of care.

Effective Date

The provisions of this rule were effective Jan. 1, 2013, but states had until March 31, 2013 to file a state plan amendment with CMS. Regardless, payers are required to adhere to the effective date for claims payment. For example, if a payer updates its claims system with the new rates in July 2013, the payer will have to reprocess claims or issue a settlement check retroactively to include dates of service on or after Jan. 1, 2013.

Primary Care Services

The applicable codes for the affected primary care services are:

- Evaluation and management (E/M) codes 99201-99499; and
- Vaccine administration codes 90460, 90461, 90471, 90472, 90473, and 90474.

Qualified Providers

This rule applies to providers with a specialty of family medicine, general internal medicine, pediatric medicine, or a subspecialty within these specialties accepted by the American Board of Medical Specialties, American Board of Physician Specialties, or the American Osteopathic Association. Providers must self-attest that they are board certified and/or have provided E/M services and vaccine administration accounting for at least 60 percent of the codes they have billed for their Medicaid patients.

Exception: This rule is not applicable to federally qualified health centers and rural health clinics.

What Do Providers Need to Know and Do?

To ensure proper Medicaid payments, PCPs should become familiar with this rule and ensure compliance officers or compliance contacts and counsel are educated in its requirements.

More good advice:

- As states have various options for implementing the requirements of this rule, research the approach your state has chosen to pursue; and
- Reach out to the payers with which you are contracted and ask them when they intend to load the updated rates in their claims systems, and when they will be reprocessing claims. Request a copy of their written policies relative to this rule. Keep in mind: These requirements also apply to payers with which you are not contracted, so you should reach out to them, as well.

If you are interested in learning more about this rule, refer to RIN 0938-AQ63 in the *Federal Register* at: https://federalregister.gov/a/2012-26507. CE

Note: The views and opinions expressed in this article are those of the author and do not reflect the official policy or position of any organization. The information contained in this article is to alert you to compliance developments and should not be considered legal advice.

Lanaya Sandberg, MBA, CPCO, is a network manager and responsible for national provider and vendor contracting.

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By Leonta Julien-Williams, CPC, CCS, RHIT

Know What an EHR Says About Your Doctor

Documentation tells a story; make sure the main character is the patient, not the physician.

The electronic health record (EHR) has made it easier for patients to access and monitor their health information. I'm sure you're aware of the type of information found in a patient's EHR—from basic demographics and current medications, to diagnoses and treatment history. But what does a patient's EHR say about his or her physician?

Physicians should be aware their documentation tells a story about them just as much as it does their patients. See if your physicians can be "summed up" by one of the following descriptions. If so, now is the time to make them aware of their role in the EHR.

Careless, MD

Spelling errors seem more apparent when seen on a computer monitor versus a handwritten note. Imagine reading five consecutive progress notes from five different dates of service and identifying the exact same incorrect spelling of a word or words on each note. This is apt to prompt questions, such as:

- Did the physician really complete the progress note for that specific date of service?
- Did he or she really see the patient on that specific date of service?

These are just a couple questions the Office of Inspector General may ask during an audit.

As a patient, I would really be annoyed if I was referred to as "him." I would like to think my physician knows me pretty well.

Impersonal, MD

Using "he" or "she," or "him" or "her," interchangeably to describe a patient makes it seem as if the physician does not know the patient. Have you ever read through a record and noticed Mrs. Jane Doe was referred to as "him," or Mr. John Doe was referred to as "she?" As a patient, I would really be annoyed if I were referred to as "him." I would like to think my physician knows me pretty well.

Pill Pusher, MD

Some EHRs have the capability to automatically insert a medication refill into the note at the appropriate time. The problem with automatic refills is the lack of documentation from the chief complaint to the assessment, supporting the need for that medication (whether it is a new prescription or a refill). Physicians should also be careful with the way they document a prescription. For instance, an auditor will see red flags if a patient presents with no complaint of pain, a pain scale showing 0/10, and no pain diagnosis for that encounter, but there are prescriptions on that date of service for percocet and hydrocodone.

Faltering, MD

Coders inherently pay very close attention to documentation, so they notice things such as contradictory information in an EHR. For example: A physician documents on a single date of service, "PMH: Allergic to penicillin" and "HPI: Mrs. Doe has no prior history of allergies." From the opening remarks (chief complaint) to the history of present illness, review of systems, physical exam, and assessment, the information doesn't jibe.

