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CODING edge

May 2010

CMS vs. CPT®

LuAnn Jenkins,
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Lapeer, Mich.

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On the Cover: *LuAnn Jenkins, CPMA, CPC, CEMC, CFPC, president/owner of MedTrust LLC in Lapeer, Mich. knows deciding between CMS and CPT® guidance isn't as easy as choosing a soft drink, especially when there is conflicting global guidance on postoperative services. Cover photo by Rick DeLorme, MA, MS (www.delormephoto.com).*

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

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

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May 2010

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Looking Forward to Coding in Nashville

Our annual national conference will be hosted in Nashville, Tenn. at the magnificent Gaylord Opryland Resort, June 6-9. I am looking forward to meeting a few thousand of my closest friends there. Registrations are running well ahead of previous years and it looks like this will be our largest conference ever.

If you come, here's what to expect:

An incredible hotel. Warning: Gaylord properties are jaw dropping and HUGE, and the Gaylord Opryland Resort is no exception. With over 30 restaurants at every price, amazing fauna and plant life, a river flowing through it, and nice meeting rooms, you may need a map to navigate it.

More education than ever before. There are eight specific tracks you can follow: Surgery, Orthopaedics, Interventional, Primary Care, Audit, Advanced General Coding, Facility, Payer, and Practice Management. Feel free to follow these tracks or choose from any of the more than 60 sessions. Our anatomy expo will be held Monday and Tuesday afternoons.

Continuing Medical Education (CME) credits for physicians are available for the first time. See our "Bring Your Physician" offer in the conferences section (under CEUs) on the AAPC website for how you can save $300 on your registration fee by bringing a doctor with you.

Tuesday night at the Grand Ole Opry. Tickets are available for all. If you registered by the early bird date, March 15, then your packet already has a ticket. Otherwise, tickets are $40. With the Country Music Association (CMA) Music Festival the following week, we're sure to see a couple award winning singers!

More music. Famed jazz musician Rod McGaha will perform at the Member Appreciation Luncheon on Tuesday. To top off the music theme, what Nashville conference would be complete without some foot-stomping entertainment from our National Advisory Board (NAB)? Plan to whoop and holler on Sunday for an afternoon kick-off featuring the NAB's Country Coding Jamboree.

Significant announcements will be made during my "State of the AAPC" keynote speech on Monday morning, June 6.

Fun. We always have fun, and this year the tradition continues.

If you haven't registered, call to see if there are any remaining spots. Bring your doctor; get the latest on coding; ask questions and get answers; listen to great country music; and have fun. While you're at it, tour Nashville's great honky tonk downtown area. You might even take a ride on the General Jackson Showboat down the Cumberland River, or go shopping at the Opry Mills Mall adjacent to the Gaylord Opryland Resort. See you in Nashville! CE

Sincerely,

Reed E. Pew
CEO and President

www.shopingenix.com/aapc

See what's in store for AAPC members.

INGENIX®

Professionally, Conference is Important

What a great opportunity the 2010 AAPC National Conference in Nashville, Tenn. will be professionally.

Experience tells me that attending conference is about much more than obtaining continuing education units (CEUs), continuing medical education (CME), or helping you pass a coding exam. Professionally, it's about the following:

Networking

Coding conferences provide a great opportunity for you to meet other coders and medical professionals. These contacts can lead to partnerships, mentoring, business exchanges, sharing coding information, and career opportunities.

Making Personal Connections

Many coding professionals meet online through forums or email exchanges creating online friendships or business contacts. Bonding via the Internet is great; however, there is nothing that replaces the personal connection coders have when they meet in person. Face-to-face contact can push your relationship to the next level, which fosters a higher level of trust that can't be achieved online.

Confronting Similar and Relevant Issues

Working in a small practice or remotely can leave coders feeling isolated from other coders. Conferences are an opportunity for you to meet other coders and make a connection with someone who struggles with similar issues. You may even find someone who knows the solution to a specialty-specific coding problem from which you can benefit from their past experiences and knowledge.

Conference attendees naturally discuss issues specific to their area of specialty. You get to know and understand real-life coding complexities much better. It's a great way for coders to unite and face industry issues and challenges.

Learning About Career Opportunities

Coding career opportunities are everywhere at conferences. Coding conferences are full of medical professionals, vendors, health care businesses, offering a variety of coding products, learning tools, and new business opportunities of which you weren't previously aware.

Gaining Professional Exposure

Whether you are a consultant, physician or facility coder, student, vendor, or billing manager; gaining exposure is always good to do professionally. It builds credibility in the coding world.

Expanding Coding Know-how

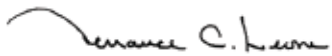
Conference workshops, general sessions, breakout sessions, keynote speeches, and review classes are designed specifically for coders and billing professionals. Conferences provide you with tools to overcome nagging coding, billing, and reimbursement challenges to maximize your coding skills and revenue. Attending the breakout sessions and seminars will enhance your knowledge in specific coding areas, which directly impacts your physician practice, facility, studies, and career goals.

Leaving Inspired by Coding Excellence

Attendees find a renewed passion for coding and compliance after attending conference. When you're surrounded by people promoting coding excellence, you absorb their enthusiasm. It's contagious. This inspiration carries over to your day-to-day coding interactions.

I hope to see y'all in Nashville. For more information, go to www.aapc.com.

Sincerely,



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

coding news

2011 Medicare Advantage Capitation Rates Hold Steady

2011 capitation rates for Medicare Advantage (MA) plans were published in the *Federal Register* on April 15 and are effective June 7. The Centers for Medicare & Medicaid Services (CMS) 2011 Rate Announcement was accompanied by the final 2011 Call Letter for Medicare Advantage (Part C) and Medicare prescription drug (Part D) plans.

As required by Section 1102 of the Health Care and Education Reconciliation Act of 2010, the capitation rates for 2011 are the same as the capitation rates for 2010. Besides a $10 increase in the Initial Coverage Limit, annual parameter updates to Medicare Part D benefits are identical:

Part D Benefit Parameters	2011
Defined Standard Benefit	
Deductible	$310
Initial Coverage Limit	$2,840
Out-of-Pocket Threshold	$4,550
Minimum Cost-sharing for Generic/Preferred Multi-Source Drugs in the Catastrophic Phase	$2.50
Minimum Cost-sharing for Other Drugs in the Catastrophic Phase	$6.30
Retiree Drug Subsidy	
Cost Threshold	$310
Cost Limit	$6,300

Because the capitation rates for 2011 are the same as 2010, MA growth percentages have no relevance for the 2011 capitation rates. And the rate announcement does not include final estimates of MA growth percentages or their key assumptions tables.

In response to this new legislation, several key changes were made in the Rate Announcement, which discusses provisions in the health reform legislation that begin to close the Part D coverage gap in 2011 and these provision effects on plans' Part D bids.

Updates prompted by public comments were made to the Advance Notice and draft Call Letter

Read the 2011 Announcement and 2011 Advance Notice at: www.cms.gov/MedicareAdvtgSpecRateStats/AD/list.asp.

A fact sheet with additional details is at www.cms.gov/apps/media/fact_sheets.asp and the regulation is available at www.federalregister.gov/inspection.aspx#special.

Medical Conditions List and Instructions Updates

Change Request (CR) 6896, issued April 2, updates the Ambulance Fee Schedule Medical Conditions List and Instructions found in Pub. 100-04, chapter 15 of the *Medicare Claims Processing Manual*. CR 6896 communicates these revisions effective May 3.

The Medical Conditions List is set up with an initial primary column and an alternative column of ICD-9-CM codes. The primary column contains general ICD-9-CM codes that fit the transport conditions as described in the subsequent columns. Ambulance crew or billing staff must choose from ICD-9-CM codes listed in this column describing the appropriate ambulance transport, and place it in its designated space on the claim form. Additional information may be provided in the narrative field. Persons with more comprehensive clinical knowledge may select an ICD-9-CM code from the alternative ICD-9-CM code column. These ICD-9-CM codes are more specific and detailed.

When a claim is submitted, an ICD-9-CM

code from the medical conditions list that best describes the patient's condition and the medical necessity for the transport may be chosen. A transportation indicator from below may be included on the claim to indicate the circumstances for why it was necessary to transport the patient that way.

Air and Ground

C1: Inter-facility transport to a higher level of care.

C2: When a patient is transported from one facility to another because the originating facility doesn't have the service or therapy required to treat the patient's condition.

C3: May be included as a secondary code where a response was made to a major incident or mechanism of injury. All such responses are appropriately Advanced Level Service responses.

C4: Indicates an ambulance provided a medically necessary transport, but mileage on the claim appears excessive.

Ground Only

C5: For patients with an advanced life support (ALS-level) condition who is encountered, treated, and then transported by a basic life support (BLS-level) ambulance with no ALS level involvement.

C6: For situations when an ALS-level ambulance is chosen based upon medical dispatch protocols of the requested service, but once on scene, the crew determines the patient requiring transport has a BLS-level condition instead.

C7: When IV medications are required en route for patients requiring ALS level transport in a non-emergent situation. Does not apply to self-administered medications and does not include crystalloid intravenous fluid administration.

Air Only

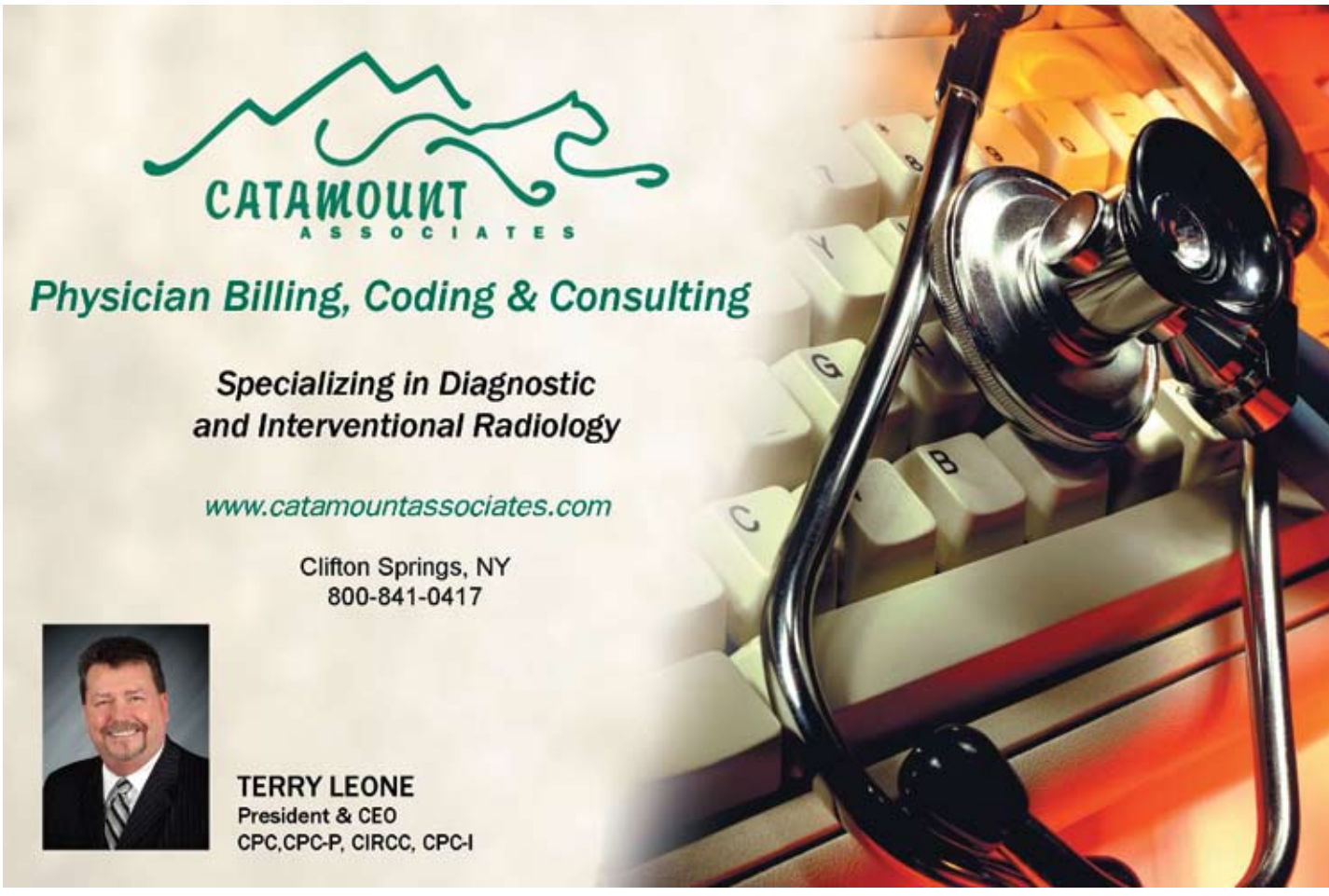
D1: Long Distance. Condition requires fast transportation over a long distance.

D2: Traffic patterns preclude ground transport at the time the response is required.

D3: Patient needs closest appropriate hospital due to condition which precludes transport by ground ambulance to minimize out-of hospital time and maximize clinical benefits for patient.

D4: Pick up point is not accessible by ground transportation.

The Ambulance Fee Schedule Medical Conditions List is found at: www.cms.gov/transmittals/downloads/R1942CP.pdf.



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

Letters to the Editor

Consultative Services Kibosh Pays Off

Thank you for the article on the Centers for Medicare & Medicaid Services' (CMS) guidance of reporting consultative services ("CMS Provides Reporting Consultative Services Details," March 2010, pages 34-37).

As an employee of a multi-specialty medical group for both commercial and Medicare Advantage plans, we are both the provider and payer of services for our health maintenance organization (HMO) members. When CMS first announced the intent to do away with consult codes, I began polling the health plans to see what route they would take and couldn't really get a clear answer from them.

We decided, for consistency, to follow CMS rules for the Medicare Advantage plans and disallow consult codes as of Jan. 1. This has been working well. Health Net notified us in February that, effective May 1, they no longer will pay consult codes for commercial members. They will map outpatient consult codes to the appropriate new patient evaluation and management (E/M) service, and pay that until the end of 2010, but will deny inpatient consult codes because they cannot be mapped to a direct hospital visit code. After Dec. 31 they will deny all consult codes. Again, for consistency, we will follow those rules for our commercial Health Net members to avoid confusion for the offices.

Putting on my "auditor's hat," I'm glad to see these changes coming. Auditing not only our physicians but contracted physicians as well, it's obvious most physician offices don't understand the difference between transfer of care and a consult, and what documentation is required to substantiate billing consult codes. CMS has made it clear that because most providers don't get it right, they are just going to eliminate the problem.

Because removing the consult codes from the fee schedule was done as a revenue neutral move by adjusting the relative value units (RVUs) for other services, I believe they have done the health care system a favor by eliminating a confusing and costly coding issue. I hope other health plans follow suit soon and the American Medical Association (AMA) will drop consult codes entirely from CPT®.

David Peters, CPC, CPC-P, PCS
Contracts Manager
Sutter Pacific Medical Foundation

Thanks for your compliments and the update.

