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REIMBURSEMENT

Legislators Give Docs a Happy Holiday With 0.5 Percent Pay Raise

▶ ***But the rule only extends until June 30, so you'll still need another fix mid-year***

If you were holding your breath for a Medicare pay increase, you can finally exhale.

The Senate and House passed the Medicare, Medicaid and SCHIP Extension Act of 2007 earlier this week, replacing the scheduled 10.1 percent Medicare pay cut for 2008 with a 0.5 percent increase.

The downside: The law expires on June 30, so Medicare allowances after that are still up in the air.

"This is a political football," says **David C. Harlow, Esq.,** of **The Harlow Group.** "Congress has never let the sustainable growth rate (SGR) rules kick in. I don't think that they will let them kick in mid-year. The pending action is a political compromise involving SCHIP as well and merely avoids a physician pay cut that would otherwise be automatic in January."

Despite the congressional reprieve, however, physicians should not take their attention off of the legislative wrangling that will be required to fix payments after June 30, says **Jean Acevedo, LHRM, CPC, CHC, PCS,** of Acevedo Consulting Inc. "They should be worried that come July 1, 2008, their reimbursement will drop to the 10.1 percent reduction," she says.

Potential upside: "I've never seen Congress attempt just a six-month fix," Acevedo says. "Maybe the Senate is planning to actually tackle the core problem with the fee schedule between now and June. If so, that could actually be good news."

New payment structure possible: "Physicians may note that Congressional support for their position is eroding" based on last year's 1.5 percent increase and this year's 0.5 percent boost, Harlow says. "The **AMA** wants Congress to abandon this sort of cost control, and simply adopt an indexed approach to automatic increases, rather than sticking with the current zero-sum game. Congressional leadership is eager to find a permanent solution, though wholesale adoption of the AMA proposal is unlikely."

The new ruling also extends the PQRI program, the 5 percent bonus provision to physicians who practice in physician scarcity areas, the geographic index floor of 1.0 and the therapy cap exceptions process, among other provisions. To read a breakdown of the bill, visit www.senate.gov/~finance/press/Bpress/2007press/prb121807.pdf. ■

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CCI 14.0

Stop Reporting 36000 With Injections, Surgeries

▶ *Plus, pulmonologists should be ready for scores of edits to affect them*

The latest version of the Correct Coding Initiative (CCI) spares almost no specialty, with more than 8,000 new edits that will affect your claims in 2008.

Effective Jan. 1, CCI bundles needle or intracatheter introduction code 36000 into 78 other codes, including injection codes such as 20555, fracture care codes like 27726-27267, and catheterization codes 32550-325551. You can use a modifier to separate most of these edits.

Biggest bundle: New neonatal initial hospital care code 99477 is bundled into a whopping 418 codes, according to **Frank Cohen, CMPA,** of **CPA Health Partners** in Clearwater, Fla. If you report 99477 with individual psychotherapy codes 90804-90828, therapy evaluation/re-evaluation codes 97001-97004, or scores of anesthesia or radiology codes, Medicare carriers will reject the 99477 charge. And 141 other codes (including almost all of the E/M codes) bundle into 99477 and are therefore not separately payable if you report them with neonatal initial hospital care.

Pulmonology hit hard: CCI now bundles intercoastal nerve injection codes 64420-64421 into more than 330 codes a piece, including many of the respiratory surgery codes. "The most logical rationale here is that physicians are using these nerve injections as local anesthesia with respiratory procedures, and they shouldn't bill the anesthesia separately in these cases," says **Heather Corcoran** with **CGH Billing** in Louisville, Ky.

Also hurting pulmonologists is the edit bundling new thoracostomy code 32551 into 336 codes, while new thoracentesis code 32422 bundles into 323 other procedures. These two new codes bundle mainly into services from CPT's respiratory and cardiovascular sections (such as 33300-33335) with the rationale that they are "separate procedures." You can use a modifier to separate most of these bundles.

Column reversal: And rounding out the big news for pulmonology practices, several codes related to this specialty did a "column swap," jumping from column one to column two. For instance, 11 codes that used to be bundled into 31643 (bronchoscopy) have now been switched, meaning that 31643 is now bundled into those codes, including lung removal codes 32440-32488.