Lobbyist, MD

The EHR should reflect information about the patient. You should not read an encounter note and immediately recognize which political party the physician is affiliated with. Advise your physician to refrain from documentation such as "patient will get insurance coverage when President _____ allows her to" or "patient would benefit from stem cell research, but our current president does not agree." This type of documentation is inappropriate. The patient's EHR is not the platform to express personal opinions. There are medical boards and other resources available for this type of conversation.

The EHR may tell as much about the physician as it does the patient. Don't allow your physician to fall into any of the categories above. The EHR is a legal document. In an audit or a lawsuit, documentation should be your best defense, not evidence to be held against you. Patients deserve and expect the information in their record to be correct and useful.

Leonta Julien-Williams, CPC, RHIT, CCS, has worked in the healthcare industry for the past 10 years. She has worked as a coder, auditor, and educator. She is a member of the Greater Atlanta, Ga. chapter of AAPC.

By Judy A. Wilson, CPC, CPC-H, CPCO, CPC-P, CPPM, CPC-I, CANPC

Don't Cross the Lines of Professionalism in

Used wisely, providers can take advantage of social media benefits.

Takeaways:

- Social media is a great tool for providers, when used correctly.
- Inappropriate use of social media poses several risks.
- Include the whole staff in your social media plan to ensure compliance.

Because social media is a staple in the average household, a growing number of healthcare providers are using it as a marketing tool, among other things. This technology doesn't come without challenges, however. Here's a quick review to help you avoid common pitfalls.

What is Social Media, and How is it Used?

Social media is any web-based communication interface used to share or exchange information, including videos or audio messages. Facebook™, YouTube, Linked in®, and Twitter™ are just a few social media tools.

Many providers have incorporated social media into their practices to educate patients and to collect pre-visit review of systems (ROS) information. Social media also can effectively generate business and interest in a provider's services.

While social media can help to create a more personal medical experience, providers must observe strict policies when using it. The Internet is full of individuals trying to pass themselves off as legitimate medical providers, looking to profit from unsafe or ineffective treatments, or even fraudulent medical schemes that can harm patients. Professionalism is important in regards to compliance, patient satisfaction, and credibility.

What NOT to Post Online

What you post online creates a near-permanent record that will follow you wherever you go. **Warning:** Courts have said you do not own what you post on a website—the website owns it. When you post to social media, you no longer control your own words. When in doubt, don't post.

When using social media, keep the following in mind:

Providers must be careful not to violate patients' privacy rights. Never post online anyone's protected health information (PHI). Ever. Providers need to use security settings, so only those with security access can see a patient's PHI. In other words, access to information on the Internet should work the same as in the office—on a "need to know" basis only.

Be careful how much medical advice or opinion you provide online, for several reasons:

- Comments made or advice given on a social media site could be misconstrued. There is a potential for liability from patients who misread or misapply information a provider posts online.

Patients may become angry if they post comments or questions on your social media sight and don't receive a response in what they consider to be a timely fashion.

- Without seeing the patient, the provider can't accurately determine the nature of the patient's problem or that the patient understood the medical advice.
- If a patient from another state posts a question on your practice's website, and the provider gives medical advice, is he or she now practicing without a license? I am not an attorney, but I do know that a license to practice medicine is issued and controlled by each state's medical board. A provider is subject to a criminal offense if it's determined that he or she is practicing without a license for that state.
- State medical boards can also initiate an investigation if a patient complains and the board believes it's valid. **Remember:** When you post something on a social media site, assume it's there forever.
- An employee who is not aware he or she is actually giving medical advice may end up crossing the line. This will leave the employee and the provider exposed to liabilities if there is a negative outcome from what was posted.
- Anyone can use a website against a provider, and it's very easy to obtain evidence of misconduct if it has been posted online. It's very difficult to defend against something permanently posted online.

Don't be offensive. Avoid profanity, discriminatory remarks about another provider or practice, incorrect or misleading comments, and sexually suggestive remarks or materials.

Make Everyone Accountable

Patients may become angry if they post comments or questions on your social media site and don't receive a response in what they consider to be a timely fashion. Avoid this by monitoring your social media sites regularly and by having clear policies in place against dispensing specific medical advice online.

Warning: If you allow comments on your sites, you are likely to get some negative remarks. The plus side is that negative feedback is sometimes your best indicator of problem areas or needed improvements in your practice. The real problem comes from "anonymous" comments, where the practice is unable to contact the commenter to make amends (or verify the validity of the complaint). To combat this, consider requiring users to register on the site before they can post comments. This makes the user responsible for his or her comments and allows the practice the option to contact the user, if necessary.