Although not all providers may agree that the elimination of consultation codes for Medicare payment is a good thing, the evidence does weigh heavily that consultation services frequently are misreported. For instance, the Office of Inspector General (OIG) issued a report claiming that nearly three-fourths of consultation services billed to Medicare in 2001 were inappropriate, and subsequent education efforts to improve reporting of these services have failed to produce the results desired. The decision CMS made to eliminate payment for consultation codes likely will not be reversed. In such an environment, consistency of reporting requirements across all payers may be the best possible outcome.

Coding Edge

Ear Flushing Alone Doesn't Justify 69210

In the article "Take Four Steps Toward Preventive Medicine Coding Success" [April 2010 *Coding Edge*], an example is given on page 19, a patient comes in for an annual physical and the nurse flushes the patient's ears. The author recommends that the physical be billed along with 69210 *Removal impacted cerumen (separate procedure), 1 or both ears*; however, from what I have studied and researched, 69210, is not for the flushing of the ears. We have had this discussion in our practice many times, and I continue to look at what others have found regarding this procedure, as well. What I have found from American Medical Association (AMA) is that this procedure is the removal of impacted cerumen by instrumentation such as cerumen spoon or delicate forceps by the physician.

Tara Farmer, CPC

The reader is correct: Simply flushing the ears by the nurse does not qualify for 69210. What typically is done in our practice is that the nurse flushes to ears to remove any loose cerumen, then the physician re-examines the ears and removes any retained (i.e. impacted) cerumen. Per CPT® and the Centers for Medicare & Medicaid Services (CMS) instruction, removal of impacted cerumen is covered if it is reasonable and necessary for the diagnosis or treatment of illness or injury and adequately documented in the medical record, and these conditions should have been indicated in the example. Because the focus of the example was illustrating the use of modifier 25 *Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service* with the evaluation and management (E/M) preventive service, I failed to provide full procedural details.

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

Coding Edge had our schedules mixed up in the April issue's article "2010 National Conference: Memories in the Making." The Meet Your Local Chapter event is listed at 4-6 pm and should be listed as 5:30-7 pm, Sunday. We apologize for this error.

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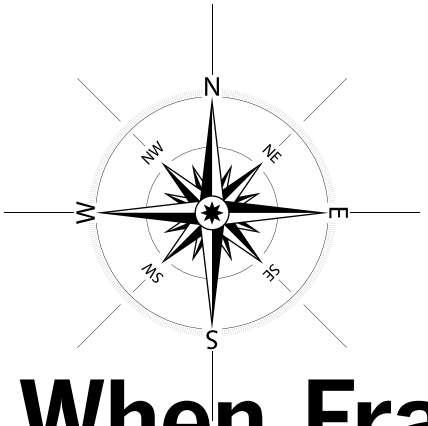


When Fraud Falls on Deaf Ears, Can You Blow the Whistle?

By G. John Verhovshek, MA, CPC

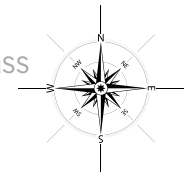
This whistleblower determined ethics outweighed his employer's expectations and helped usher in a new era of compliance.

In the spring of 2003, Columbia/HCA agreed to pay $631 million in civil penalties and damages for filing false claims to Medicare, along with an additional $250 million to resolve overpayment issues. Several years earlier, in late 2000, Columbia/HCA pled guilty to related criminal charges, for which the company paid $840 million in criminal fines, civil restitution, and penalties. In total, the largest and lengthiest health care fraud investigation in the nation's history netted a return of nearly $1.7 billion for the federal government, and caused a huge shakeup at one of the country's largest health care conglomerates.

A major player in the drama was John W. Schilling, an otherwise unassuming accountant who had served as Columbia's Southwest Florida Medicare reimbursement supervisor during the mid-1990s. Schilling uncovered major problems in the company's cost reporting, which lead to windfall payments from Medicare. Repeated attempts to correct the problems through the proper chain of command produced no results, and Schilling realized to his dismay that his superiors seemed to be acting purposefully to perpetrate the errors.

Feeling that his personal ethics and responsibility as a certified professional accountant (CPA) were at odds with his employer's expectation to "look the other way," and failing to convince his superiors to do the right thing, Schilling made the difficult decision to become a whistleblower and reported Columbia's accounting irregularities to federal authorities. For much of the decade that followed, Schilling was embroiled in the resulting investigation, serving as an FBI informant, testifying on behalf of the Justice Department, and coming under scrutiny himself.

Schilling currently is a partner with EthicSolutions LLC, a consulting firm that specializes in providing confidential direction and advice to whistleblowers and potential whistleblowers, and assists law firms and the federal government with civil and criminal fraud cases. Schilling wrote about his role in the Columbia/HCA case in *Undercover: How I went from Company Man to FBI Spy—and Exposed the Worst Healthcare Fraud in U.S. History*. He agreed to share some of his experiences, and how they are relevant to coders in the medical environment, with *Coding Edge*.



I became concerned that if I went along with these practices, I may be jeopardizing my CPA license, and possibly even facing jail time. After months of debate, I knew I couldn't just look the other way. I had to do something.

***Coding Edge* (CE):** *You began working in Columbia's Fort Myers regional office in 1993, overseeing Medicare cost report filings and coordinating audits with the fiscal intermediary. At what point did you recognize irregularities with Columbia's accounting?*

Schilling: About six months after I started, I had to address how interest expense was handled at one of my hospitals, Fawcett Memorial. Interest expense could be classified either to operating or capital outlays. By over-representing the portion of costs allotted for capital purposes, the hospital received higher reimbursement from Medicare. That is, costs were inflated by including non-reimbursable expenses, and as a result the hospital had received Medicare payments to which it technically was not entitled.

When I began reviewing other reserve issues, aside from the interest issue, I realized many of them were suspicious. Being new, however, I initially assumed—and was told repeatedly—that this was the "normal" course of business.

CE: *When you knew for sure that there were problems, how did you handle it? Did you notify superiors or take steps to address the irregularities?*

Schilling: Shortly after I noticed the improper cost allocation and brought it to my boss's attention, I was invited to a meeting with three company executives, including my immediate supervisor, in which this "Fawcett Interest Issue" was discussed. Although it was characterized as a legitimate accounting mistake, it had led to windfall payments for Fawcett Memorial. At the meeting, there was open discussion of how the mistake could be hidden, so those payments would not have to be repaid. I knew then something wasn't right.

A new manager came into place, reviewed the same reserve documents I had, and likewise concluded many of the reserves were improper if not fraudulent. My new manager and I expressed our concern to upper management, both separately and together. I also wrote memos and provided documentation that went to the director and assistant vice president of our department, showing them a number of reserves I believed to be improper. But nothing happened. Six months later, new management above my manager and me reviewed the issues, and indicated they were not going to reimburse Medicare retroactively for any overpayments. They felt they had no responsibility to self-report, and if the government didn't discover the error, it wasn't a problem.

CE: *What did you think when those you were reporting to ignored or even seemed to encourage the practices you knew to be inappropriate? What made you decide, finally, to become a whistleblower?*

Schilling: I felt self-doubt and frustration, but also thought I might be over-reacting. Very few people within the company seemed concerned with the reserve issues, and it seemed to be normal practice within the industry. On the other hand, I knew what was being done was unethical, if not illegal. And I was frightened. I became concerned that if I went along with these practices, I may be jeopardizing my CPA license, and possibly even facing jail time. After months of debate, I knew I couldn't just look the other way. I had to do something.

CE: *Acting as a whistleblower was not as easy as just telling your story. You were deeply involved in the case for nearly a decade. Did you doubt your decision?*

Schilling: I often doubted that I was doing the right thing, or if it was worth the effort. I was intimidated. I had been told "jobs could be lost" if anyone found out about the costly accounting errors. I feared for my own job and reputation. The prospect of physical harm remained in the back of my mind. I uprooted my family, and accepted a job in the public sector at 25-35 percent less pay than I had been making, at a time that I was the sole wage earner. I spent hundreds of hours away from my wife and children each year, in meetings with attorneys and government prosecutors, educating them on the issues, reviewing documents, and preparing for trial. As the criminal trial approached, I had renewed doubts. My decision could send people to jail—people I had worked with and known personally. The case was under seal for years: I wasn't allowed to discuss it with anyone—even my spouse. I had to distance myself and withhold the truth from family and friends and co-workers. It put a strain on every relationship in my life.

Overall, I'd say it was quite an emotional roller coaster.

CE: *The Columbia/HCA case ended with a huge settlement for the government. As a whistleblower, or qui tam relator, you shared in that settlement. How was it decided what your share should be?*

Schilling: One would think the government would have an objective process to determine a whistleblower's reward, but they don't. Even if you are a team player up to the settlement, you will be forced to battle those with whom you worked side-by-side to obtain your settlement. Even though the law stipulates the relator is entitled to 15-25 percent, the Justice Department is reluctant to reward more than the minimum. The average

The coder should document the facts and evidence believed to be in violation, and report this to either a superior or the compliance officer, depending on internal protocols. It is imperative for the facts and evidence to be tangible and reported in a way that shows exactly why there is a potential violation.

is 17 percent. You must engage in a negotiation to prove your worth. It becomes a battle with the Justice Department to argue how instrumental you, as the whistleblower, were in obtaining the settlement. Being a whistleblower isn't an automatic payday. It's a challenge at every step. If your motive as a whistleblower is solely money or revenge, or if you haven't got your facts and evidence in line, you'll not likely get anywhere.

CE: *The problems you saw at Columbia revolved around cost reporting and accounting issues, not coding. Does your experience apply to coders?*

Schilling: Absolutely! Coders, like accountants, are obligated to properly adhere to Medicare rules and regulations. Whether it's bookkeeping or coding claims, everyone on the reimbursement team has a responsibility. And, a certified professional coder (CPC®) agrees to abide by a code of ethics, just as a CPA does.

CE: *Columbia/HCA was a large, multi-facility company. Are compliance issues as big a risk at small facilities, or the single-provider office? Are payers or government regulators really interested in the little guys?*

Schilling: Yes. The government is interested in anyone committing fraud, whether big or little. From a practical perspective, the government has limited resources and can't police compliance in all health care providers all over the country. As a result, they try to influence providers to self-report and police themselves. Their interest in the big fish is because there is the potential for larger settlements, and there is a much better chance there will be national publicity. This national publicity serves as a potential deterrent for others who either already are committing fraud or contemplating committing fraud.

But, compliance issues actually may be a bigger risk at smaller, single-provider offices because smaller entities do not have the financial resources to hire trained, experienced compliance professionals. They are more likely to rely on individuals who wear many hats—with compliance being a low priority. With increasing scrutiny of health care costs by payers, government, and consumers, compliance crackdowns will continue to trickle down to smaller and smaller providers.

CE: *If I'm a coder in a facility or office, and I notice what I believe to be compliance or coding risks, what would you advise I do?*

Schilling: Double check yourself. Review the facts and review the Medicare regulations to help you determine compliance. If you determine what you're reviewing is non-compliant, you need to start internally. The coder should document the facts and evidence believed to be in violation, and report this to either a superior or the compliance officer, depending on internal protocols. It is imperative for the facts and evidence to be tangible and reported in a way that shows exactly why there is a potential violation—for instance, what regulation is in violation, and how and why it is being violated.

If repeated attempts to correct the issue fail or fall on deaf ears and the practice or facility refuses to correct the problem in spite of clear evidence that it exists, then reporting a violation in an attempt to force compliance is an option. As a partner at EthicSolutions LLC, I help provide confidential direction and advice to potential whistleblowers, and assist attorneys and government prosecutors in civil and criminal fraud cases. One of our current clients is a coder; unfortunately, I cannot discuss anything about this case because it is under a court seal.

There are places where you can get advice on how to proceed. The first step, however, always is to arrange your facts and to attempt to correct the problem internally.

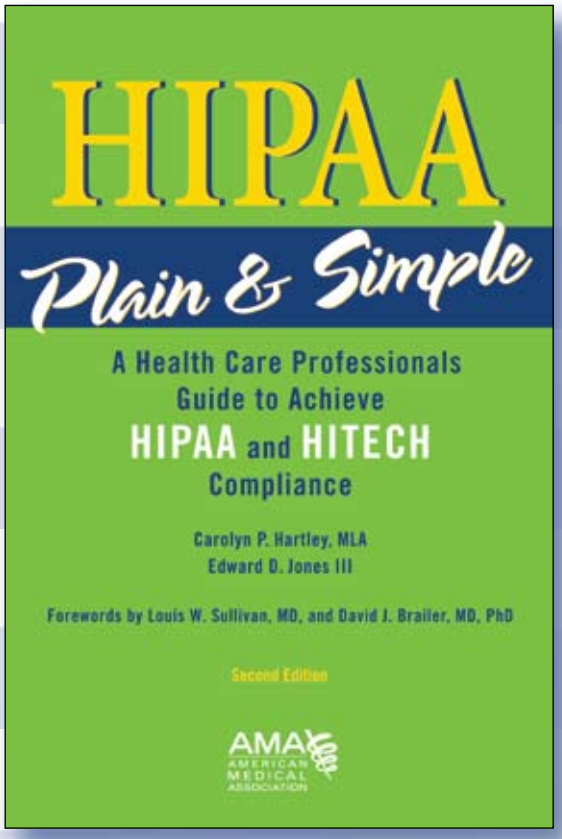
CE: *What about preventing compliance risks and improper coding: What influence can coders have, and do you see their role as expanding or contracting in the years ahead?*

Schilling: Coders should be proactive in reporting areas that are a potential problem. Doing so will result in a culture change within the organization where compliance is continuously being discussed and reported. To keep compliance an active topic for ongoing discussion, coding compliance should be made part of the agenda of all coding department meetings, or at least on a monthly basis in meetings exclusively devoted to coding compliance. This proactive approach will result in coding compliance being part of the organization's culture that could serve to prevent government intervention. Or, if there is government intervention for whatever reason, the government may be more lenient in dealing with the organization should they discover an area of non-compliance. Coders also should be advocates for self-reporting to the government should problems be discovered. This will serve the organizational well both short and long term.

Coders can have a significant influence on their organization's compliance program to benefit the organization and the professional status of coders.