"This makes sense," Corcoran says, "because lung removal is obviously the more extensive service." ■

 Comments? Suggestions? Contact Torrey Kim, Editor-in-Chief, at torrey@partbinsider.com.

CCI 14.0

CCI Strikes Allergy, Urology, Neurology and Other Specialties

▶ *New medication therapy management codes suffer scores of bundles*

If you were delighted about all of the wonderful new CPT codes for 2008, keep in mind that CPT giveth, but CCI taketh away.

You'll find that many of the new codes, as well as existing codes, are subject to CCI's bundling in version 14.0, effective Jan. 1.

Spine: CCI bundles 234 codes (including most E/M services and hundreds of spine surgery codes) into new spine anesthesia codes 01935-01936. No modifier can separate the bundle of the E/M services with these anesthesia codes, but a modifier can be used on most of the surgical edits.

Allergy: Version 14.0 bundles 90 procedures (including most E/M codes) into allergy testing codes 95004-95075.

"The interesting thing is that in Version 7.2, CCI said that codes with an 'xxx' global fee actually do have a small global period, so you really shouldn't have been billing the E/M with allergy testing anyway unless the E/M was significantly and separately identifiable and qualifies for a 25 modifier," says **Barbara J. Cobuzzi, MBA, CPC-OTO, CPC-H, CPC-P, CHCC,** president of **CRN Healthcare Solutions**.

Example: These edits can be separated with a modifier if the physician performs a significant and separately identifiable procedure. If a new patient presents and the physician performs and documents a history, exam and medical decision-making (MDM) and the allergy testing during the same session, you could report the appropriate E/M code with modifier 25 appended, as well as the allergy testing code.

Alternative: Suppose, however, that the physician performs and documents a history, exam and MDM and schedules the testing for a later date. When the patient returns for testing, the physician does a brief exam to ensure that the patient is healthy enough for the allergy testing. In this case, you should not report a separate E/M code, Cobuzzi says.

Orthopedics: Over 100 procedures now bundle into new osteotomy codes 22206 and 22207. For example, all of the primary codes in the 22210-22224 range (osteotomy) bundle into 22206-22207, as do laminectomy codes 63001-63047, among others. You can use a modifier to separate these bundles.

Plus, you'll find the new fracture care codes 27767-27769 on the edit list. Version 14.0 bundles these services into more than 50 codes each, such as other ankle fracture codes 27808-27823 and amputation codes 27880-27886.

General surgery: The new CCI bundles over 70 procedures into new tumor excision codes 49204-49205, including exploration (49000-49010) and hernia repair (49560-49587).

Injections: CCI Version 14.0 bundles injection code 90772 into 78 codes, most of which are new, such as new J- and G-tube codes 49450-49465. In addition, 36410 (venipuncture) now bundles into 77 codes, most of which are new, such as 51100-51102.

Urology: Bladder study code 78730 does a column swap and jumps to column two, meaning that 60 E/M codes that CCI formerly bundled into 78730 are now the primary codes, so carriers will deny 78730 if you bill it with the E/M services.

Possible rationale: "It looks like it costs less for Medicare to pay for 78730 versus the exam," says **Tina Lee, CPC,** coding specialist with **UACC** in Fresno, Calif. Indeed, 78730 has relative value of 1.98, whereas 99215 is worth only 1.38 relative value units (RVUs).

Modifier changes: You may notice that the edit bundling dilution study codes 93561-93562 into catheterization codes 93527-93529 previously had a modifier indicator of "1," meaning that you could append a modifier if the procedures were performed as significant, separately identifiable services. But the new CCI changes the modifier indicator to "0," which means that you cannot report the codes together under any circumstances.

Keep in mind, however, that this should not hurt too many practices. "Because the dilution studies have a 'separate procedure' designation, they really have never been covered separately with cardiac catheterization services," says **Terry A. Fletcher, CPC, CCS-P, CCS, CPC-EM, CPC-Cardio, CMSCS, CMC,** a healthcare coding consultant in Laguna Beach, Calif. "So these edits really have not changed anything, but just confirmed the fact that these codes are not billed together anyway." ■

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PART B MYTHBUSTER

Give Your Emergency Dept. E/M Coding a Makeover

▶ ***Tip: The ED is an outpatient setting, not inpatient***

Myth: Only a certified emergency department (ED) physician can report 99281-99285.