Do not hire someone to make comments about your practice. There is a line between marketing and fraud; it's inappropriate to pay someone to make favorable comments about a provider or his or her practice on a physician rating website.

Get Your Staff Onboard

Social media is here to stay; providers need to incorporate effective social media policies into their compliance plan. Training is the most important part. Providers need to recognize that their actions online can negatively affect their professional reputation and medical career. Make sure there are safeguards to protect your practice.

Put in place a policy for using smartphones, cameras, and other devices in the workplace, and another policy specifically addressing the use of social media by providers and other clinical staff. Good advice is not to allow any employee's smartphone in the office during working hours. It's way too easy to use a smartphone to take a picture of patient PHI or other private information, which could then end up somewhere on the Internet.

There are very specific federal rules a business must follow if a PHI breach involving more than 500 individuals is detected. Employees should be made aware that it's a requirement to immediately report a breach to their compliance office, no matter who is responsible, even if it involves a supervisor. Your compliance office will then confirm the breach, and take the necessary steps.

All employees, including physicians, must be trained on these policies to ensure they know what actions will be taken if social media is misued at work.

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By Julia Croly, MPA, CPC, CPC-P, CPC-I

Do the Math: Relative Value, Resource Use, Reimbursement

Know how insurers account for physician payment.

Takeaways:

- Insurers use various fee schedule systems, but there are basic building blocks common to all.
- RVS assigns a weighted unit value to a CPT® code based on the cost and intensity of the service.
- RBRVS bases payment for physician services on the relative cost of the resources required to provide them.

A fee schedule is the maximum fee determined as acceptable by the payer for a procedure or service, and which the provider agrees to accept as payment in full. It may also be called a fee allowance, fee maximum, or capped fee. Regardless of what you call it, it's important to know how payments are calculated, and to be sure payments are both competitive with other insurance carriers and equitable for your geographic location.

Insurers use various fee schedule systems, but there are basic building blocks common to all. The first step to making sure your practice is being appropriately compensated is to review the type of system an insurer uses. Let's take a look at the two most commonly used systems.

Relative Value Scale Payment Systems

A relative value scale payment system assigns a weighted unit value to a CPT® code based on the cost and intensity of the service. The weight is multiplied by a conversion factor to determine the fee the insurer will pay the provider. The conversion factor is typically based on historical cost experience, and is updated periodically to reflect growth in actual expenses. Services requiring greater resources are assigned a higher number of units and a higher fee.

Example: Assuming the conversion factor is negotiated to be $20 per unit, a service that is assigned a unit value of 30 will be reimbursed at $600 (30 units x $20 per unit).

Procedures such as surgeries and diagnostic testing have higher unit values than cognitive services, such as office visits.

Resource-based Relative Value Scale (RBRVS)

The RBRVS was developed in 1991 by the Health Care Financing Administration (HCFA), now the Centers for Medicare & Medicaid Services (CMS), as a mechanism to address the shortcomings of a relative value scale in assigning a unit value. It attempted to account for all of the resources providers use to deliver care: physical or procedural, education, cognitive, and financial. Simply put, the concept behind the RBRVS is to base payment for physician services on the relative cost of the resources required to provide them.

Under the RBRVS, the payment for each procedure code is the product of three factors:

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The concept behind the RBRVS is to base payment for physician services on the relative cost of the resources required to provide them.

- **Nationally Uniform Relative Value Units (RVUs)**. The RVU for each procedure code has three components: one for physician work, a second for practice expense, and a third for malpractice. Each RVU is a number that quantifies the sophistication and resources necessary to perform the procedure.
- **A Geographic Adjustment Factor**. Each of the RVU components (work, practice, and malpractice) is adjusted by a geographic practice cost index (GPCI). GPCIs were employed to account for variation in costs in different parts of the United States. GPCIs reflect the relative costs of the physician work, practice expense, and malpractice insurance in each fee schedule area compared to the national average.
- **A Nationally Uniform Conversion Factor**. The conversion factor is a dollar figure used to convert the geographically adjusted RVU to a payment amount. Originally, HCFA used three different conversion factors to derive fees. One factor was used for surgical services, one for non-surgical services, and yet another for primary care. Each procedure code was classified into one of these three types of services. In some instances, HCFA defined surgical and non-surgical services differently than CPT®. In CPT®, codes 10000-69999 are classified as surgical. In the 1990s, HCFA classified approximately 350 of the codes in this range as non-surgical. Over time, this dilemma has been overcome, so there is now a single conversion factor used to calculate billing for all services.