G. John Verhovshek, MA, CPC, is AAPC's director of clinical coding communications.

Achieve HIPAA and HITECH compliance



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- Health IT company profiles and 12-month HIPAA training ideas
- Crisis communication management guidelines
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- An additional foreword by David Brailer, MD, the nation's first National Coordinator for Health Information Technology

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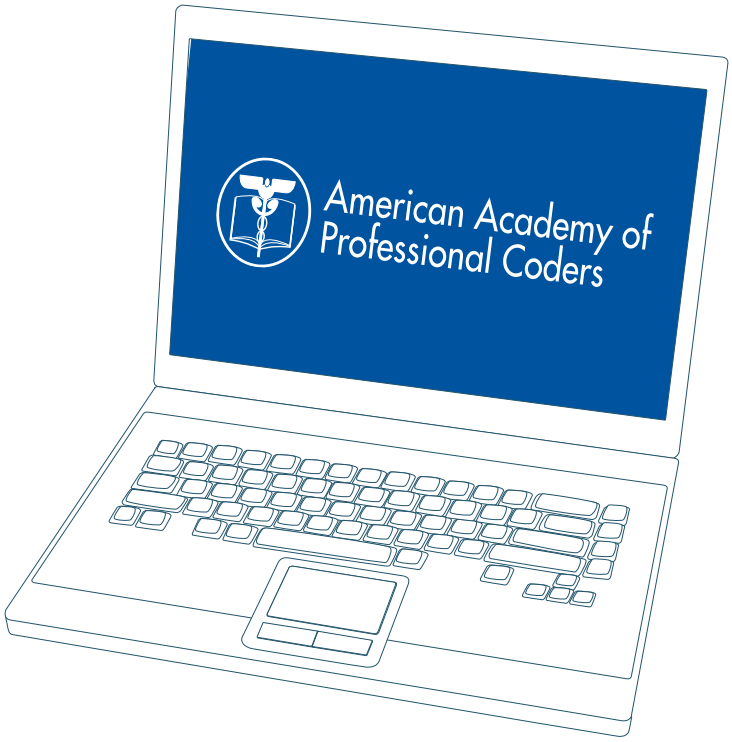

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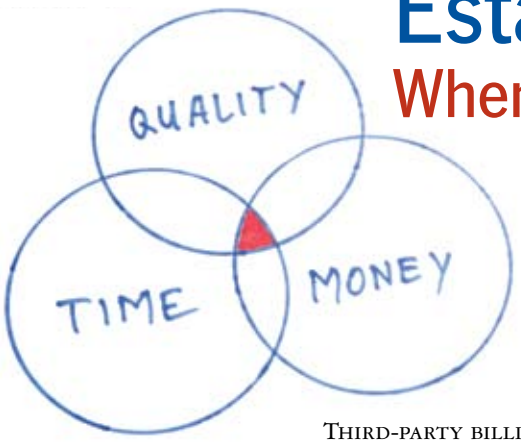

Establish Baseline Metrics

When Outsourcing Billing Operations

When seeking outside billing expertise, effective communication gets the best ROI.

By Rebekah M. Stewart, JD, MBA, CPC, CHC

EXPERT

THIRD-PARTY BILLING companies provide a valuable service for providers who need assistance not only in Medicare, Medicaid, and private payer claim submission, but for those who are looking for outside expertise to optimize reimbursement, increase efficiency, and decrease overhead cost. If you establish upfront communication strategies and be an active partner with your outsourced billing firm by monitoring key revenue cycle metrics, you will have a direct influence on your return on investment (ROI).

It's important to create the basic framework to have a positive and productive relationship with your third-party billing firm by addressing operational performance standards and financial billing metrics, and providing suggestions for ongoing communication. Here's how to do it.

Determine Performance Standards

Each practice and billing firm account manager should hold a kick-off or "on-boarding" discussion at the onset of the contract, and a yearly discussion on the practice's work flow, growth, and financial goals. Another annual task for the same individuals should be to develop and agree upon specific and measurable performance standards for the fiscal year. Upfront discussion allows aligning the provided billing services with the practice to support internal financial and operational goals, equipping both parties with a common framework to objectively monitor effectiveness of services, and identifying and proactively remediating when standards are not met.

Standard items on the agenda for discussion are:

- Timeframe for clean claim submission after complete information is provided by the practice;
- Timeframe for payment posting;
- Response and follow-up time for customer service calls and written correspondence;
- Communication method and frequency of significant Medicare and Medicaid updates, payer changes in policy, and intermediary bulletins;
- Response timeframe when documentation requests are received for audit inquires initiated by or on behalf of the practice; and
- Detail and frequency of practice management reports (for example, charges entered, payments posted, accounts receivables, credit balances, write-offs).

Although a practice may be anxious to transition the billing to the outsourced firm as soon as the contract's ink is dry, key practice members should be actively involved in planning, discussing standards, and evaluating the practice's dynamics to help ensure a common understanding of expectations and goals.

Implement Billing Activity Metrics

In addition to creating overall performance standards, practices should request regular activity reports with key metrics or core indicators that provide a dashboard view of production and profitability. At a minimum, a monthly dashboard report and a month-to-month and yearly trend report should include the following:

- Daily, weekly, and monthly charges;
- Gross and net collection rates;
- Denial percentages broken down by category and procedure code;
- Rejections broken down by rejection code and payer;
- Outstanding accounts receivable (A/R) age;
- Days in A/R calculated;
- Volume of charges and payments by provider;

Although a practice may be anxious to transition the billing to the outsourced firm as soon as the contract's ink is dry, key practice members should be actively involved in planning, discussing standards, and evaluating the practice's dynamics to help ensure a common understanding of expectations and goals.

- Total number of procedure codes billed by provider;
- Percentage of write-offs; and
- Analysis of credit balances and refunds.

The dashboard should be an intuitive, robust document that can provide quick insight into the performance of the practice. It also should allow the practice to determine if the goals discussed during the kick-off meeting are on target with respect to items such as volume, procedure mix, collections, and days in A/R. Although the metrics above are typical core indicators, each practice should work with its billing firm to customize the dashboard based on changes in priorities, risk identification, and performance feedback.

Communicate for Continued Success

As with any successful relationship, communication is key. Performance standards and reporting metrics requested from the billing firm are only as useful as the feedback data provided by the physician practice. Weekly or bi-weekly calls with the billing firm account manager to interpret data, identify red flags, and discuss obstacles in claims submission will provide a forum to monitor and remediate challenges proactively—before it is deemed as a performance issue. A regular metrics and claims review also provides an educational opportunity for both parties to collaboratively work through problems, suggest opportunities for process improvement, and ultimately, leverage resources to meet established billing targets and validate the investment to outsource. CE

Rebekah M. Stewart, JD, MBA, CPC, CHC, is a manager in Huron Consulting Group's Life Sciences Advisory Services practice. She focuses on health care and billing compliance, compliance program effectiveness, risk assessments and mitigation planning for health systems, academic medical centers, and third-party billing companies. Rebekah also serves on the board of the National Association of Health Services Executives – Virginia Chapter.

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PROFESSIONAL

Answer These Professional SNF and NF Billing Questions

Responsible coding depends on accurate answers.

By Kerin Draak, MS, WHNP-BC, CPC, CEMC, COBGC

Providers of long-term care services must comply with several different regulating criteria, and it is the coder's responsibility to understand applicable rules when coding these unique services. In recent years, there have been extensive changes in the Nursing Facility Services section of the CPT® manual. Although this article cannot include all you need to know to bill for skilled nursing facility (SNF) or nursing facility (NF) services, it will answer some basic questions and give you a good place to start.

What is the Difference Between a SNF and a NF?

For starters: They have different place of service (POS) codes. Use POS code 31 for a Medicare Part A SNF stay, and POS code 32 for a patient who doesn't have Part A benefits. Always make sure you use the correct POS.

Per CPT®, POS code 31 describes a facility that primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitation services but does not provide the treatment level available in a hospital. POS code 32 is somewhat similar and describes a facility that provides nursing care and related services for the rehabilitation of injured, disabled, or sick people above the level of custodial care to those other than the mentally disabled.

Secondly: The care rendered is different. Care provided in a SNF requires skilled nursing and/or rehabilitative staff involvement on a *daily* basis, which might include registered nurses, licensed practical and vocational nurses, physical and occupational therapists, speech-language pathologists, and audiologists.

Care given by non-professional staff isn't considered skilled care, but rather custodial or personal care, and includes assistance with activities of daily living, such as: bathing, dressing, eating, grooming, getting in and out of bed, or toileting.

How are Professional Services Billed for SNF and NF?

Although there is a difference in the setting and the care provided, the codes used to report the professional services in either facility are found in the same nursing facility evaluation and management (E/M) category. CPT® doesn't have subcategories to differentiate a SNF from an NF.

In 2006, we saw an overhaul to the Nursing Facility Services codes to reflect better current medical practice and to provide a consistent format throughout CPT®. Three codes were introduced to report nursing facility admissions (Initial Nursing Facility Care: 99304-99306), along with four codes to report follow-up nursing facility care (Subsequent Nursing Facility Care: 99307-99310), and a new a new code to report yearly assessments (Other Nursing Facility Services: 99318 *Evaluation and management of a patient involving an annual nursing facility assessment, which requires these 3 key components: a detailed interval history; a comprehensive examination; and medical decision making that is of low to moderate complexity*). In 2008, we saw typical/average times re-established for these codes, and language added to the code descriptions.

The Initial Nursing Facility Care codes are *per day*, and include all work in all sites performed on the same service date. They require all three key components of history, exam, and medical decision making to be satisfied to report a particular level.

Consider the following example documentation for an initial service:

CC: hip fx

HPI: 84 yo female here after left hip fx for rehab. Had hip surg on 2-18-10. Had post-op anemia and was transfused in the hosp. Moderate pain with ambulation and taking Vicodin for pain.

PMH: CAD s/p CABG 1987, angioplasty 2001, HTN, hypothyroid, hyperlipidemia

PSH: CABG, vag hyst/bladder repair, cataracts, appy

Meds: ASA, Lovenox, Zetia, Fe, HCTZ, glucosamine, synthroid, Toprol XL, Accupril, Zocor, Vit. E, Tyl PRN, Prilosec, Vicodin PRN

Soc hx: married, ⊘ tob/alcohol abuse

FH: negative for bleeding/clotting disorders

ROS: some trouble with sleeping here, naps during day, ⊘ CP, SOB, abd c/o, using depends, ⊘ legs pain, walking with walker, some memory problems

Allergy: NKDA

PE: Alert and oriented, NAD, HEENT: PERRL, pharynx clear; Neck: supple, ⊘ adenopathy, COR: RRR w/o murmur; Lungs: CTA; ABD: soft, NT; Extremities: ⊘ edema, left hip non-tender, incision site clean and dry without s/s infection

IMP:

s/p hip fx here for rehab

CAD stable on meds

Hypothyroidism on replacement

HTN, will monitor

↑ chol - cont meds

GERD prophylac Prilosec

DVT prophylaxis w/Lovenox

Based on the above documentation, the service may be reported using level I Initial Nursing Facility Care code 99304 *Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these 3 key components: a detailed or comprehensive history; a detailed or comprehensive examination; and medical decision making that is straightforward or of low complexity.*

For Medicare payers, remember also to add modifier AI *Principal physician of record* to indicate the services were provided by the principal physician of record, who is overseeing the patient's care (as opposed, for instance, to a provider reporting a consultative service in the nursing facility for a Medicare patient).

The Subsequent Nursing Facility Care codes also are per day, and include diagnostic studies chart and results review, and any changes in the patient's status since the last assessment. These codes only require two of the three key components to be satisfied to report any particular level.

For example, subsequent service documentation for the patient above might state:

CC: F/U Left hip fx, Doing well with rehab and pt is expecting to go home soon. Ambulating better. Pain minimal.

HTN, Hypothyroid, hyperlipidemia are stable.

ROS: doing better getting sleep at night. ⊘ CP, SOB.

PE: VSS, COR RRR w/o murmur, Lungs CTA, Left hip incision healing nicely.

IMP: Responding to rehab nicely, Awaiting PT clearance, Hypothyroidism on replacement; HTN good control; ↑ chol - cont meds, DVT prophylaxis w/ Lovenox.

Continue current meds.

In this case, the detailed history, expanded exam, and moderate medical decision making would warrant a level III subsequent nursing facility care service, 99309 *Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: a detailed interval history; a detailed examination; medical decision making of moderate complexity.*

Who Can Bill the Initial Professional Service in the SNF and NF?

This answer depends on whom you ask.

Some states allow non-physician practitioners (NPPs), as well as physicians, to perform the initial visit. But if you ask Medicare, there is a difference between a SNF and an NF, and who can perform the initial visit.

According to Medicare (PHYS-079), use Initial Nursing Facility Care codes to report an initial visit in a SNF, and this service *must* be performed by the physician and *cannot* be delegated. In the NF setting, a qualified NPP (such as a nurse practitioner (NP), physician assistant (PA), etc.), who is *not* employed by the facility, may perform the initial visit when within the scope of their practice and state law.

One exception to this rule is if the patient's condition warranted a medically necessary visit due to illness or injury prior to the physician's initial visit in either the SNF or NF setting. Qualified NPPs may bill a Subsequent Nursing Facility Care code, even if their service is provided before the physician's initial visit. The documentation and diagnoses codes associated with the service need to support the medical necessity of such a service.

An example of a medically necessary, subsequent note (in the **SOAP** format) prior to the initial visit might be:

Do not misconstrue the word "comprehensive" in Medicare's description to have the same meaning as "comprehensive" in the documentation guidelines as it pertains to history and exam.

S: Acute visit; asked to see pt for a blister on her right upper abdomen, it opened and is described as dry, scabbed with mild redness at the site.

O: It measures 0.9 x 0.8 cm without swelling or increased warmth. She does c/o pain with mild palpation. Today the scab is off. There is yellow-green slough in the wound bed with mild redness around the site. T. 98.2, BP. 130/80, P. 72, R. 20

A: Stage II open area RUQ abdomen—Questionable etiology.

P: Moist to dry dressing.

Based on the above documentation, it would be appropriate to report level II Subsequent Nursing Facility Care code 99308 *Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: an expanded problem focused interval history; an expanded problem focused examination; medical decision making of low complexity* for this service.

The initial visit, according to Medicare (PHYS-079 and *Internet Only Manual*, Pub. 100-04, chapter 12, section 30.6.13), is "defined as the initial comprehensive assessment visit during which the physician completes a thorough assessment, develops a plan of care and writes or verifies admitting orders." This visit must occur no later than 30 days after admission.

Although the verbiage in the Medicare description states "comprehensive" assessment, the required documentation to report the lowest level Initial Nursing Facility Care code is only a detailed history and examination with straightforward/low medical decision-making. Do not misconstrue the word "comprehensive" in Medicare's description to have the same meaning as "comprehensive" in the documentation guidelines as it pertains to history and exam.

Where, When Can the Initial NF Visit Take Place?

An initial nursing facility service can occur in the physician's office, the hospital, or the SNF/NF—and it can occur on a different date than the admission date to the SNF/NF. Medicare will reimburse for these services only when billed with POS codes 31 or 32. The documentation should show the location and date that the face-to-face service occurred.

Who Can Bill Subsequent Professional Services in the SNF and NF?

Again, depending on whom you ask, the answer may be different.

According to Medicare, either the NPP or the physician can perform the mandated follow-up visits in the SNF or the NF. But in the NF, qualified NPPs cannot be employed by the facility.

Use the Subsequent Nursing Facility Care codes to report federally mandated and any medically necessary visits that might arise. Qualified NPPs may perform alternating federally mandated physician visits. Medicare doesn't offer guidance regarding the frequency of physician-continued involvement in the patient's care throughout their SNF stay. Some states don't allow NPPs to perform *all* the mandated visits, but they can perform *some* of them. Check your state laws and create an internal policy outlining the frequency of physician visits to demonstrate their continued involvement.

Bill the annual nursing facility visit using CPT® code 99318, which can be used in lieu of a Subsequent Nursing Facility Care code.

Can SNF or NF Services Be Billed Split/Shared?

No.

How Is SNF or NF Discharge Billed?

Similar to Hospital Discharge Services, Nursing Facility Discharge Services, too, are time-based codes.

CPT® 99315 *Nursing facility discharge day management; 30 minutes or less* is used to report a discharge service of less than 30 minutes, while 99316 *Nursing facility discharge day management; more than 30 minutes* is appropriate for a discharge service of greater than 30 minutes.

