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CLAIMS ACCURACY

Healthcare Practitioners Threw Away $259 Million Last Year

▶ *ASCs boast low error rates, general practices show the highest*

If the latest CERT report is any indication, you could have made a lot more money last year.

According to the Comprehensive Error Rate Testing (CERT) results that **CMS** released last week, Medicare carriers discovered more than $259 million in undercoding billing errors, which means that medical practices shorted themselves that much last year.

For example, the report highlights a practice that billed 40 units of J1756 (*Iron sucrose, 1 mg*). CMS discovered, however, that the practice actually injected 200 mg, which would have allowed it to have billed 200 units. That practice shorted itself over $200.

The only non-E/M CPT codes on the list of the top 20 "underpayment coding errors" were 20610 (major joint aspiration/injection) and 92012 (eye exam), which puzzled some practices.

Potential rationale: Some practitioners may have performed joint injections bilaterally, but only billed them unilaterally, suggests **Leslie Follebout, CPC-ORTHO,** coding department supervisor at **Peninsula Orthopaedic Associates** in Salisbury, Md. Or the physician may not have indicated the injection on the charge document or encounter form, even though he performed and documented it, she says.

General practices are error-prone: Error rates among the different provider types showed that general practices had an alarming 27 percent error rate, with ob-gyns close behind at 24 percent.

The lowest error rates were found in claims from ASCs, CRNAs, interventional radiologists, mass immunizers and public health agencies.

"I think the error rate is lower in ASCs because we have less to worry about than most clinics do," says **Christopher Felthauser, CPC, CPC-H, ACS-OH, ACS-OR,** a coding consultant in Seattle. "Most of what we do are surgical procedures, and we do not deal with E/M coding at all, which makes a huge difference."

Avoid this $1,000 mistake: The CERT report offers examples of claims that contained errors. For example, one Part B payer reimbursed a physical therapist $1,120, but the claim reviewer couldn't find documentation of the physician's order, therapy evaluation or plan of care, causing the reviewer to count the entire payment as an error.

Find out more: For more information on the CERT results, read, "Medicare Paid $1.7 Billion in Upcoded E/M Claims Last Year" on page 306. ■

CLAIMS ACCURACY

Medicare Paid $1.7 Billion in Upcoded E/M Claims Last Year

▶ *But CERT report reveals improvements in coding accuracy*

If your favorite code is 99205, watch out. A new **CMS** report reveals that nearly 25 percent of claims submitted to Part B for this code last year were upcoded.

CMS' Comprehensive Error Rate Testing (CERT) program reviewed claims submitted between April 1, 2006, and March 31, 2007, and released the results last week.

(See "Healthcare Practitioners Threw Away $259 Million Last Year" on page 305 for more on the CERT report results).

The most frequently upcoded E/M code was 99310 (Subsequent nursing facility care), which had a 26.3 percent error rate. Code 99205 (new patient visit) came in a close second, followed by 99204 (new patient visit, 21 percent error rate), 99255 (inpatient consult, 19 percent error rate) and 99245 (outpatient consult, 18.8 percent error rate).

"Not surprisingly, the upcoded claims seem to all be high-level codes," says **Angel Connor** with **AC Billing** in Little Rock, Ark. "Practices should be aware of what it takes to bill level five codes because Medicare is going to be watching to determine whether those error rate numbers come down."

Undercoding also evaluated: Not all physicians billing Part B were upcoding. The CERT results demonstrated that nearly 10 percent of claims for 99241 were undercoded, noting that the documentation for these claims supported higher codes.

"It's really important to get the point across that you shouldn't undercode," says **Felice Rogers,** a coding consultant in Miami. "Not only is it incorrect coding, but if you undercode a 99243 down to 99241 10 times over the course of a year, you've just thrown away almost $1,000."

Document those 99211 claims: The CERT report also found that 12 percent of claims for 99211 were insufficiently documented. "This is actually not surprising," Rogers says. "Staff members may think that 99211 is simple to document, so they just write down a quick note saying something like 'BP check,' which isn't going to cut it by Medicare's documentation standards."

Despite the startling numbers, however, CMS found that improper Medicare claim payments declined from 14.2 percent in 1996 to just 3.9 percent in 2007, which shows proof that coders have been tightening up their accuracy.