Under RBRVS, the general formula for determining the fee schedule amount for a given procedure code is:

[(RVU work x GPCI work)
+ (RVU practice x GPCI practice)
+ (RVU malpractice x GPCI malpractice)]
x Conversion Factor
= Provider Payment

The RBRVS system has historically presented shortcomings. Originally developed for Medicare, not all procedures (such as childhood immunizations) had assigned RVUs. HFCA also did not assign units to anesthesia. To fill the gaps, other stakeholders (such as McGraw-Hill, St. Anthony's, Medicode, and the American Society of Anesthesiologists) researched and published recommended units.

Regardless of the method chosen, insurers need to give the provider information regarding the source of units and the conversion factor, as well as their method for updating the conversion factor.

Determine Whether Negotiating Is Warranted

Although RVUs and GPCIs are seldom bargaining areas, providers may want to negotiate conversion factors with their insurers. When establishing a conversion factor for primary care, the complex, cognitive ability required for the primary care providers to diagnose, prescribe, and coordinate treatment for patients with multiple problems may be considered.

RBRVS Benefits

The industry advantages to RBRVS are cost control and easier use and maintenance. In today's consumer-driven age of healthcare, fee schedules provide patients with a simplified basis for comparing health plans. Fee and payment comparisons under new consumer-directed health plans further introduce a competitive and cost-containing influence into the healthcare system.

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Did You Know?

On July 30, 1965, President Lyndon B. Johnson signed the Social Security Act, which established both Medicare and Medicaid. The Health Care Financing Administration (HCFA) was established in 1977 by the Department of Health, Education, and Welfare (HEW). HCFA became the Centers for Medicare & Medicaid Services (CMS) in 2001. According to *Emergency Medicine News* (September 2001, vol. 23, issue 9, p. 24), "Another name that was under consideration, the Medicare and Medicaid Administration, was rejected for fear that its acronym, MAMA, would be considered insulting to women and paternalistic to all."

By Marcia Brauchler, MPH, CPC, CPC-H, CPC-I, CPHQ

Contract Negotiation

More Strategies to Help You Master Contract Negotiations

Use strategies five through 10 to achieve optimal payer negotiations.

Because negotiating is a difficult skill to master, I've compiled 10 lessons I learned the hard way and condensed them into simple strategies. Last month in "Four Strategies to Help You Master Contract Negotiations" (pages 44-47), we focused on strategies one through four. We'll continue this month strategies five through 10. Use them well and you'll have an extra edge during your next payer contract negotiation.

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Strategy No. 5: Read the Contract in Detail

If you've skimmed the draft contract and the proposed rates are sufficient to continue discussion about that version of the agreement, you're ready to read every word of the contract. If the rates are unacceptable, however, forget about the language until you get a rate exhibit that makes reading the contract worth your time and effort.

To stay focused on what you established as important initially, be sure to use the checklist of relevant points you created (Strategy No. 3: Make a Checklist of Key Terms). Don't get carried away on words or definitions that you originally decided weren't important.

List your areas of concern with the agreement. If you don't understand a phrase or the concept being conveyed by a section, note it. Do not make an assumption. Question everything until it's resolved to your satisfaction, and so you can interpret the phrase in layperson terminology for other staff to understand. If you're negotiating on behalf of another party, they'll expect you to know the meaning behind each phrase in the agreement.

Strategy No. 6: Prioritize Your Needs (Contract Language Changes)

Ask yourself these questions as you prepare for negotiations:

- What facts must be verified?
- What are the deadlines and timeframes for the negotiations?
- What are the deadlines and timeframes for the contract implementation? If you are opening a new practice, you are in no position to insist on new rates; you need any agreement in place by the effective date. If this is the case, your negotiation strategy might be to agree to a short-term agreement (e.g., 90 days). You can take the time to finalize better terms after the practice opens.
- Which terms and clauses in the contract need to be clarified?
- Which terms are negotiable and which are non-negotiable?
- What are the personalities of their negotiators?

Never assume the red-lined agreement contains all of the changes agreed on up to that point.