Discharge visits include the final examination of the patient, discussion of the nursing facility stay, patient care instructions, and completion of medical records/forms. Report the date the service was actually performed, even if that date differs from the calendar date the patient was discharged from the facility.

Kerin Draak, MS, WHNP-BC, CPC, CEMC, COBGC, has been involved in the health care field for over 18 years, specializing in women's care. She is the coding educator for a 220+ provider multispecialty clinic and was instrumental in the development of its internal chart audit program. Kerin has developed educational tools, guides, and policies for the clinic. She is an AAPC National Advisory Board (NAB) member and serves as president of her local AAPC chapter.

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Members of the American Academy of Professional Coders (AAPC) shall be dedicated to providing the highest standard of professional coding and billing services to employers, clients, and patients. Professional and personal behavior of AAPC members must be exemplary.

- AAPC members shall maintain the highest standard of personal and professional conduct. Members shall respect the rights of patients, clients, employers, and all other colleagues.
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- Members shall respect and adhere to the laws and regulations of the land, and uphold the mission statement of the AAPC.
- Members shall pursue excellence through continuing education in all areas applicable to their profession.
- Members shall strive to maintain and enhance the dignity, status, competence, and standards of coding for professional services.
- Members shall not exploit professional relationships with patients, employees, clients, or employers for personal gain.

This code of ethical standards for members of the AAPC strives to promote and maintain the highest standard of professional service and conduct among its members. Adherence to these standards assures public confidence in the integrity and service of professional coders who are members of the AAPC.

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Just Change the Code

Another example of why coders are so important to their practices.

By Simone Tessitore, CPC, COBGC

"If you'll just change the code, insurance will pay for it."

These are the 11 most frustrating words in the English language. Hearing these words makes me want to scream.

In my almost 20 years in health care, I can't begin to guess how many times I've heard these words from patients, accounts receivable staff, doctors, and even from insurance representatives. And today, for the first time, I saw it in print.

While reading the January/February 2010 issue of *Cooking Light*, I came across the article "Yes, You Can Ease Anxiety About Health-care Costs." Of course, being one of my favorite topics, I plunged right in. There was a lot of good information in the article … until I read this:

"You may not think of medical bills as negotiable, but in some ways they are. For example, items such as annual blood work are assigned codes for billing purposes; the code affects how much your insurance provider will pay (or not). A friendly call to your doctor's billing office may result in a change to the code applied to your treatment and a more favorable outcome on the bill."

I choked on my sandwich. Did I read that correctly? I read it several times and even read it to another coder. Luckily, she was not eating lunch at the time.

This brought to mind the 15 most infuriating words ever spoken by a patient: "My insurance says that if you had coded it right, they would have paid it." Ugh! After reviewing the notes and the coding as submitted, we usually need to explain to the patient that what their insurance really means is that if you had a different kind of service/problem, and we had coded it for that issue, then "yes," it may have been a covered service. But as it stands, correctly coded and billed, it will not be paid by the insurance company.

Customer service has an extremely difficult job. Trying to explain the mysteries of medical coding and billing to patients can sound like you're speaking a foreign language—especially if its coming from someone who doesn't understand the dialect. Education should start at the front end, rather, before services are provided. Patients should fully understand their benefits and payment responsibilities prior to treatment. Do this and rather than being told later to "change the code," we'll instead hear two of the nicest words spoken: "Thank you."

Simone Tessitore, CPC, COBGC, has worked in coding and billing for almost 20 years, in payer, private practice, and large group environments. She works as a coding and billing supervisor for the University of Oklahoma (Simone-Tessitore@ouhsc.edu).

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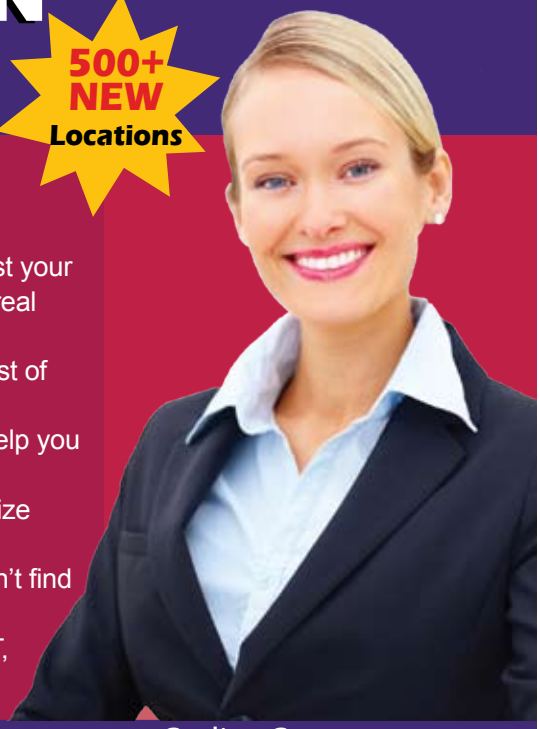

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CMS vs. CPT®

What Can You Bill Postoperative?

Surgical complication billing gets tricky when global surgery guidance conflicts.

By LuAnn Jenkins, CPMA, CPC, CEMC, CFPC

In 1992, the "global surgery" concept was introduced under the Resource Based Relative Value Unit System (RBRVS) and payment policy. Medicare adopted this method to control costs and to pay providers based on the value of services provided before, during, and after surgical procedures. Many commercial payers also adopted this system as the basis for their fee schedules and global periods; however, not all payers follow all of Medicare's global surgery payment policies. The CPT® manual provides guidance on coding and also defines what a "global surgery" includes from a coding perspective.

This can be very important for surgical complication billing because CPT® policy is less restrictive than Medicare.

Know Your Payer, Know the Rules

Accurate coding and billing requires knowing your payer rules prior to claims submission. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) named CPT® and HCPCS Level II as the national code sets and required all entities to be able to accept those codes. It did not, however, require payers to pay all codes or adopt uniform CPT® coding policies.

Do not assume all payers follow all of Medicare's policies; payers may choose to use all or part of the Medicare global fee rules. They may use the global days and relative value units (RVUs), but not the national Correct Coding Initiative (CCI) or other specific rules. For example, Michigan's Workers' Compensation Agency uses the RBRVS system as a basis for their fee schedule and global days, but follows the CPT® post operative complication rule.

Postoperative complications may consume significant time and resources. If the services legitimately can be billed, be sure to capture that revenue. Gathering policy information can be time consuming, but provide a valuable tool to share with coders and billers. Adopting a "one size fits all" coding/billing policy may be easier in the short term, but can be costly and result in lost revenue for your practice.

In the end, it is your contracts that dictate the coding and billing rules you must follow. What you can bill to an insurance company depends on the payer involved.

In the end, it is your contracts that dictate the coding and billing rules you must follow. What you can bill to an insurance company depends on the payer involved. As a result, what you bill for a particular service may vary from one patient to another. Postoperative complications that never would be billed to Medicare, for example, may be allowable under a commercial payer contract.

Gather information pertaining to your specific type of practice. Issues such as complication rules, global days, and modifier definitions are crucial to each practice and vary by payer. In medical billing, too often we learn by trial and error; we bill a service, receive a denial or partial payment, and then contact the payer and discover what created the problem. Often, an unknown or misunderstood payer rule is to blame. Unfortunately, this information isn't always documented or shared, and the same (wrong) steps are repeated.

If you are unable to get specific answers in payer manuals, contact medical directors in writing to ask what the medical policy is on postoperative complications.

Create a resource for your office. Following documented guidelines will enable you to confidently submit clean claims to all payers, which will result in lower denial rates and fuller reimbursement for services provided.

Applying Modifiers for Postoperative Reimbursement

Modifiers are the key to payment for surgical complications. Both CPT® and Medicare agree that a complication requiring a return to the operating room (OR) should be paid separately using the appropriate modifier. Complications requiring treatment outside of the OR that are provided in the office, outpatient, or inpatient setting also will require modifiers for those non-Medicare payers that follow CPT® guidelines.

Complications requiring additional surgical procedures in the OR related to the original surgery require modifier 78 *Unplanned return to the operating room/procedure room by the same physician following initial procedure for a related procedure during the postoperative period* to be appended to the appropriate procedure code. Under the Centers for Medicare & Medicaid Services (CMS) policy for this purpose, an OR is defined as "a place of service specifically equipped and staffed for the sole purpose of performing procedures. The term includes a cardiac catheterization suite, a laser suite, and an endoscopy suite. It does not include a patient's room, a minor treatment room, a recovery room, or an intensive care unit (unless the patient's condition was so critical there would be insufficient time for transportation to an OR)."

For example, a patient undergoes carotid endarterectomy (35301 *Thromboendarterectomy, including patch graft, if performed; carotid, vertebral, subclavian, by neck incision*), performed in the morning. Later that day, the patient is returned to the OR for exploration of the neck for postoperative hemorrhage. The return to the OR is coded as 35800 *Exploration for postoperative hemorrhage, thrombosis or infection; neck*, with modifier 78 appended.

Note: In certain circumstances, a return to the OR during the global period may call for modifier 58 *Staged or related procedure or service by the same physician during the postoperative period* rather than modifier 78. *Medicare Claims Processing Manual*, chapter 12, section 40.1.B states "If a less extensive procedure fails, and a more extensive procedure is required, the second procedure is payable separately." In such a case, modifier 58 is appropriate.

For example, a patient is seen and treated with closed reduction of a tibial shaft fracture (27750 *Closed treatment of tibial shaft fracture (with or without fibular fracture); without manipulation*). One week later, it is determined the closed reduction failed, and the patient is taken to the OR for an open treatment. Coding for the more extensive procedure is 27758 *Open treatment of tibial shaft fracture (with or without fibular fracture), with plate/screws, with or without cerclage*, with modifier 58 appended.

Unrelated post-operative evaluation and management (E/M) services are reported with modifier 24 *Unrelated evaluation and management service by the same physician*

Postoperative complications that never would be billed to Medicare, for example, may be allowable under a commercial payer contract.

during a postoperative period appended. Beware: CMS' Office of the Inspector General (OIG) has added modifier 24 to its annual Work Plan due to concern of misuse and resulting overpayments. The appropriate use of modifier 24 depends on what rules your payer follows.

Under Medicare policy, modifier 24 applies for:

- Visit for a new problem unrelated to surgery—supported by different ICD-9-CM code
- Visit for treatment of the underlying condition (**not** wound care, pain management, or a repeat procedure)

Under CPT® guidelines, modifier 24 applies for:

- Visit for a new problem unrelated to surgery—supported by different ICD-9-CM code
- Visit for treatment of the underlying condition, *and*
- Visit for treatment of complications, exacerbations, recurrence

For example, a Medicare patient is returning for a 30-day follow-up visit for a hip replacement. At the visit, the patient complains of new onset shoulder pain, which is evaluated and treated. Because the new complaint is unrelated to the previous surgery, you may separately report the E/M service using an established patient office visit code (9921x) with modifier 24 appended. The visit should be linked to a new diagnosis of 719.41 *Pain in joint; shoulder region.* A surgical procedure at the same visit—for example, a joint injection 20610 *Arthrocentesis, aspiration and/or injection; major joint or bursa (eg, shoulder, hip, knee joint, subacromial bursa)*—requires you to append modifier 79 *Unrelated procedure.*

In a different example, a patient with third-party insurance returns for a 10-day follow-up visit to hip replacement surgery complaining of a painful incision and fever. The excision is not healing and shows redness and drainage. The physician assesses the wound and treats the patient for postoperative wound infection. Assuming the payer follows CPT® guidelines, this visit is separately billable as 9921x-24, at the service level supported by documentation. For Medicare payers, however, the visit is not separately billable; the postoperative wound infection is "related" to the original surgery and did not require a return to the operating room. The service is bundled into the global surgical package for Medicare payment.

An example of treating the underlying problem is a breast biopsy (19101 *Biopsy of breast: open incisional*). If the result of the biopsy is a malignant neoplasm, and the patient is seen within the global period (10 days) to discuss treatment of a malignancy, the E/M service is reported with modifier 24 to indicate treatment of the underlying condition. If major surgery is performed within this 10-day period, modifier 58 would be applied to the service as a more extensive procedure. CE

LuAnn Jenkins, CPMA, CPC, CEMC, CFPC, is the president/owner of MedTrust LLC a practice management consulting firm located in Lapeer, Mich. With over 27 years in coding and reimbursement, LuAnn performs office assessments, chart reviews, education/training and provides medical billing services for multiple specialties including physical therapy, cardiology, neurosurgery, allergy, chiropractic, physical medicine, and internal medicine. She speaks on coding and reimbursement issues for the AAPC and the Michigan State Medical Society with whom she is a contracted consultant. LuAnn is vice president of the Michigan Medical Billers Association and 2006 AAPC Coder of the Year.

Define the Global Surgery Package

As outlined in the *Medicare Claims Processing Manual*, Pub. 100-4, chapter 12, section 40.1, CMS includes the following items/services in the global surgical package:

- Preoperative visits after the decision is made to operate, beginning with the day before the day of surgery for major procedures and the day of surgery for minor procedures;
- Intra-operative services that are normally a usual and necessary part of a surgical procedure;
- Complications following surgery, including all additional medical or surgical services required of the surgeon during the postoperative period of the surgery because of complications which do not require additional trips to the operating room;
- Follow-up visits during the postoperative period of the surgery that are related to recovery from the surgery;
- Postsurgical pain management by the surgeon;
- Supplies (except for those identified as exclusions); and
- Miscellaneous services/items such as dressing changes; local incisional care; removal of operative pack; removal of cutaneous sutures and staples, lines, wires, tubes, drains, casts, and splints; insertion, irrigation, and removal of urinary catheters, routine peripheral intravenous lines, nasogastric and rectal tubes; and changes and removal of tracheotomy tubes.

In contrast, CPT®, as detailed in the Surgery Section Guidelines, defines the global surgical package to include:

- Local infiltration, metacarpal/metatarsal/digital block, or topical anesthesia;
- Subsequent to the decision for surgery, one related E/M encounter on the date immediately prior to or on the date of the procedure (including history and physical);
- Immediate postoperative care, including dictating operative notes, walking with the family and other physicians;
- Writing orders;
- Evaluating the patient in the post-anesthesia recovery area;
- Typical postoperative follow-up care.

CMS and CPT® also *exclude* different services from the global surgical package. Per Medicare, the following items/services are NOT included in the global surgical package:

- The initial consultation or evaluation of the problem by the surgeon to determine the need for surgery. Please note that this policy only applies to major surgical procedures. The initial evaluation is always included in the allowance for a minor surgical procedure;
- Services of other physicians except where the surgeon and the other physician(s) agree on the transfer of care. This agreement may be in the form of a letter or an annotation in the discharge summary, hospital record, or ambulatory surgery center (ASC) record;
- Visits unrelated to the diagnosis for which the surgical procedure is performed, unless the visits occur due to complications of the surgery;
- Treatment for the underlying condition or an added course of treatment which is not part of normal recovery from surgery;
- Diagnostic tests and procedures, including diagnostic radiological procedures;
- Clearly distinct surgical procedures during the postoperative period which are not re-operations or treatment for complications. (A new postoperative period begins with the subsequent procedure.) This includes procedures done in two or more parts for which the decision to stage the procedure is made prospectively or at the time of the first procedure. Examples of this are procedures to diagnose and treat epilepsy (such as craniotomy procedures 61533, 61534-61536, 61539, 61541, and 61543), which may be performed in succession within 90 days of each other;
- Treatment for postoperative complications that require a return trip to the operating room (OR). An OR for this purpose is defined as a place of service specifically equipped and staffed for the *sole purpose of performing procedures*. An OR may include a cardiac catheterization suite, a laser suite, and an endoscopy suite. It does not include a patient's room, a minor treatment room, a recovery room, or an intensive care unit (unless the patient's condition was so critical there is insufficient time to transport to an OR);
- If a less extensive procedure fails, and a more extensive procedure is required, the second procedure is payable separately;
- For certain services performed in a physician's office, separate payment no longer can be made for a surgical tray (code A4550). Splints and casting supplies are payable separately under the reasonable charge payment methodology;
- Immunosuppressive therapy for organ transplants; and
- Critical care services (codes 99291 and 99292) unrelated to the surgery where a seriously-injured or burned patient is critically ill and requires constant physician attendance.