To read Medicare's CERT results in their entirety, visit www.cms.hhs.gov/CERT. ■

PART B REVENUE BOOSTER

Limit 69990 to Once Per Session — Not Per Level

▶ *Medicare is finicky about reimbursing operating scope, so be careful*

Just because your surgeon documents using a "microscope," you aren't always justified in reporting 69990. Medicare's guidelines are written in stone, and practices should be careful to follow them to the letter.

You may have noticed that your CPT manual lists instructions for when to report +69990 (*Microsurgical techniques, requiring use of operating microscope [list separately in addition to code for primary procedure]*) in a note preceding the code descriptor.

Medicare payers, however, allow you to report 69990 in far fewer instances. For example, some private payers may reimburse you for using the operating scope with mastoidectomies (such as 69501), but Medicare won't.

Specifically, Chapter 12 of the *Medicare Claims Processing Manual*, section 20.4.5, allows separate payment for using the operating microscope only with procedures 61304-61546, 61550-61711, 62010-62100, 63081-63308, 63704-63710, 64831, 64834-64836, 64840-64858, 64861-64870, 64885-64898 and 64905-64907.

For example: A hand surgeon dictates that he used the operating microscope for microdissection during suture of a single digital nerve of the hand (64831, *Suture of digital nerve, hand or foot; one nerve*). In this case, you can report 69990 in addition to 64831.

Remember: Because 69990 is an add-on code and is valued for intraoperative work only, you do not need to append modifier 51 (*Multiple procedures*).

For all other procedures, Medicare considers the operating microscope an inclusive component of the procedure and not payable. According to the July 22, 1999, *Federal Register*, "In specific, payment for primary codes where an operating microscope is an inclusive component will be denied."

Correct Coding Initiative (CCI) edits can signal that you shouldn't report certain services to Medicare with 69990, says **Heidi Weber,** coder for **Shekhar Dagam, MD,** in Waukesha, Wis. The CCI edits can also help you strengthen appeals if the carrier denies 69990 when it isn't bundled. "I regularly use the edits when coding to know when a modifier is required to unbundle a particular combination," Weber says. "I also use the edits when appealing unpaid procedure codes. I find it helpful to send supporting documentation of the edits to the payer, which can only strengthen the appeal."

Know your keywords: Keep in mind that using surgical loupes does not qualify you to report 69990. Key documentation you may find in the operative report may include terms such as "Weck scope," "Zeiss scope" or "Leica."

"I watch for words such as 'under magnification,' which is a red flag for me," says **Rena Hall,** coder and auditor with **KC Neurosurgery** in Kansas City, Mo. "The surgeon must be specific when he puts the microscope into the field. If I never see where the scope was set up and I see 'under magnification,' I will not charge a microscope, even if he lists it on the 'procedures performed' section of the report. It must be well documented in the body of the report."

Consider separate lines: "I suggest to my physician to dictate a separate line in his operative report stating whether the assistant surgeon used the microscope," Weber says. This process improves payment odds for the assist, she advises.

Although this may seem like an unpleasant effort, most payers will reimburse roughly $130 for 69990, so your work researching which codes you can report with it can be well worth the effort.

Don't Bill Multiple Units of 69990

Keep in mind that you should report 69990 only once per operative session no matter how many times the physician uses the operating microscope while in the OR. "There is only one microscope, and the surgeon can use it several times, but it is still only billed once," Hall says.

Tip: Even if the surgeon addresses separate spinal levels or nerves during a procedure, you should only list one unit of 69990 on your claim. ■

COMPLIANCE

Make a List — And Check It Twice Before Giving Gifts

▶ *Stark II refinements change little, but caution is still the name of the game*

Bear too many gifts this holiday season, and you could wake up with a huge compliance headache — even a felony charge — in the New Year.

Providers who aren't circumspect in their holiday gift-giving can run afoul of the Stark Law, which regulates physician referrals to certain healthcare services, and the broader federal Anti-Kickback Statute. Many states also have their own anti-kickback laws, making compliance even trickier.

To bring cheer without bringing legal action, keep these issues in mind before handing out presents:

1. Make it official. To steer clear of trouble, share your practice's gift-giving guidelines with your staff.

The **OIG** "encourages all healthcare professionals billing Medicare, Medicaid and similar programs to have corporate compliance plans that can be scaled for large and small practices," says **Howard L. Sollins, Esq.**, of **Ober Kaler** in Baltimore.