- What do they want?
- What are your acceptable ranges on rates? What are, most likely, their ranges?
- What are the counteroffers that can be anticipated?
- How can we support our arguments? (For example, consider these arguments to support a pure cost-of-living increase: rent increases, malpractice premium increases, or your own health insurance premium increases with that payer since the contract went into effect originally.)
- What items do you agree with before the negotiations begin?
- Should a physician or an executive be at the negotiation? If so, should he or she be present for the whole negotiation, or just the beginning or end?
- Who will record the terms of agreement during the negotiation? It's OK to have a "parking lot" of issues you don't agree on. The "scribe" should simply write the issue(s) down, so the negotiations can move on. If it's documented well, you can return to the topic when passions cool.
- Does our negotiator have limited or full authority to bind our organization?
- Does their negotiator have limited or full authority to bind their organization?
- Who needs to ratify the terms of the agreement at the practice and for the payer?

Strategy No. 7: Ask for Everything

Create an agenda for the negotiation. The person or party who offers the agenda controls the negotiation. Timing is the most important element in the negotiation process. To capitalize on time management, you must have your own deadlines and understand the other party's deadlines. Bad decisions are made in haste at the 11th hour, which can be to your advantage or disadvantage.

An agenda might include:

- Introduce both parties' representatives.
- Request basic payer introduction information (Strategy No. 2: Assess Your Position and the Payer's).
- Present your practice's data, referring to your Health Plan Proposal letter (see "Contracts: Write Health Plan Proposal Letters with Value," *AAPC Cutting Edge*, May 2013, p. 52-53).
- Ask for what you want.
- Listen to the payer's response and explore all options.
- Document interaction, tasks, and assigned due dates, and determine who is responsible.
- Summarize what was discussed.

Strategy No. 8: Endure the Negotiation Process

Keep your stakeholders apprised of the negotiations. You run a huge risk if your stakeholders are not in the loop. Some health plans attempt to derail negotiations by going around you to the party you represent.

This derailment can actually help you if your party is educated about the deal points and the status of negotiations—it will show you are united in your beliefs, even when caught off guard—or it could work against you, if you are unsuspecting and ill-prepared. The person contacted may be flattered to be perceived as the "real" decision-maker, and may succumb to making a deal without knowledge of all points being considered.

Strategy No. 9: Finalize the Contract

After negotiations are complete and a final version of the agreement is issued for signature, compare the final draft to the exact text you desire. Never assume the redlined agreement contains all of the changes agreed on up to that point. You have no recourse after the contract is signed, so be sure all changes are in the final draft and that no "new," last-minute changes were made to advantage the other party.

Initial each page, including attachments, so no one can claim to

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Most terminations require a 90-day notice, which starts the clock ticking for a renegotiation.

have not seen a page of the agreement. For example, a health plan once claimed the third page of the exhibit containing reimbursement information was not part of their version of the final contract. The signer's initials were absent on the copy of that last page, so we could not prove otherwise. The terms of that page would have significantly advantaged our party, but our only recourse was to renegotiate the issue. In the end, we had to compromise our position to get the deal finalized.

It is customary to have two copies of the agreement for signature. After each party has executed the agreement, each will have an original version. Retain your copy in an easy-to-find location, in a folder or file that is well marked so anyone can easily identify the agreement.

Strategy No. 10: Know When to Walk Away

If you must terminate a payer agreement, the best time to get the most effect would be before open enrollment, which begins Oct. 1 for most employer groups. A termination notice to the payer in April through August will be noticed. Most terminations require a 90-day notice, which starts the clock ticking for a renegotiation. For your practice to be included in the payer's in-network directory, you'll need to be contracted with the insurer by Oct. 1. If you terminate at any other time, you'll be considered out-of-network. This is bad news for your patients, who will more than likely be unable to change insurance plans so they may continue seeing your physician in-network until the next open enrollment, and will be charged more for seeing an out-of-network physician.

Next installment: We will discuss ways to monitor the implementation of the new agreement terms to make sure your work is translating into real rate improvements for the practice.

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Why Are You a Coder?

AAPC Cutting Edge wants to know why you chose coding as a profession. Tell us why you're a coder, how you got to where you are, and your future coding goals. Send your inspirational coding success stories to AAPC Executive Editor Michelle Dick (michelle.dick@aapc.com).

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By Michelle A. Richards, CPC, CPMA

Make the Most of Patient Complaints

Find value in dissatisfied customers.

Takeaways:

- Complaints by patients offer an excellent opportunity for improvement.
- Using the LAST model, invite the patient to a private area to learn more about the situation.
- Track and re-evaluate processes.

Photo by iStockphoto/Brandy Taylor

Practice managers wear many hats, from overseeing daily operational activities to optimizing revenue. For many practice managers, handling patient complaints is a least favorite part of the job. But consider this: In most cases, a patient will not leave the practice due to a complaint, but rather the way it was handled.