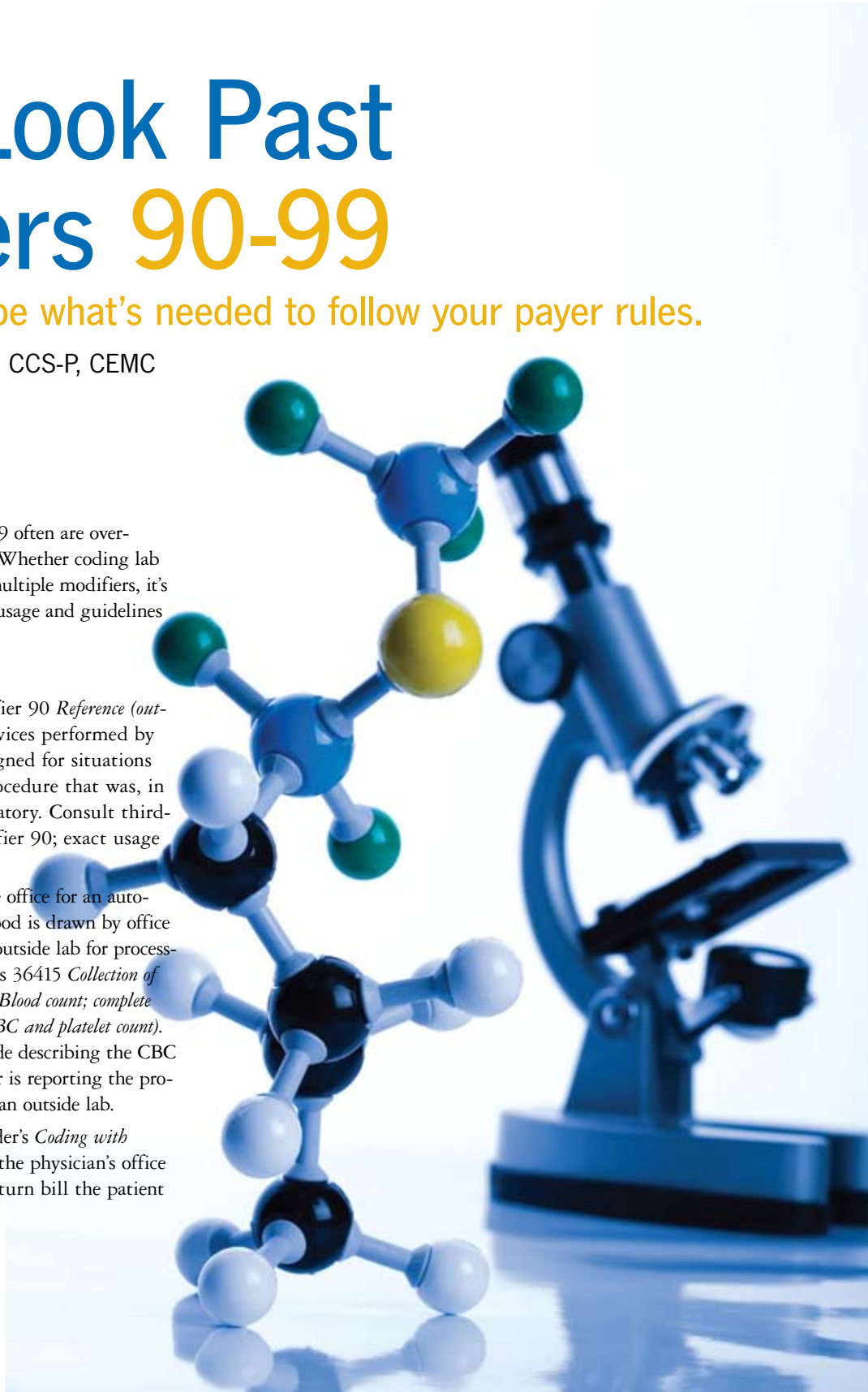
Under CPT® rules, the following services are NOT included in the global surgical package:

- Follow-up care for diagnostic procedures (eg, endoscopy, arthroscopy, injection procedures for radiography) includes only care related to the recovery from the diagnostic procedure itself. Care of the condition for which the diagnostic procedure was performed or of other concomitant conditions is not included and may be listed separately.
- Follow-up care for therapeutic surgical procedures includes only care which is usually a part of the surgical service. Report complications, exacerbations, recurrence, or the presence of other diseases or injuries requiring additional services separately.

Don't Look Past Modifiers 90-99

One of them may be what's needed to follow your payer rules.

By Dawson Ballard, Jr., CPC, CCS-P, CEMC



CPT® modifiers 90, 91, 92, and 99 often are overlooked by providers and coders. Whether coding lab procedures or procedures requiring multiple modifiers, it's important to understand the correct usage and guidelines for reporting these modifiers.

Modifier 90

The CPT® 2010 states to use modifier 90 *Reference (outside) laboratory* for reporting lab services performed by an outside or reference lab. It's designed for situations where the provider reports a lab procedure that was, in fact, performed by an outside laboratory. Consult third-party payers before reporting modifier 90; exact usage rules vary by payer.

For example, a patient presents to the office for an automated complete blood count. The blood is drawn by office staff, and the specimen is sent to an outside lab for processing. Appropriate coding in this case is 36415 *Collection of venous blood by venipuncture*, 85027-90 *Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count).* Append modifier 90 to the CPT® code describing the CBC to indicate that although the provider is reporting the procedure, it actually was performed by an outside lab.

In such cases, according to Deb Grider's *Coding with Modifiers*, the lab generally will bill the physician's office for its service, and the office will in turn bill the patient for the lab.

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Modifier 91

Use modifier 91 *Repeat clinical diagnostic laboratory test* to report the same lab test when performed on the same patient, on the same day, to obtain subsequent test results.

Modifier 91 causes a lot of confusion when differentiating its use from that of modifier 59 *Distinct procedural service.* When reporting lab procedures, use modifier 59 when the same lab procedure is done, but different specimens are obtained, or the cultures are obtained from different sites.

The June 2002 *CPT® Assistant* provides a great example of the correct use of modifier 91:

A 65-year-old male patient with diabetic ketoacidosis has multiple blood tests performed to check the potassium level following subsequent potassium replacement and low-dose insulin therapy. After the initial potassium value, three subsequent blood tests are ordered and performed on the same date following the administration of potassium to correct the patient's hypokalemic state.

Coding for this scenario would be:

84132 Potassium; serum, plasma or whole blood

84132-91

84132-91

84132-91

Per CPT® guidelines *don't* use modifier 91 to report lab tests that are repeated to confirm the initial results, due to malfunctions of either the testing equipment or the specimen, or when another appropriate one-time code is all that is needed to report the service. If the test is rerun to confirm the initial results or because of a malfunction of the equipment, the service cannot be coded and modifier 91 would not apply.

If multiple tests are run, but a single code describes the test, only report one code, and modifier 91 would not apply. For example, 82951 *Glucose; tolerance test (GTT), three specimens (includes glucose)* includes three specimens so if three specimens were obtained during the encounter, only report 82951.

Modifier 92

Append modifier 92 *Alternative laboratory platform testing* when lab testing is done using a transportable kit with a single use, disposable analytical chamber. CPT® states the test does not require permanent space, and it can be hand held and carried to the patient for immediate testing.

As explained in *CPT® Assistant* (March 2008, page 3 and April 2008, page 5), the use of this modifier 92 is limited to three specific lab procedures dealing with HIV testing:

86701 Antibody; HIV-1

86702 Antibody; HIV-2

86703 Antibody; HIV-1 and HIV-2, single assay

For example, a female patient presents to the office for a sexually transmitted disease (STD) screening. The patient is concerned about HIV exposure after engaging in unprotected sexual intercourse. The patient is tested for HIV using a hand-carried transportable kit. Correct coding in this case would be 86701-92. Modifier 92 is appropriate because the HIV testing is performed using the hand held transportable kit.

Modifier 99

Modifier 99 *Multiple modifiers* often is not reported because many coders and providers are not aware of its correct use. Modifier 99 is designed for situations where two or more modifiers may apply to the procedure, and notifies the payer that multiple modifiers are being reported. According to Ingenix's *Medicare Desk Reference for Physicians*, the Centers for Medicare & Medicaid Services (CMS) does recognize modifier 99, as do most third-party carriers; however, the modifier is "informational only" and its use does not affect claims' payment.

Correct reporting of modifier 99 varies by carrier; but, the most common usage is to report the procedure and to append modifier 99 immediately after, then report any additional modifiers. Coders and providers should refer to their third-party payer guidance for correct reporting of modifier 99.

As an example, a physician assists with the percutaneous skeletal fixation surgery of a patient's posterior pelvic bone fractures, resulting from a severe, head-on car accident in which the car rolled several times. In this case, correct coding would be 27216-99-80-50 *Percutaneous skeletal fixation of posterior pelvic bone fracture and/or dislocation, for fracture patterns that disrupt the pelvic ring, unilateral (includes ipsilateral illium, sacroiliac joint and/or sacrum).* It is appropriate to append Modifier 99 to the procedure code here because more than one modifier is being reported for the surgical procedure. Modifier 80 *Assistant surgeon* indicates the physician's role as an assistant surgeon, while modifier 50 *Bilateral procedure* denotes that this was a bilateral procedure. CE

Dawson Ballard, Jr., CPC, CEMC, CCS-P, is the coding educator for Take Care Health Systems, a Walgreens Company, in Franklin, Tenn.

Admission Date, Initial Hospital Service Date: Two in the Same?

Here's guidance for when the physician doesn't provide the initial service on the admission date.

By William P. Galvin, CPC

There is no requirement within CPT®—or within the Centers for Medicare & Medicaid Services (CMS) Medicare policy—indicating an initial service be reported only on the admission date.

In a perfect world, a patient's admission date and the initial hospital service date would be identical. In the real world, however, the physician doesn't always provide the initial service on the admission date. The question often arises: How do you code such a case?

Call on 99221-99223

Codes 99221-99223 often are referred to casually as "admission codes." In fact, these codes do not describe an admission service, but rather the initial evaluation and management (E/M) of the patient in the hospital. CPT® guidelines, found within the text preceding the Hospital Inpatient Services/Initial Hospital Care codes, specify: "The following codes [99221-99223] are used to report the **first hospital inpatient encounter** with the patient by the admitting physician" [emphasis added].

There is no requirement within CPT®—or within the Centers for Medicare & Medicaid Services (CMS) Medicare policy—indicating an initial service be reported only on the admission date. You would report 99221-99223, as appropriate to the documented level of service, for the initial hospital service, regardless of whether the initial service occurs on the same day as the admission.

Several Medicare carriers post advice that supports this coding. For example, WPS Medicare—Part B carrier in Illinois, Michigan, Minnesota and Wisconsin—offers the following Q&A examples on its web page (www.wpsic.com/medicare/part_b/education/2009_0706_emfacility.shtml):

"Question: *When the physician provides a direct admit from the office, can we bill an initial hospital visit even though the physician does not go to the hospital on that day?*

"Answer: No. An initial hospital visit code is the first encounter with the patient as an inpatient in the hospital. Billing an initial hospital visit procedure code is not appropriate if the physician does not see the patient in the hospital. The physician would bill the office visit and then bill the initial visit code when he/she sees the patient in the hospital. If the physician sees the patient in the hospital on the same day as a visit in another site of service, only the initial hospital visit may be billed.

"Question: *The patient was admitted to the hospital on the 10th, but the Admitting Physician did not see the patient until the 11th. Should the Admitting Physician bill the initial visit on the 10th or 11th?*

"Answer: The admitting physician bills the initial hospital visit the first time he/she sees the patient in the hospital. You can only bill the initial visit on the day it was performed — the 11th.

"Question: *The Admitting Physician admitted the patient on the 10th and saw them briefly. I performed the H&P on the 11th. Can I bill a subsequent code on the 10th and the hospital admission on the 11th?*

"Answer: The initial hospital visit procedure codes are used the first time the admitting physician sees the patient in the hospital. In the example, the initial visit is on the 10th. Choose the procedure code based on the documentation. The service on the 11th is a subsequent hospital visit.

"Note that the same rules apply to teaching physicians, even when a resident sees the patient on a previous day. For example, a history and physical exam (H&P) is performed by a resident on the 15th at 11:30 p.m. The teaching physician physically sees the patient at 7:30 a.m. on the 16th. If the claim is filed under the teaching physician's unique physician identification number (UPIN), the initial hospital code (99221-99223) would not be coded until the teaching physician physically saw the patient and incorporated the resident's notes and documented their own notes accordingly (that is, on the 16th)."

William Galvin, CPC, is the compliance manager for The Cambridge Health Alliance in Massachusetts. In his 20-year career in the health care field, Bill says he has been fortunate to have worked with many great people in world class health care facilities in and around the greater Boston area. Bill received his CPC® in 2004.

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For Continued Education and Training

The key to "How?" is explaining "Why?"

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

As certified coders, we are required to fulfill yearly continuing education unit (CEU) requirements to maintain our credentials and stay current with medical coding updates. This requirement may be the driving force that motivates you to seek out education and training. If it is, perhaps you're doing yourself an injustice. Earning your CEUs should be a source of fun, and the joy comes not just from learning but from becoming an active participant in the industry.

Why CEUs Aren't Just About Education

Obtaining CEUs is about much more than just gaining text book education. It's an opportunity to go above and beyond the minimum annual requirement and open doors to unlimited knowledge.

I am a perfect example of how obtaining CEUs started a path to career-building achievements. Early in my coding career, I attended my first chapter meeting. I was told attending chapter meetings was how to obtain CEUs. I quickly discovered I really liked the group of coders in my chapter. We had more in common than just coding. Before I knew it, I was invited and honored to become a chapter officer. I considered what my duties would entail, I watched the other officers, and how they interacted with each other and chapter members. I got involved.

While I was learning, opportunity was presented to me. I embraced these opportunities and with them came bonuses I had not anticipated, such as:

- Having a large network of friends both on a personal and professional level.
- Building schedule and coordination skills by organizing local chapter meetings and conferences.
- Developing a local and national network of specialized experts in numerous health care-related fields.
- Accessing instant help with a perplexing coding, billing, or auditing scenario.
- Gaining experience, becoming an expert, and offering any assistance in return.