2. Obey the gift limit. "The best approach is to use the Stark ceiling on such compensation arrangements, which is adjusted annually and is currently $328.00," Sollins advises. "However, that is an annual amount, so that if there have been other gifts, dinners, or other items of value given during the year, those have to be taken into account in determining what can be given during the holidays."

Keep in mind that the anti-kickback act provides no blanket escape clause for small gifts, if even one purpose of the gift is to induce a referral.

"One of the few changes in Stark II's Phase III that actually loosened the rules concerns these nonmonetary gifts," says **David C. Harlow, Esq.,** of **The Harlow Group** in Boston. "If it turns out that the value of gifts given in the course of a calendar year was over the limit (but not more than 50 percent over), the physician has 180 days from date of receipt to pay back the excess."

3. Don't assume nonphysicians can accept unlimited gifts. One orthopedic surgeon told the *Insider* that a physical therapist refers a lot of patients to him, so he sends that PT a gift card each year. Because Stark laws cover referrals made by physicians, he assumes he is free to send the PT any gift he pleases.

Not so fast, Harlow says. "He wouldn't violate Stark, but the anti-kickback law prohibits soliciting or giving anything of value in return for a referral that could be reimbursed by Medicare or Medicaid — that would govern the orthopedist's gift to the PT."

OIG compliance guidelines say that gifts of "nominal value" are OK under these circumstances. "OIG advisories peg 'nominal value' at $10 per item, no more than $50 per year," Harlow says. "Unlike the Stark law, which is a strict liability statute, proving a violation of the anti-kickback law requires proving intent: Was one intent of a more-than-nominal gift to reward or induce referrals? If the answer to that question is yes, then there is at least a technical violation of the statute, but enforcement is left to the government's discretion."

4. Don't take the "no one will find out" approach. Suppose a speech-language pathologist gets a lot of referrals from a family physician. She sends him a $500 gift basket each year for the holidays, but believes that no one would know what she spent on it, so there's no way she could be discovered to be in violation of the $300 limit.

"As a general matter with respect to any compliance issue, whether in connection with the Stark law, anti-kickback law or otherwise, the applicable standard governing conduct should never be whether the particular practice would be discovered or not," Sollins advises. "As with relationships between various kinds of Part B suppliers and whether 'designated health services' referrals are involved, the Stark law may or may not be implicated. But the federal anti-kickback law would always be implicated in such referral relationships."

For information on how to determine whether your gifts to patients are in line with federal regulations, see "Take A Fresh Look At Your Beneficiary Gift-Giving" on page 309. ■

COMPLIANCE

Take a Fresh Look at Your Beneficiary Gift-Giving

▶ *Regulators could construe goodwill as influence*

You may feel compelled to help disadvantaged patients or their families during the holiday season, but go about it in the wrong way and you could find yourself paying up to $10,000 in fines.

That's according to government regulations, which limit practices from offering these types of incentives to patients. On the other hand, we've got some advice that can help you stay on the straight and narrow this holiday season, while still helping out the truly needy patients.

Background: The Health Insurance Portability and Accountability Act of 1996 (**HIPAA**) amended the Social Security Act to prohibit any person from "offering Medicare or Medicaid beneficiaries remuneration that might influence them to order or receive from a particular provider, practitioner, or supplier items or services payable by Medicare or Medicaid."

That means a civil money penalty of up to $10,000 may be waiting for anyone who offers payment or a gift of monetary value to a beneficiary. Even if you are feeling charitable and your patient is in need, handing out cash or other expensive items to beneficiaries is a bad idea.

Better idea: Instead, the physician "could make a contribution to organizations that provide support for needy patients in the community," advises **Howard L. Sollins, Esq.,** of **Ober Kaler** in Baltimore.

Keep in mind: If the patient is truly "needy," the physician may want to examine his or her office policies on indigent care.

"For example," Sollins suggests, "if the patient is uninsured and can demonstrate indigency in a bona fide way, the physician may elect on an ad hoc basis, in a way that is not generally advertised to the public, to discount the physician's bill."