Consider Complaints Carefully

An effective practice manager creates a work environment that values complaints as a means of strengthening the practice and improving patient relations. In other words, you should greet complaints as opportunities, rather than liabilities.

An effective complaint-handling system should embrace the principles of fairness, accessibility, responsiveness, efficiency, and integration (effectively adopting new protocols, etc.). One simple model to consider when handling complaints is LAST:

- **L**isten to the patient
- **A**pologize for not meeting his or her expectations
- **S**ervice the patient
- **T**hank the patient

Managers or other staff handling complaints must be skilled and professional at all times. No exceptions. It's extremely important to remain calm and de-escalate situations, especially when dealing with an irate patient. If the patient is complaining in the waiting room, he or she should be asked to move to a private office so as not to disturb other patients.

Use Tracking to Isolate Problem Areas

Always track patient complaints. You may be surprised to find patterns, such as complaints consistently directed toward or stemming from:

- The same provider
- The same employee(s)
- The same situation (not getting results, orders, prescriptions)
- The same time of day
- The same day of the week

Information about complaints should be examined as part of a continuous process of organizational review and improvement. The longer a trend continues, the more difficult it becomes to hold accountable those responsible. Tracking allows you to identify and correct potential problem areas early. Unfortunately, many managers wait until they have an influx of complaints, and it may be too late to perform recovery. The rule of thumb is if more than one person has complained about the same issue, review the process.

Prepare for Occasional Failure

How you handle complaints relates directly to patient outcomes. Patients are more informed, and they know how competitive healthcare has become. Put a process in place for handling complaints to reassure patients the practice is committed to resolving problems and improving processes. In doing so, you will build loyalty and efficiency in your practice. CE

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An effective practice manager creates a culture that values complaints as a means of strengthening the practice and improving patient relations.

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By Brandi Tadlock, CPC, CPC-P, CPMA, CPCO

Established Patient E/M Component Requirements Debatable

When coding established outpatient E/M services, level of service requirements are clear, in my opinion.

When it comes to office or other outpatient evaluation and management (E/M) services, we are all familiar with the requirements for new patient visits. Each level of service, from 99201 to 99205, lists three key components. To qualify for a particular level of service, the provider's documentation must meet or exceed the level of every component listed.

When visits are **not** comprised predominately of counseling and coordination of care (which would make time the controlling factor in selecting the level of service), there is no doubt that the provider's documentation must include all three key components—history, exam, and medical decision-making (MDM)—for a new patient.

But in the case of established patient encounters, the guidelines are not as clear. The descriptors for 99212-99215 contain the phrase, "Office or other outpatient visit for the evaluation and management of an established patient, which requires *at least 2 of these 3* key components …" [emphasis added].

Interpretation Varies

Some coders have interpreted this to mean that only two of the three key components must be documented to report an E/M service for an established patient. Consequently, they believe the provider can omit documentation for one of the key components (typically the exam or MDM), and still report 99212-99215.

Other coders (and I am among them) interpret the guidelines to mean all three key components must be documented. But for the purpose of selecting the overall E/M level, only two of the component levels are taken into consideration. Only two of the key components must *meet or exceed* the criteria listed for the overall service to qualify for a particular E/M level.

CPT® guidelines do not state explicitly that all of the key components are required for every encounter, but the guidelines do specify that the contributory factors of counseling and coordination of care are not required services for every E/M encounter. This implies that the other components mentioned (history, examination, MDM, and the nature of the presenting problem) are expected to appear in E/M documentation. Per CPT® E/M guidelines, the only exception to this rule occurs in the case of visits that "consist predominately of counseling or coordination of care."

Check with Your Regional Contractor

As with any matter of interpretation, I would advise that every coder refer to his or her regional Medicare contractor's guidance for the most relevant opinion on how the rules should be interpreted. For example, WPS Medicare and CGS Medicare offer specific guidance on their websites:

Q: "Is it necessary to document all three components (History, Exam, and Medical Decision Making) for an established patient visit to bill an E/M 99211 - 99215 visit or must you bill 99499 if only two are documented. Keeping in mind, only two are required for established patients."

A: "The 1995 and 1997 DG provide the general principles of medical record docu-

CPT® guidelines do not explicitly state all of the key components are required for every encounter, but the guidelines do specify that the contributory factors of counseling and coordination of care are not required services for every E/M encounter.

mentation which states: 'The principles of documentation listed below are applicable to all types of medical and surgical services in all settings. For E/M services, the nature and amount of physician work and documentation varies by type of service, place of service and the patient's status. The general principles listed below may be modified to account for these variable circumstances in providing E/M services.'