AAPC offers more than 91,000 members as resources—that is a large network to tap into. To this day, I maintain the networking friendships I've built, continue to support my local chapter, and stay involved.

Education by Choice

Each of us learns differently. Some coders need the social interaction they gain from attending chapter meetings, workshops, and conferences. Others like their solitude and listen to audio conferences, download educational material, and participate in interactive online sessions.

If you're a social being, sharpen your communication skills by attending local chapter meetings, as well as statewide and local chapter conferences. Better yet, participate in planning a local chapter conference. You'll pick up all sorts of new skills, such as:

- Selecting topics conference attendees would like to hear.
- Seeking out the appropriate speakers.
- Scheduling events on a large scale.
- Selecting a venue to hold the conference.
- Choosing the right food and how much food is necessary for a two-day conference.
- Marketing the conference.
- Registering members.
- Arranging an array of vendors and door prizes.
- Assigning CEUs.

Apply Chapter Experience to the Workplace

While I attended local chapter meetings to obtain CEUs, I learned much more than coding and became educated on many levels. I quickly learned getting involved was the key to bolstering coding education.

During this time period, I became responsible for giving presentations and conducting training. It takes a lot of work to research and prepare a training course. Every time I prepare a presentation, even if it is a topic I have presented before, I learn something new. When we acquire new skills, we can do our jobs better by building confidence and applying the know-how to our work environment. We can put more into our jobs and offer more to our employers.

From my experience, education and training is the key to getting involved, which unlocks the door to career advancement. Seeking and utilizing education benefits everyone.

Gain Employer Supported Education

In this financially challenged time, one of the first budget cuts is made to training and education. Fortunately, there are several ways to gain employer support of continue education and keep it. You have to show there is a return on investment (ROI). You need to give back to your employer the time and money he or she invests on education resources. Do this by considering:

Cost: The dollars and cents it will cost your employer to send you to training locally or out of your area. In other words, think about if an employer sends you to training, what will he or she get out of it financially? Can you assign a dollar value?

Value: If you can't assign a monetary value on what the company will gain from your training, you should at least bring back training materials, write a report about what you've learned and the value the training has on your job performance. Better yet, bring back the material, file them on the shelf, share them, and spread the word. If you put effort into the training and really learn something, the employer should know the value of the investment they just made in your education.

Recouping lost revenue: Look at the training as much more than CEUs or a free trip to a conference. Apply what you've learned during training by identifying lost revenue, recovering money, or knowing how to prepare for an audit in your practice. This demonstrates the value of education to your employer.

Remember: When you are at educational events, make contacts and get business cards. You may return from training and have additional questions or need clarification on coding specific to your employer's specialty.

When Employer Support Is NOT an Option

If outside training simply is not an option, then arrange your own training. This might sound like a daunting task, but you will reap the rewards. Get creative. Use your network of coder buddies and local chapter to get a committee together, or join an existing group and organize an event. Start with location, then topics, and then speakers. Don't forget to consider topics for potential CEUs.

Remember: "If you build it, he will come," (Ray Liotta, *Field of Dreams*, 1989). This holds true in coding circles.

Again, bring your knowledge and value back to your employer because this time the cost may be only one day out of the office for an event you organized. If your employer still doesn't support taking a day off of work for free education, make it a Saturday event.

One of my students said to me once that she thought coding was "just working in a cubicle all day." She had no idea there was so much more to coding—until she heard my story. And it all started with an AAPC coding credential and a chapter meeting I attended simply to earn CEUs.

Jonnie Massey, CPC, CPC-P, CPC-I, CPMA, AHFI, is director of payers and audits at AAPC.

Make Education Fun

Education doesn't have to be boring or an obligation. When planning an educational event, make it fun. Here are some creative and fun ideas to try at your next coding event or conference:

- Invite a local Federal Bureau of Investigation (FBI) agent to speak at the event. Each state/area has a training department and is happy to have an agent speak about health care fraud. Agents come with great stories about fraud cases and health care fraud victims, which is always a big draw.
- Have goody bags at the registration table. Pick a theme (coding, seasonal, regional, etc.).
- Invite vendors. In lieu of paying a vendor fee, ask them to donate a prize for your event, and then hold drawings. Include the "win a prize" verbiage when advertising your event. Have a vendor sponsor a break or meal.
- Consider vendors who have anything to do with coding, the medical field, coding education, or educational materials. Even consider local massage schools, staffing agencies, etc.
- Ask a local chapter(s) to donate a workshop registration to the event.
- Have a networking breakfast.
- Speakers often write books. If so, you can have book signing featured.
- Have raffles and drawings. Do you have a quilter in your group who would donate? You can raise money for a good cause by offering a raffle for a donated item.
- Auction off a ham and cheese sandwich autographed by AAPC President and CEO Reed Pew. Reed's autographed sandwich can raise enough money to offer several scholarships to students. Honest!

Get a Better Perspective on Mentoring

Don't let mentoring misconceptions stop you from realizing the benefits.

By M. Julia Croly, CPC, CPC-P, CPC-I

A person new to the medical coding field can be overwhelmed as even simple things that an experienced coder takes for granted can be a source of confusion for a new coder. For example, AAPC credential designations (CPC®, CPC-P®, CPC-H®, etc.) and the coding language (add-on codes, modifiers, evaluation and management (E/M), V codes, etc.) may seem foreign. Only a small number of new coders have someone they can ask nagging coding questions of while the majority stumble through the AAPC certification maze.

Let Experience Help You Guide Someone

The best mentors are found in the AAPC coding community. As a certified coder, you are the perfect person to provide coding guidance to a new coder. Besides, you might like it.

Becoming a mentor is easier than you think. A mentor is:

- A knowledgeable and experienced guide who teaches (and learns) through a commitment to the mutual growth of both mentee and mentor.
- A caring, thoughtful facilitator who provides access to people, places, experiences, and resources.
- A role model who exemplifies in word and deed what it means to be an ethical, responsible, and compassionate person and who "Upholds a Higher Standard."
- A trusted ally or advocate who works with the mentee on behalf of their best interests and goals.

Studies show that often the most important factor associated with a person's choice to stay on a career path (such as mastering medical coding) is the student's ability to find a mentor. Mentors in the medical coding field understand their interactions with new coders will help discover the new person's potential for success and help to obtain their certification.

You're a mentor when:

- You help a new coder reveal their hidden potential to others as well as him or herself.
- You share stories with the new coder about your education, and the way you overcame obstacles similar to theirs—like taking the AAPC exam.
- You help the new coder overcome their fears.
- You share time management skills to everything done.
- You listen and offer advice to solve the problem.
- You help a new coder navigate through AAPC's resources.

Banish Five Mentoring Misconceptions

1. *Misconception: To be a mentor, you need to be an old person with gray hair (or no hair).*

Reality: Mentors can be any age, young or old.

2. *Misconception: Becoming a mentor requires a lot of time and a lot of work.*

Reality: Becoming a mentor requires a change in consciousness. For example, how you think about yourself and how you think about others. Mentoring is not a matter of working harder or longer, or adding to your job responsibilities. It is about seeing your work differently.

3. *Misconception: A mentor only can help a limited number of people. Although a mentor may want to help a lot of coders, it is only possible to work with a select few.*

Reality: Each interaction with a new coder is a mentoring opportunity, even a single encounter. The key is to acknowledge the importance of mentoring during interactions with other coders and to infuse this consciousness into your daily coding work. It also is important for mentors to see themselves as part of a network of mentors. To truly mentor, you'll find yourself calling upon that AAPC community of mentors. Mentoring occurs in a community, not in isolation.

4. *Misconception: Only the person being mentored benefits from mentoring.*

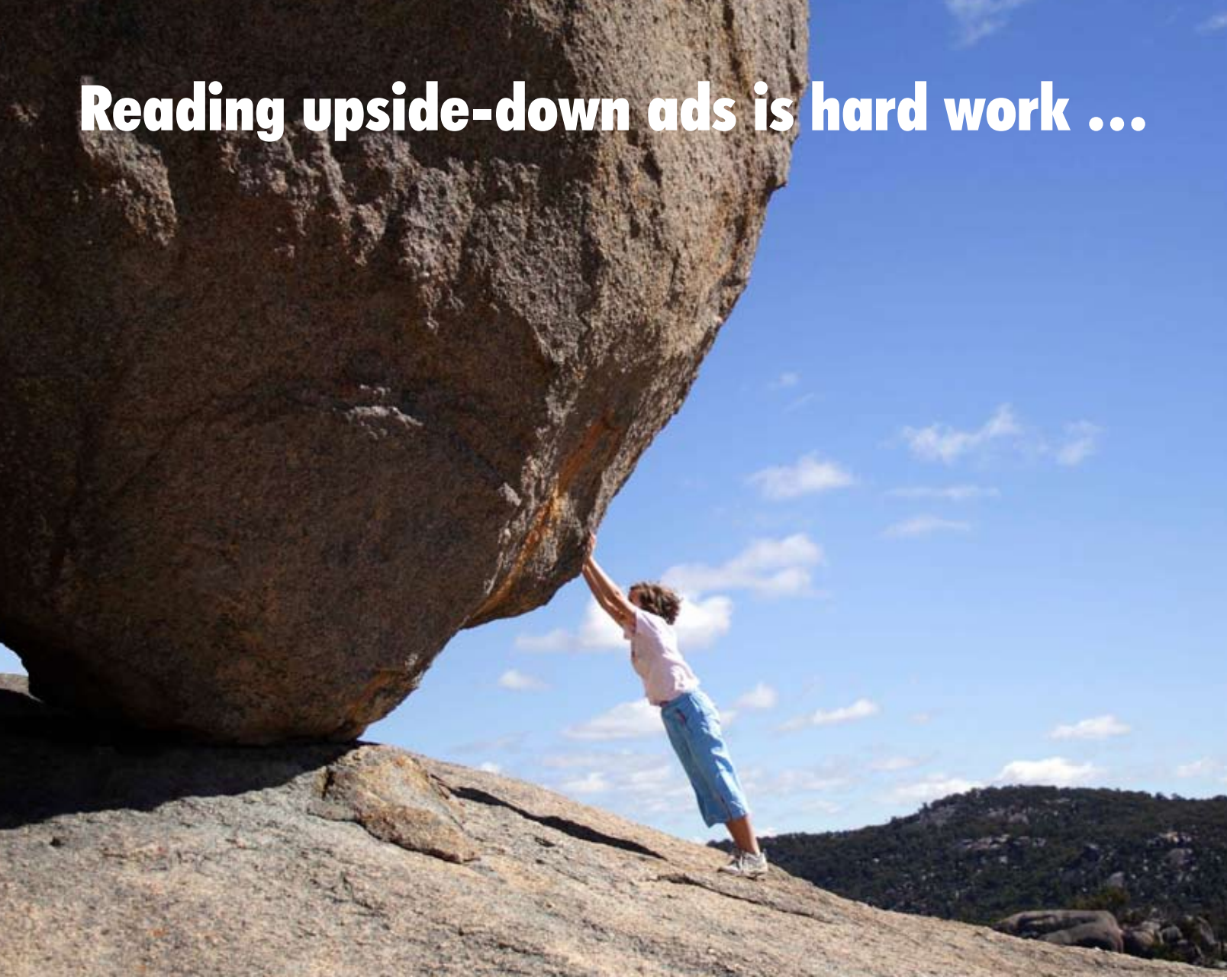
Reality: By definition, mentoring is a reciprocal relationship where both the mentee and mentor learn from each other. True mentors use their wisdom to learn from their mentee and reap the full benefits of the relationship.

5. *Misconception: Mentoring only happens one-to-one on a long-term basis.*

Reality: In medical coding, mentoring occurs in many different ways. Some mentoring relationships are traditional relationships involving a one-to-one setting over a long period of time. Effective mentoring also occurs in a group setting or even providing guidance through a single encounter with a new coder.

As a certified coder, take someone under your wing. Think about ways to bring mentoring into your daily work and see each interaction with fellow coders as an opportunity for mentoring. The new coder will benefit and **YOU** will too.

Julia Croly, CPC, CPC-P,CPC-I, has 25 years experience in health care insurance and works as an independent health care consultant and educator in Honolulu, Hawaii. She is on the AAPC executive board and is a past member of the National Advisory Board (NAB). She can be reached at mjcroly@gmail.com.



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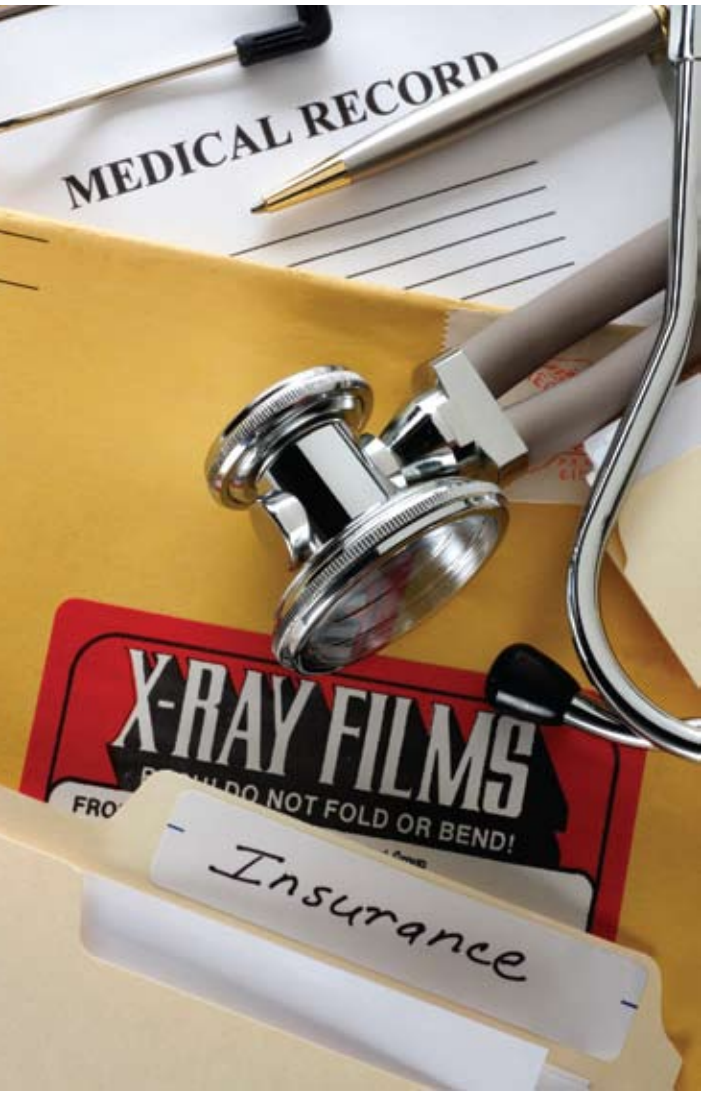
PROFESSIONAL

Combine Communication and Quality of Care

Bring value to your medical records by uniting these concepts.

By Lynn S. Berry, PT, CPC



As we move into the era of pay for performance, value-based purchasing, and bundled or global payments, our documentation must represent clearly the services we perform, and the rationale and medical necessity for our actions.

Patient care and documentation of that care given by any provider should have four elements of focus:

- The patient
- Clear communication with other health care providers
- Quality, evidenced-based care
- Best resource use

Let's review these points one by one.