"There is available guidance on healthcare indigent care policies that are not considered beneficiary inducements and do not violate prohibitions on billing Medicare for more than the physician's usual or customary charges," Sollins says. "Medical practices interested in helping needy patients can, as part of compliance efforts, adopt indigent care policies." This would be a better idea than offering the beneficiaries cash or expensive gift cards. ■

Part B Coding Coach

Here's How Vascular Families Can Vary Your Selective Cath Coding Choices

▶ *Learn the most overlooked services experts say you should be reporting*

Vascular coding basics tell you not to report nonselective catheter placement with selective placement from the same access site. But how should you report situations when the physician positions the catheter in multiple vascular families from the same access site?

Our peripheral vascular (PV) experts have outlined what you should — and shouldn't — do when coding these tricky procedures.

Key: Pay attention to whether the physician catheterized more than one vascular family during the procedure, PV coding experts say.

Use 2 Codes for Additional Second-, Third-Order Branches

You should code each vascular family separately. Determine the highest-order branch the physician accesses in each vascular family.

Example: From a right femoral access point, the physician positions the catheter in the right subclavian artery, performs imaging and then repositions the catheter in the right common carotid artery. Both of these vessels are branches of the brachiocephalic/innominate artery that arises at the arch of the aorta, and they both represent second-order selective catheter positions.

For the initial second-order catheter position above the diaphragm, you should report 36216 (*Selective catheter placement, arterial system; initial second-order thoracic or brachiocephalic branch, within a vascular family*). Report the second cath position with +36218 (*... additional second-order, third-order, and beyond, thoracic or brachiocephalic branch, within a vascular family [list in addition to code for initial second- or third-order vessel as appropriate]*).

Important: You should assign all additional second- and third-order branches within the same vascular family using either 36218 or +36248 (*Selective catheter placement, arterial system; additional second-order, third-order, and beyond, abdominal, pelvic, or lower-extremity artery branch, within a vascular family [list in addition to code for initial second- or third-order vessel as appropriate]*).

Know the difference: You'll use 36215-36218 to report thoracic and brachiocephalic selective arterial procedures and 36245-36248 to report abdominal, pelvic and leg selective arterial procedures. In other words, you should use 36215-36218 for arteries above the diaphragm and 36245-36248 for arteries below the diaphragm, says **Jackie Miller, RHIA, CPC,** senior consultant with **Coding Strategies Inc.** in Powder Springs, Ga. You should look to 36014-36015 for selective pulmonary artery catheterization.

Avoid Coding 'On The Way' Services

On the other hand, you shouldn't code the branches traversed as a pathway to the second- or third-order branches beyond. In other words, you should code only the highest-order catheter placement the physician achieved within each vascular family. You should avoid coding the lower-order catheter placements that are "on the way to" the higher-order position.

Learn When You Should Report S&I Codes

You should also separately code all supervision and interpretation (S&I) services when your documentation supports it. Sometimes, you should not separately code the imaging S&I. For instance, you should not separately report contrast injections that the physician specifically performs to obtain a map of the vascular territory (to facilitate catheter manipulation).

But you should always assign the appropriate S&I code for the vessel the physician studies. If your physician does a further selective catheterization in a higher-order branch after the basic study, and CPT offers no more specific code, use +75774 (*Angiography, selective, each additional vessel studied after basic*

Part B Coding Coach

examination, radiological supervision and interpretation [list separately in addition to code for primary procedure]) to denote the S&I.

You should use this code for additional studies of the same basic anatomic region (additional runs/images). "Make sure to share these guidelines with your physicians," says **Jim Collins, CPC-CARDIO, ACS-CA, CHCC,** president of **The Cardiology Coalition** in Saratoga Springs, N.Y. "Unless physicians realize that these additional studies are separately billable, they may not document appropriately. This is one of the most commonly undocumented and unbilled services that I identify during physician training programs."

Example: The physician places a sheath in the right femoral artery and, using a guide catheter, manipulates to the supra-renal abdominal aorta to perform an abdominal aortogram. He then repositions the catheter at the bifurcation of the aorta into the common iliacs for separate runoff injection of the lower extremities, followed by a selective study of the left common iliac (which would then be considered an "additional study" to the initial lower extremity study).