"The information then goes on to state in part:

i. 'Reason for the encounter and relevant history, physician examination findings, and prior diagnostic test results

ii. Assessment, clinical impressions, or diagnosis

iii. Medical plan of care

iv. Date and legible identity of the observer.'"

Source: WPS Medicare, "History Element of E/M (Q&As)," www.wpsmedicare.com/j5macpartb/resources/provider_types/2009_0526_emqahistory.shtml

Requirements of Key Elements

Recently Medical Review (MR) at CGS has received questions concerning the requirements for the key elements (history, physical exam, and MDM) for E/M services involving an established patient. Discussion around the requirement of a physical exam has made it necessary to clarify documentation requirements.

Per the CPT® E/M parenthetical guidelines: "The first three components (under the service descriptors-defining the seven components used to determine level of E&M)-history, examination, and medical decision making; should be considered the key components in selecting the level of E&M services."

Also in this section, CPT® states:

"For the categories and subcategories of established E/M codes "two of the three key components (history, exam, and medical decision making) must meet or exceed the stated requirements to qualify for a particular level of E/M services; established ...."

In both citations, the requirements are "two of three requirements must meet or exceed;" meaning the components must all be present, but one may be below the requirement described in the level description. CGS does not interpret this to mean one may be absent in reviewing documentation and meeting medical necessity requirements. It would be hard to establish MDM without an exam of some type. MDM (at any level) refers to the complexity of establishing a diagnosis and/or selecting a management option. Without an exam, it would be difficult to support the need for MDM above and beyond a 99211 *Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem is minimal. Typically, 5 minutes are spent performing or supervising these services*.

Source: CGS, "Evaluation and Management Services (E&M)," www.cgsmedicare.com/ohb/pubs/news/2012/0512/cope18822.html

My Advice in a Nutshell

Needing to satisfy only two of the three key components for established patient E/M visits does not relinquish the provider from having to perform and document all three components. It merely provides flexibility in selecting the overall level of service to account for the fact that established patients' histories and/or problems may be familiar to the provider, and would require less work than would be expected when evaluating a new patient.

For example, the qualifying key components for 99213 are "*An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity*." In my opinion, 99213 is defined in this way to allow for a variety of levels within the three key components. For instance, if the provider has documented a problem-focused history, an expanded problem-focused exam, and MDM of moderate complexity, the encounter would qualify for a level III E/M service for an established patient; whereas, it would only qualify for a level I E/M service, for a new patient.

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A&P Quiz (from page 16)

Answer: The correct answer is D. Signs and symptoms of pneumonia include:

- Fever, sweating, and shaking chills
- Lower than normal body temperature in people older than age 65, and in people with poor overall health or weakened immune systems
- Cough, which may produce thick, sticky fluid
- Chest pain when you breathe deeply or cough
- Shortness of breath
- Fatigue and muscle aches
- Nausea, vomiting, or diarrhea
- Headache

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Veronica "Lorene" Winfrey, CPC

Billing/Coding Manager, Credentialing Coordinator

1. Tell us a little bit about your career—how you got into coding, what you've done during your coding career, what you're doing now, etc.

I started my career in medical collections for an agency, and then went into inpatient collections for a hospital. I became interested in finding coding and billing errors that carriers were making patients responsible for paying. I went on to bill for physicians, which was a challenge because there were no, or limited, laws and regulations for medical coding and billing. I stayed current on new regulations as they gained momentum, and it became very evident that physician reimbursement hinged on proper coding.

I worked for **David B. Dunn, MD, FACS, CIRCC, CCVTC, CPC-H, CCC, CCS, RCC,** for five and a half years. During that time, I developed an interest in coding education and certification. I pursued certification a year or so after Dr. Dunn closed his solo surgical practice.

I now work for a plastic and reconstructive surgeon, **John D. Rosdeutscher, MD,** in Hermitage, Tenn. He is great to work for and very good with coding. Dr. Rosdeutscher has spoken at a Mount Juliet, Tenn. chapter meeting on "Excision, Repair and Wound Care," and the members always ask when he is coming back. He also presented at the AAPC regional conference in 2011 and the AAPC national conference in 2012.

And beginning in June, I will be working part time for **Kristina O'Shaughnessy, MD**. Dr. O'Shaughnessy is also a plastic surgeon in Nashville. I'm looking forward to working with her.