The Patient

First, information is gathered regarding the patient using all possible resources. Information is derived from the patient, family members and other caregivers, past providers or charts, and from direct questions to the patient about a particular problem or impairment. Depending on the chief complaint, subjective questionnaires are used, such as the Visual Analog Pain Scale, the Oswestry Disability Index, or the New York Heart Association, Classification for Congestive Heart Failure, etc. This information should be recorded completely in the most concise format.

Next, the patient is physically examined for pertinent elements utilizing in-office investigational tools and objective measures, depending on subjective information. For instance, based on the patient's presenting problem, the examination may include: heart and respiratory rates, blood pressure, height and weight, and temperature; objective reflex testing; objective sensation testing; auscultation of the heart and lungs; palpation of organs and arteries; range of motion, strength testing and specialized tests for joint stability such as Lachman or McMurray's tests; tests for gait and/or balance, such as the Tinetti Performance Oriented Mobility Test; otoscopic or specialized eye exams, such as slit lamp testing, etc.

Outside testing may be used if required, and if a rationale for medically necessary tests is provided—beginning with the most conservative and least costly alternatives, and always keeping

in mind which procedures can provide the most information regarding a particular condition.

The physician or other provider's decision making then comes into play as a conclusion is reached regarding the patient's care plan. This is the most important part of the process. The rationale for the care used must be justified and be clearly quality, evidence-based care that is medically necessary for this patient, at this time.

Clear Communication with Other Health Care Providers

The next step is to document what was done. A clear picture should be painted of the above actions and intentions in a way that is evident to anyone who reads the medical record.

Ask yourself: Does the picture provided in the documentation have all of the required elements of form and substance? Does it have a focal point? Does it bring all of the elements together toward a conclusion? Is the picture of the quality wanted, or does it need revision? In documentation, the picture painted should be clear to other providers or suppliers who will see the patient in the future. Documentation should paint a clear picture, as shown in **Figure A**.

For instance: What was the patient like before the injury or problem? What problems were presented? Did the patient have problems with function or activities of daily living? Were there problems with cardiovascular endurance? Were open wounds documented, and if so, were they accurately described and objectively classified? Was there a language barrier or cultural barrier that needed to be overcome to treat this patient? Was the primary and any pertinent secondary diagnoses clearly documented? Does the reader know what has been done to investigate the patient's problems and why a resource was chosen over another? There should be a reason for every ordered test.

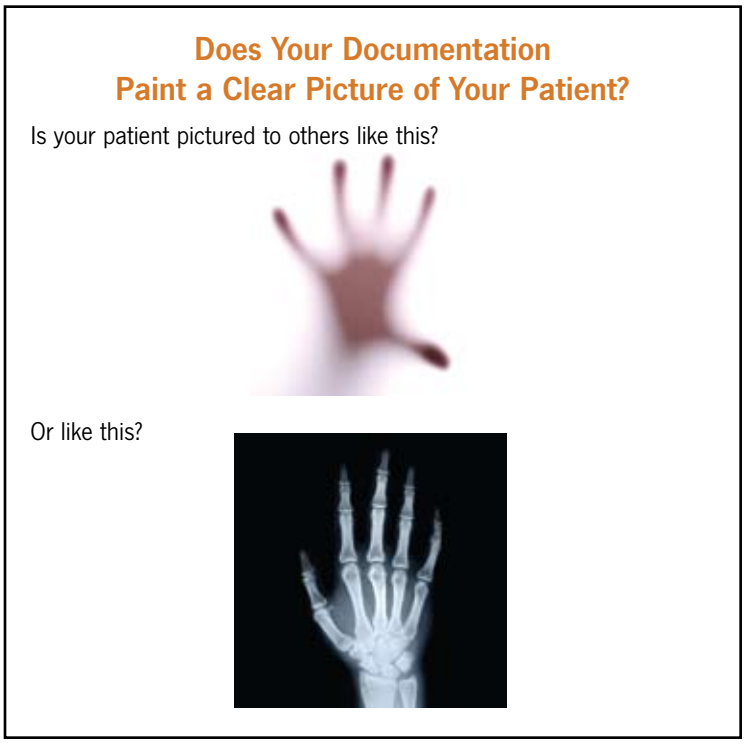
What was done to alleviate the problems? Was the care plan the best care possible as recommended by evidence-based practice and utilizing the least costly resources to help this particular patient with this particular diagnosis? There should be a reason for hospitalization, home health, nursing facility care, outpatient services, or referral to another provider. Will the reader know how long the treatment plan takes and what the expected patient outcome is when the treatment is concluded? There should be a reason for how often a patient is seen and for how long, and a reason for the expected time frame of when the patient needs to return for another visit.

In short: Was medical necessity for their care demonstrated and documented?

Quality, Evidenced-based Care

In 1991, the Institute of Medicine defined quality as "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and knowledge and are consistent with current professional knowledge." Similarly, in 2009, the Centers for Medicare & Medicaid Services (CMS) published a "Roadmap for Quality Measurement in the Traditional Medicare Fee-for-Service Program," which can be found at: www.cms.hhs.gov/QualityInitiativesGenInfo/downloads/QualityMeasurementRoadmap_OEA1-16_508.pdf. The agency defines quality measure goals as:

Figure A



"**Safety**—where care doesn't harm patients.

Effectiveness—where care is evidence-based and outcomes-driven to better manage diseases and prevent complications from them.

Smooth Transitions of Care—where care is well-coordinated across different providers and settings.

Transparency—where information is used by patients and providers to guide decision making and quality improvement efforts, respectively.

Efficiency—where resources are used to maximize quality and minimize waste.

Eliminating Disparities—where quality care is reliably received regardless of geography, race, income, language, or diagnosis."

In its quality program, the Physician Quality Reporting Initiative (PQRI), CMS "works with organizations, such as the Joint Commission on Accreditation of Healthcare Organizations, National Committee for Quality Assurance, Hospital Quality Alliance, Ambulatory Quality Alliance, National Quality Forum, medical specialty societies and many other organizations and government agencies including the Agency

The PQRI program will soon be based on pay for performance instead of pay for reporting, and voluntary efforts will soon be mandatory. It is moving toward value-based purchasing, where you may earn back reimbursement by demonstrating quality outcomes.

for Healthcare Research and Quality and the Veterans Health Administration, in the development and compilation of measures that have been tested and found to be reliable and valid in assessing quality."

In England, pay for performance is a reality for its general practitioners. Pricewaterhouse Cooper's Health Research Institute's article, "Paying for Performance – Incentives and the English Health System" states, "Pay for performance (P4P) is becoming an increasingly popular mechanism for incentivizing quality improvement globally. P4P is the only mechanism whereby quality metrics are explicitly linked to reward, however. As such, it is arguably the most effective mechanism for incentivizing quality over activity and/or volume."

What does this mean for the provider in practice today? When the decision is made for a test or an intervention or procedure, it should have a rationale defined by agencies with tested measures that exhibit consistency and reliability in the treatment of patients. When work is documented, such measures must be used to demonstrate medical necessity and establish that the best possible care is provided.

The health care system is moving away from fee-for-service and pay for volume of care and toward pay for performance. The PQRI program will soon be based on pay for performance instead of pay for reporting, and voluntary efforts will soon be mandatory. It is moving toward value-based purchasing, where you may earn back reimbursement by demonstrating quality outcomes across a variety of service places (hospital, office, hospice, home care, etc.). This applies not only to Medicare, but more recently also to many third-party payers. The only way to show that this quality and performance is provided is through clear and precise documentation.

Best Resource Use

One element of the CMS "Roadmap for Quality Measurement in the Traditional Medicare Fee-for-Service Program" is efficiency, in which the resources used will maximize quality and minimize waste. CMS is leading us into bundled payments with some of their demonstration projects, where physicians and different providers will work with hospitals and others to provide the best quality solution for their patients utilizing the least resources. Another way to reduce health care costs as a portion of overall Gross National Product (GNP) might be a global payment system in which providers manage patients across all delivery systems, earning reimbursement for how they care for their patients. This might include specific diagnostic groups using very specific guidelines for all patients, reducing the volume of services delivered overall.

The issue of transparency is not quality alone. CMS is already publishing procedure prices in various hospitals and will expand this to physicians in the near future. As consumers become more educated in these areas, competitive pricing and quality will determine market factors for patient choice, which should decrease overall health care costs. Documentation should include the least costly resource reasons for utilizing one testing method, procedure, or product over another, as well as what is best for the patient.

Follow the Practice Standards of your professional organizations. Follow local and national Medicare and Medicaid rules if you choose to receive their reimbursement. Follow the documentation standards of your third-party payers. All providers should be participating in or should begin to participate in the PQRI initiative, as this is part of the future of health care.

What About Malpractice?

If every diagnostic test and new technology available isn't utilized, how can malpractice lawsuits be avoided?

If some time honored treatment that always has been done to protect a practice is provided unnecessarily with increased services or prolonged treatment time, then increased services and increased revenue of the old fee for service system is gone and quality treatment in care suffers, which is a malpractice risk. When best practices guidelines as outlined by national agencies and professional societies are followed, and documentation is clear as to why one test is chosen over another for being the best and least costly test to diagnose a patient, then the patient has received quality care.

Back to the Basics

It's the patient that counts. If the above care and documentation is provided, everyone involved in every health system that a patient has or will encounter should understand what was done and the rationale for choosing a particular treatment plan and can carry out appropriate care from there. Everyone benefits from knowing the test and assessment results, and treatments and placements to avoid repetitious, unnecessary, and costly procedures. Documentation should demonstrate the quality and medical necessity of the care plan chosen over the continuum of the patient's care and lifespan. CE

Lynn S. Berry, PT, CPC, after over 35 years of clinical and management experience began a new career as a coder and auditor and later became a provider representative for a Medicare carrier. She owns the consulting firm, LSB HealthCare Consultants, LLC, which furnishes consulting and education to diverse provider types. She has held a variety of AAPC local chapter offices and is a director of the St. Louis West Chapter.

AAPC Welcomes 90,000 Member

Donna Peters, Yorba Linda, Calif. became the association's record-making member in March.

Like so many of our new members, Donna Peters has an interesting story which led her to the AAPC. She has a Bachelor of Arts in communications from California State University – Fullerton and eight years of human resource (HR) experience, giving her a unique view of health care on the employee side. She told Coding Edge that leaving the HR field was a hard decision but that it gave her a chance to stay home with her children for a few years.

Because going back into the HR field proved difficult for Donna, a coding friend encouraged her to start a new career in medical coding. Now, she is excited to build on her experience in HR and plans to take the Certified Professional Coder (CPC®) exam in July of this year. Once certified, she plans to research and find a specialty to best match her interests and experience. She is confident her education and certification with the AAPC will help her grow professionally.

"As far as education, experience, and coding," Donna said, "I feel that in the long run I may end up teaching/training in some capacity. It is so important to educate people about their benefits and try to simplify the EOB process. I think coding will give me some great ideas on this goal."

After hearing the news, AAPC National Advisory Board (NAB) President Terry Leone said, "Reaching 90,000 members demonstrates our commitment to providing high-quality, cost-effective education that meets the ever changing demands of today's professional coders. We will continue to provide our members the skills necessary to succeed in the years to come."

Confident the association would reach this goal in 2010, AAPC President and CEO Reed E. Pew said, "The demand for highly qualified medical coders has steadily increased over the years as physicians feel the pain of increased workload and lower reimbursements. Many physicians are reducing time and stress by hiring a CPC®. The AAPC provides coders with the knowledge and tools necessary to help physicians manage their revenue cycle while they remain focused on patient care."

In recognition of her joining, Donna can sit for a CPC® certification exam free of charge. And like so many of us who have tested, she admits she's a little nervous.

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1. Check my CEUs
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   (Don't want to wait till the last minute
   to get them like last time!)
2. Scan Forums. Maybe I can find the answer I need
3. Go to my chapter meeting and
   introduce myself to a new member
4. Check out member savings benefits on website.
   Coupons for groceries!
5. Make hubby go grocery shopping!!
6. Read Coding Edge this month
7. Buy webinar to listen to Saturday afternoon
   while kids swim
8. Relax!

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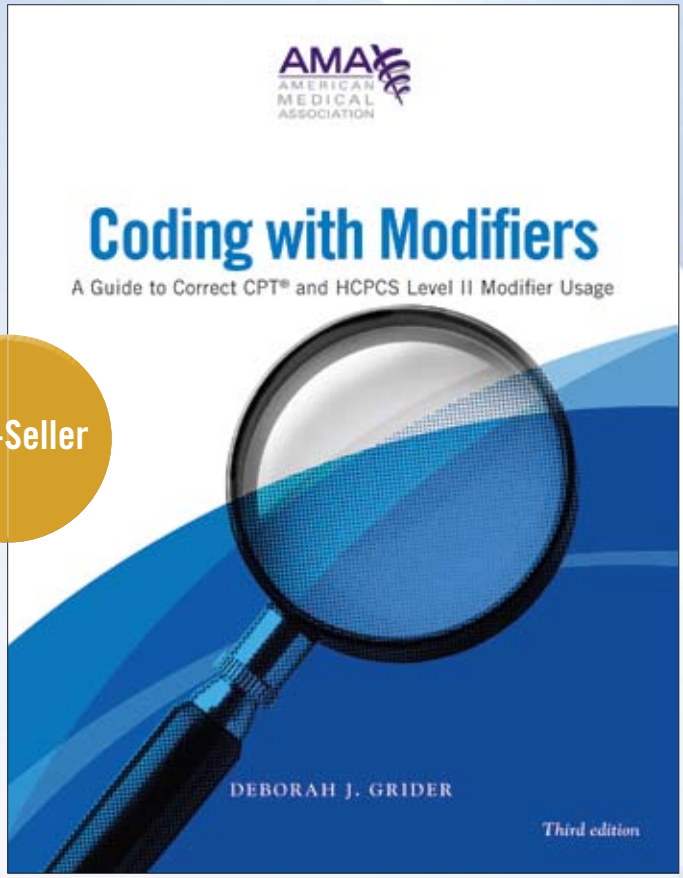

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Left, Right, or Bilateral?

Correctly identify location by applying modifiers LT, RT, and 50.

By G. John Verhovshek, MA, CPC

APPRENTICE

In medicine—and equally so in medical coding—location matters. As such, physician coders must be adept when applying the three modifiers most commonly used to identify more precisely the locations at which a procedure occur: Modifiers 50 *Bilateral procedure*, LT *Left side*, and RT *Right side*.

Mirror Image Procedures on a Single Structure Call for 50

A *bilateral procedure* occurs on both sides of a single, symmetrical structure or organ. For example, the spine is a single, symmetrical structure (that is, the left and right sides mirror one another). A spinal laminotomy (such as 63020-63044), for instance, may occur on either side of the spine or, if required, on both sides of the spine at the same level(s). The same also is true of spinal facet joint injections (64490-64496), among other procedures.

In other cases, the term *bilateral surgery* may apply to procedures performed on each of a pair of structures. For example, the eyelids are paired structures (there is a right eyelid and a left eyelid), as are the breasts, and so on. Various hernia repair procedures also are said to occur bilaterally.

CPT® provides modifier 50 to identify bilateral procedures not described specifically by an individual CPT® code.