You should report 36245 for the selective, contralateral catheter placement in the left common iliac artery, 75625-26 (*Aortography, abdominal, by serialography, radiological supervision and interpretation; professional component*), 75716-26 (*Angiography, extremity, bilateral, radiological supervision and interpretation; professional component*) and +75774-26 (*Angiography, selective, each additional vessel studied after basic examination, radiological supervision and interpretation [list separately in addition to code for primary procedure]; professional component*).

Watch Your Access Site(s)

If the physician performs a selective and nonselective catheter placement through the same vascular access site, you lose the nonselective placement because payers would consider this "en route" to the selective catheter position.

But if two access sites are involved in the procedure (one of which was selective and the other nonselective), you should report both selective catheter placement (such as 36245) and nonselective catheter placement (such as 36140, *Introduction of needle or intracatheter; extremity artery*).

Remember: You should attach modifier 59 (*Distinct procedural service*) to the nonselective catheter placement code to illustrate that it was through a different access site.

Translation: Use modifier 59 whenever you report a lower-order cath placement with a higher-order cath placement. ■

Size Up Your 2nd- and 3rd-Order Cath Skills

▶ *1 Code or 2? The answer may surprise you*

Now that you've read up on cath coding rules in "Here's How Vascular Families Can Vary Your Selective Cath Coding Choices," test your skills with this selective cath question.

Question: My surgeon performed a catheterization of the right vertebral (third order) and left vertebral (second order) from femoral access. How should I report this?

Answer: You should report both catheterizations because these are different vascular families. The two codes you'll use are 36217 (*Selective catheter placement, arterial system; initial third-order or more selective thoracic or brachiocephalic branch, within a vascular family*) for the right vertebral and 36216 (*… initial second-order thoracic or brachiocephalic branch, within a vascular family*) for the left vertebral.

Modifier round-up: A few years ago, Medicare changed the bilateral procedure status of codes 36215-36217. You should not use modifiers RT (*Right side*), LT (*Left side*) or 50 (*Bilateral procedure*) with these codes. But because the national Correct Coding Initiative still bundles each of the first-, second- and third-order catheter placements into each other, you should still use modifier 59 (*Distinct procedural service*). In other words, you would submit 36217 and 36216-59. ■

PHYSICIAN NOTES

CPT Committee Releases Five Pages of Errata

If you had trouble finding "Sengstaaken" in your medical dictionary, that's because it was a typo in CPT 2008.

The **AMA** has released its list of corrections to errors in CPT 2008, and the errors range from spelling mistakes (such as the misspelling of "Sengstaken" in the 43460 descriptor) to incorrect captions (for instance, the thoracentesis illustration that references 32421 should instead refer to 32422).

To read the full list of CPT 2008 corrections, visit the AMA's Web site at www.ama-assn.org/ama1/pub/upload/mm/362/08cptcorrections.pdf.

In other news:

Empire Medicare recently directed providers in Indiana and Kentucky to start requiring ABNs when performing acupuncture procedures described by 97810-97814. In its *Medicare Monthly Review,* Empire stated, "Previously, acupuncture was denied as a 'non-covered' service. However, the correct denial for acupuncture is a medical necessity denial, and therefore, the physician must give the beneficiary an Advance Beneficiary Notice … The GA modifier should be reported on the claim with the procedure code to indicate that an ABN has been signed by the beneficiary. The GZ modifier should be reported on the claim with the procedure code to indicate that an ABN has not been signed by the beneficiary."

CMS has updated its list of allowable telehealth services. Effective Jan. 1, you can report 96116 (Neurobehavioral status exam) for telehealth services, as long as you meet all of the eligibility criteria. Modifier GT describes telehealth services via interactive audio and video telecommunications systems, whereas modifier GQ refers to these services via an asynchronous telecommunications system. Visit http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5628.pdf for more on the new telehealth article.

If you're billing Medicare for oxygen therapy, you may be getting a lot of questions from patients and providers lately. A Nov. 30 article in the *New York Times*, "Oxygen Suppliers Fight to Keep a Medicare Boon," noted that Medicare pays significantly more for medically prescribed oxygen therapy delivered in the homes of Medicare beneficiaries than oxygen equipment provided by Internet suppliers to individuals. Many oxygen suppliers are balking at the article's tone, noting that their oxygen therapy involves just that — therapy — and not simply a filled oxygen tank, thus making their service a bit more costly than Web-ordered oxygen supplies. ■

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