Throughout my career, I have met a lot of very smart and dedicated coders. Most are humble and don't realize the knowledge they have to share. I see everyone as a teacher.

2. What is your involvement with your local AAPC chapter?

I am the vice president of the Mount Juliet, Tenn. chapter. After the regional conference in Nashville, I realized how much education was out there and how much I and everyone else was missing and needing. I contacted AAPC about starting a chapter in Mount Juliet, which is closer to my home and more convenient to Hermitage. Once the chapter was approved, I held the president position in 2012. The chapter has had great officers, and we really have been blessed with great education from presenters. All of the officers and speakers, current and past, deserve a special thanks for their help. The chapter also has had success with Code Arounds; members really enjoy the one on one interaction involved in these events.

3. What AAPC benefits do you like the most?

AAPC's website has a wealth of information. I go there first when I'm searching for information. I also like AAPC's ICD-10 Code Translator. I started using this just to educate myself, but have since recommended it to chapter members so they, too, can become familiar with the new codes. Another way we are preparing for ICD-10 is, at each Code Around, we present the ICD-9-CM diagnosis for the reports we are reviewing, and then show the ICD-10-CM conversion.

4. What has been your biggest challenge as a coder?

The biggest challenge for any coder these days should be education. It's a constant challenge to stay current with all the changes. Coding is an area of healthcare that will always change, so finding time to search for changes and answer questions about the changes is a definite challenge. Then there is the cost: There is so much available to coders, but most of it isn't affordable. I think many of us have an issue with this.

5. How is your organization preparing for ICD-10?

Since I'm the only coder and biller where I work, I am the one who is preparing for the change. Rosdeutscher invested in an ICD-10-CM codebook. I follow up with our software company about every 90 days, just to make sure they will be ready. In fact, I just talked with them on Monday, and they assured me they have done testing and are ready.

6. If you could do any other job, what would it be?

If I had the opportunity, I would either own an accounts receivable clean-up company and work from home, or really step out of my box and own a salon and spa.

7. How do you spend your spare time? Tell us about your hobbies, family, etc.

I like golf, NASCAR racing, fishing, reading, and spending time with family and friends. All of my spare time usually is spent with my youngest grandson, Mason, who is 7. He rules the roost with everyone, including my 79-year-old mother, and my three other grandchildren, Calen, 21, Catarina, 19, and Drale, 15.

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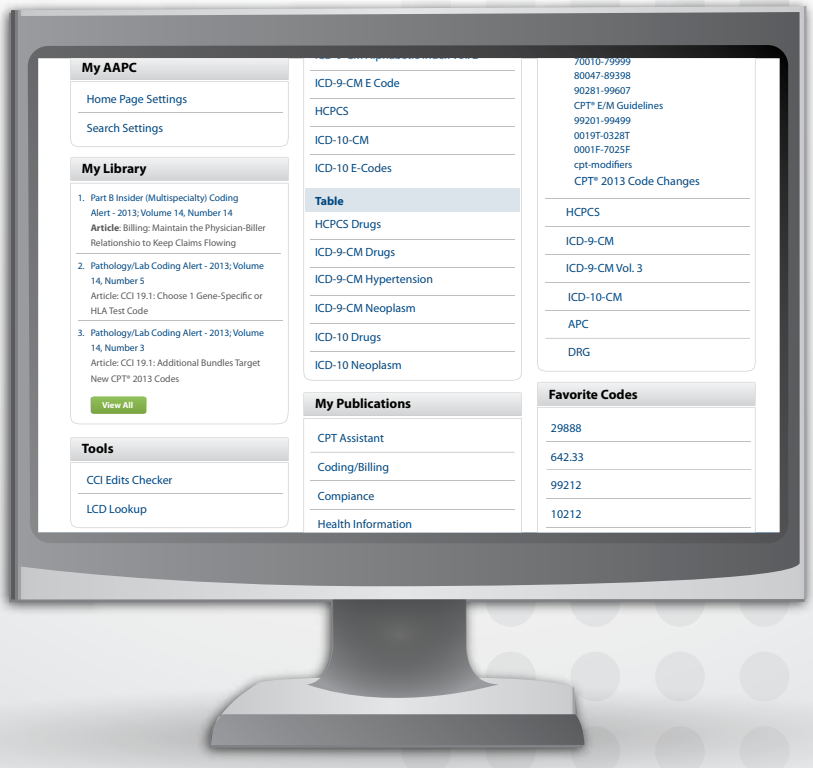

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