For example, CPT® designates 27158 *Osteotomy, pelvis, bilateral (eg, congenital malformation)* as a bilateral procedure and, as such, this code does not require modifier 50 (another modifier may be required to identify a designated bilateral procedure that occurs unilaterally, however; this is discussed below).

In contrast, codes describing spinal laminotomy (as discussed above) are unilateral (single-sided) by definition. Meaning, if a neurosurgeon performs a bilateral cervical laminotomy, append modifier 50 to the appropriate CPT® procedure code, 63020 *Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, including open and endoscopically-assisted approaches; 1 interspace, cervical*.

Not All Codes Accept Modifier 50

Not every procedure can be performed bilaterally, and some codes are bilateral by definition. For this reason, modifier 50 can only be appended to specific CPT® codes.

Most coding and billing software will identify those codes eligible for modifier 50, but this information also is specified in the Medicare Physician Fee Schedule (MPFS). The MPFS file is a free download from the Centers for Medicaid & Medicare Services (CMS) website (www.cms.hhs.gov/PhysicianFeeSched/PFSRVF/list.asp?listpage=4); be sure to download the most-recently posted file for up-to-date information.

Within the MPFS, the "BILAT SURG" column lists a modifier indicator. Only procedures with a "1" modifier indicator in the BILAT SURG column should be reported using modifier 50 to identify bilateral procedures. A "2" modifier indicator identifies procedures that are bilateral by definition, or a separate code exists to report the bilateral procedure; a "0" indicator describes procedures that, due to anatomy, cannot be bilateral, and; a "9" indicator means the bilateral concept does not apply.

Not every procedure can be performed bilaterally, and some codes are bilateral by definition. For this reason, modifier 50 can only be appended to specific CPT® codes.

Proper Application Has Payment Ramifications

For Medicare payers, and many third-party payers, as well, appending modifier 50 correctly will increase reimbursement to 150 percent of the allowable fee schedule payment.

For example, a dermatologist excises a single benign tumor from both the left and the right breast, as described by 19120 *Excision of cyst, fibroadenoma, or other benign or malignant tumor, aberrant breast tissue, duct lesion, nipple or areolar lesion (except 19300), open, male or female, 1 or more lesions*. The MPFS Relative Value File shows a 1 modifier indicator in the BILAT SURG column for this code, making use of modifier 50 appropriate to describe a bilateral procedure.

Code 19120 is valued at 5.92 physician work relative value units (RVUs). For Medicare, appending modifier 50 appropriately will raise this value by half, to a total of 8.88 physician work RVUs.

LT/RT Paint a More Detailed Picture

Unlike modifier 50, modifiers LT and RT are information only modifiers and they do not affect RVUs. Perhaps for that reason, the rules for applying modifiers LT and RT are not stringently defined. For example, the MPFS Relative Value File does not provide guidance for applying modifiers LT and RT, as it does for modifier 50. Modifiers LT and RT do affect payment, however, by providing the payer with added detail necessary to approve reimbursement.

Modifiers LT and RT differentiate those procedures performed on paired structures such as eyes, lungs, arms, breasts, knees, etc.

As an example, a surgeon may perform an excision (19120) from the left breast and a needle core biopsy (19100 *Biopsy of breast; percutaneous, needle core, not using imaging guidance (separate procedure)*) on the right breast. Excision includes biopsy at the same location (unless further excision was prompted specifically by biopsy results). In this case, however, the procedures occur at different locations. You may report the procedures separately using 19120-LT and 19100-RT. Use of the LT/RT modifiers demonstrates distinct locations. (Note, however, some payers also may require modifier 59 *Distinct procedural service* to be appended to 19100, in the primary position.)

Or, an orthopaedic surgeon scopes one compartment of the left knee, and a separate compartment in the right knee. Once again, using LT/RT will help differentiate the procedures and provide necessary detail that may prevent the payer from bundling the procedures inappropriately.

Modifiers LT and RT also are useful when describing cases when a provider unilaterally performs a procedure that CPT® defines as bilateral (although such cases are rare). For example, 58953 *Bilateral salpingo-oophorectomy with omentectomy, total abdominal hysterectomy and radical dissection for debulking* is by definition a bilateral procedure. If the procedure occurs on the right side only, however, appropriate coding is 58953 with modifier 52 *Reduced procedure*, and modifier RT to specify location.

Finally, modifiers LT and RT may be used to provide location-specific information for services defined either as unilateral or bilateral, such as ablation of soft tissue codes 30801-30802. For instance, G0268 *Removal of impacted cerumen (one or both ears) by physician on same date of service as audiologic function testing* may be either a unilateral or bilateral service. If the physician removes cerumen from the left ear only, report G0268-LT. There is no need to append modifier 52 in this case, because the service is defined as either "one or both" ears, and is not considered "reduced" when performed in one ear only.

G. John Verhovshek, MA, CPC, is AAPC's director of clinical coding communications.

Hierarchical Condition Categories Drive Disease Payment

By Laura Smith, CPC, CPC-I

Well documented chronic condition assessment improves medical care and reimbursement.

In 1997, Congress passed the Balanced Budget Act (BBA), which mandated risk adjustment methods to improve payment accuracy. Where previously CPT® codes drove payment, diagnosis codes and accurate documentation became the determining factors. As such, it became even more important for providers to sharpen their documentation proficiency and coders to fine tune their ICD-9-CM coding expertise. Complete and concise documentation and accurate coding are key elements to medical facility success—today more than ever.

Get a Clear Understanding of Risk Adjustment

Risk adjustment is a method of adapting payment to medical assistance organizations using hierarchical condition categories (HCCs). HCCs are diagnoses selected for this payment method based on factors influencing patient care. Some of these factors are age, demographics, disability, and chronic conditions. There are only limited selections of diagnosis codes included in the Centers for Medicare & Medicaid Services (CMS) HCC model. Disease hierarchies are a way to determine the severity of a disease, which is used to drive payment for the most severe disease manifestations—the sicker the patient, the higher the reimbursement is.

Provider documentation ensures patients' health status is conveyed accurately and completely while capturing appropriate reimbursement. The MA organization's ability to pay providers is driven largely by the reimbursement they receive from their state and from CMS.

Is your provider *assessing* all chronic health conditions such as hypertension, chronic kidney disease, depression, etc., at least once a year? If not, you are not receiving the reimbursement due to your facility—even if your provider is actively treating these conditions.

Is the provider listing all coexisting conditions such as diabetes mellitus and congestive heart failure or chronic obstructive pulmonary disease and congestive heart failure? These and other condition combinations increase the cost to care for the patient and, if not documented, cannot be coded. Ultimately, this decreases your reimbursement.

Providers also need to ensure they completely document these conditions—not just stating their existence. For example, a provider may list "history of …" for conditions considered as chronic. Documentation such as this will not qualify those diagnoses for capture. This is a common problem in the electronic medical record (EMR), when provid-

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Disease hierarchies are a way to determine the severity of a disease, which is used to drive payment for the most severe disease manifestations—the sicker the patient, the higher the reimbursement is.

ers copy and paste portions of other documentation. To qualify as a diagnosis, the provider must state the status of the condition, such as "well controlled," list a medication used to treat the condition, such as "on Diovan for hypertension," or order further testing and relate them to the condition. The key is for the provider to show that he or she has assessed or addressed the condition, and that it is still a current or ongoing disease.

To ensure appropriate reimbursement, the coder should review completely the documentation for any chronic conditions that are not listed in the final assessment, and list all coexisting conditions as directed by the *ICD-9-CM Official Guidelines for Coding and Reporting*. Section IV, H. states, "List first the ICD-9-CM code for the diagnosis, condition, problem, or other reason for the encounter/visit shown in the medical record to be chiefly responsible for the services provided. *List additional codes that describe any coexisting conditions*" [emphasis added]. Section IV, J. Chronic diseases states, "Chronic diseases treated on an ongoing basis may be coded and reported as many times as the patient receives treatment and care for the condition(s)."

CMS' HCC risk adjustment methods follow standard ICD-9-CM coding guidelines, so there is nothing new as far as following proper coding practices. If coders aren't informed of the importance of capturing chronic conditions, however, they are less likely to go the extra mile to ensure chronic conditions are being assigned to the claims. This is not, by any means, a reflection on the coder's ability or knowledge. Claim filing time constraints, facility policies, and numerous other factors limit the time coders have to spend on abstracting the provider's documentation to capture these chronic conditions.

For this reason, many MA health insurance providers establish methods to capture these conditions whenever possible. By reviewing claims data as it comes in, using software developed to pull certain information out and reviewing potentially related services such as tests, labs or medications they can then compile a list of members' charts to review at the facility and attempt to capture any missed chronic conditions. This information also can be (and often is) used to ensure their members receive the care they need for these conditions to increase the quality of care. These chart reviews are conducted by experienced coding professionals who must follow all standard coding guidelines and more.

The good news is: Reviewing chart and data offers coding professionals yet another possible career path.

Laura Smith, CPC, CPC-I, is reimbursement specialist for a Mass. health insurance provider in Minnesota specializing in risk adjustment and education. She has 12 years coding experience including E/M coding, dermatology and medical oncology. She offers an occasional AAPC pre-certification class at the local technical college in Bemidji, Minnesota. She started the AAPC local chapter in Bemidji and is president.

Julia Ann Holt, CPC

Teaching physician coder at Central California Faculty Medical Group, Fresno, Calif.

Coding Edge (CE): 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.

Julia: I started out in billing entering demographics for my mom, who at the time was a supervisor for a billing service. The job was only temporary but I was determined I wasn't going to be a temporary employee. Before I knew it, I was there two years and was not only entering demographics but payments and charges, as well. I moved to Fresno where I billed for an allergy and asthma doctor for six years. At that time, my dream was to bill for a major hospital. I had some difficulty realizing this dream since my main experience was in a specialty field. After some time, I was hired to bill family medicine for a different company. It was here I preformed evaluation and management (E/M) abstracting and ICD-9 coding. I was fortunate to be sent to an eight week coding class. At the end of the course I took my certification exam and passed. I now work for Central California Faculty Medical Group (CCFMG), where I have the unique opportunity to code for teaching physicians and their mid-levels. I love it. I am always learning from the physicians, from coding changes, and from how they affect my department. CCFMG really does live up to their motto of making education happen.

CE: What is your involvement level with your local AAPC chapter?

Julia: I am the local chapter president in Fresno and I am lucky to be surrounded by women of various ages and from different backgrounds. We all come together to share our individual experiences and knowledge. It's wonderful.

CE: What has been your biggest challenge as a coder?

Julia: My biggest challenge as a coder is not only to keep our physicians apprised of coding changes, but to meet each goal and standard our company holds for my department.

CE: What do you advise other coders to do if they disagree with the way a physician has coded his chart? Do you approach the physician, or have a monthly meeting?

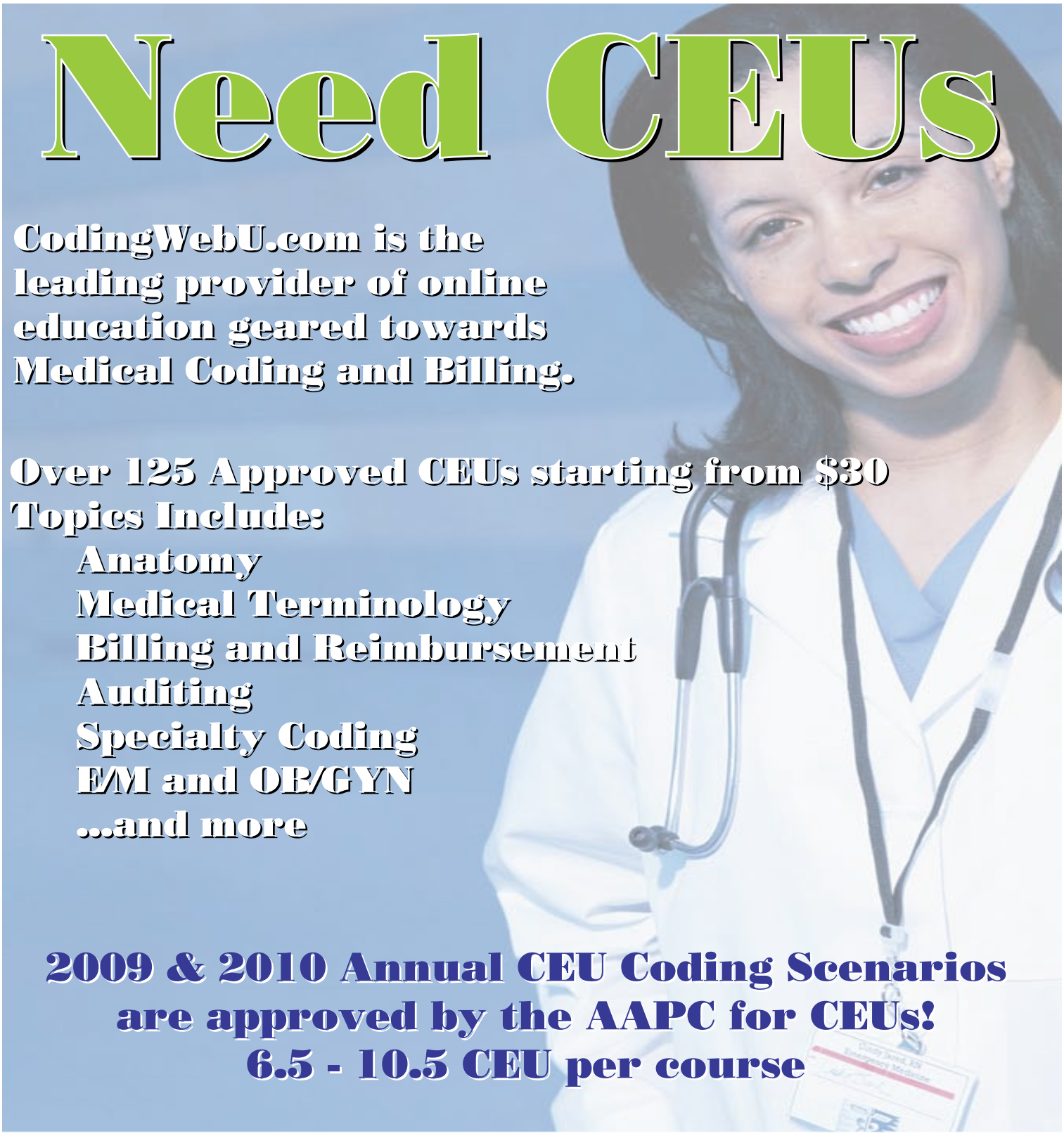
Julia: If a coder disagrees with the way a physician codes a chart, I definitely would approach him or her. It is very important to keep the lines of communication open. Some physicians prefer to have a monthly meeting to discuss their documentation or updates that may affect their coding. But we all know that there are occasions when we come across something that needs to be addressed right away. My approach depends on the physician. I have some I can e-mail and others that I need to talk to face to face. Unfortunately, we all know there are those who would rather not meet at all and feel their coding is always correct. Be vigilant and make sure you document every time you make contact with that physician.

CE: If you could have any other job, what would it be?

Julia: If I could do any other job, I think I would like to either run a coding consulting business or start my own billing service doing everything from demographics, coding, and A/R.

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

Julia: In my spare time I like to read, spend time with my family, and ride bikes.



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