Reality: Any physician can report these codes for ED services, as long as the visit meets the ED code criteria. But keep in mind that the ED service codes are not your only choice in these situations.

Depending on the circumstances and the strength of the available documentation, you may be better off to claim a consultation, admission service or even critical care.

When reporting ED services, keep three key points in mind:

1. You may report 99281-99285 only for physician services provided in the ED.

An ED, as defined by the Medicare *Internet Only Manual* (IOM, Publication 100-4, Chapter 12, Section 30.6.11B), is "an organized hospital-based facility for the provision of unscheduled or episodic services to patients who present for immediate medical attention."

You should not report 99281-99285 for services (even "emergency" services) the physician provides in the office or outpatient setting other than an ED.

2. You can report 99281-99285 even for non-emergency services provided in the ED.

"The only requirement for using the emergency department codes is that the patient be seen in the emergency department for an unanticipated service," the *IOM* states.

3. Any physician — not only those assigned to the ED — can report 99281-99285.

Medicare's *IOM* specifically states, "Any physician seeing a patient in the ED may use ED visit codes for services matching the code description. It is not required that the physician be assigned to the emergency department to use ED visit codes."

Not all ED services call for an ED code. You should not limit your choices to 99281-99285 for services your physician delivers in the ED.

For instance, if the physician admits the patient to inpatient status, you would report the initial hospital visit codes (99221-99223, *Initial hospital care*) in place of an ED services code.

Similarly, if the physician admits the patient to observation status subsequent to the ED service, you should report only the appropriate observation care code (99218-99220, *Initial observation care, per day*; or 99234-99236).

In addition, if the service the physician provides meets the criteria for a consult, you will report the appropriate-level outpatient consult code rather than an ED service code, according to the *IOM* (Publication 100-04, Chapter 12, Section 30.6.11F).

Remember: The ED is an outpatient — not an inpatient — setting.

Example: A patient with head injuries from an auto accident arrives in the ED. The ED physician requests a consult from a surgeon to evaluate for possible abdominal trauma. The surgeon provides the E/M service and shares his findings with the ED physician.

In this case, the surgeon should report the appropriate-level outpatient consultation code (for example, 99244, *Office consultation for a new or established patient* …), says **Jaime Darling, CPC,** coder with **EA Health Corporation** in Solana Beach, Calif. Although this service occurred in the ED, it meets all the consultation requirements (a request and reason for the consult, a review of the patient's case, and a report of findings back to the requesting physician), and you may report it as such.

The consulting physician should report the consult code, and "the ED physician can still bill an ED code (99281-99285) for his or her portion," Darling says.

Caveat: If the consulting physician's documentation did not meet the consultation guidelines, CMS says you should instead report an ED code for the surgeon's evaluation, Darling says. "That would mean two ED codes get billed on the same day. Since they are coming in from different physicians (most likely with different diagnoses, too), they should both be paid," she says. ■

READER QUESTION

Know How to Code Blood Draws vs. Lab Tests

Question: *We saw a patient for a blood draw and sent it to an outside lab for testing. The doctor saw the patient that morning. Can we report the E/M service and the blood draw? Which code should we report for the blood draw since we didn't do the testing?*

Answer: Once you've determined that a blood draw is not actually therapeutic phlebotomy (99195), you need to turn to the venipuncture codes — and, in some cases, the lab testing codes.

If you're sending your patients to an outside lab for both the blood draw and testing, you cannot report any blood draw codes. If your practitioners collect the blood themselves, however, you have two options for coding the service, depending on where the blood goes next.

Outside: If the blood specimen that your practice collects goes to an outside lab for testing, report 36415 (*Collection of venous blood by venipuncture*) for the blood draw and the appropriate-level E/M service code for the visit.

Example: An oncologist meets with a cancer patient during a follow-up, draws blood for analysis and provides a level-four E/M service. On the claim, report 99214 for the E/M service and 36415 for the blood draw.

Most Medicare carriers allow for one collection fee for each patient encounter, regardless of the number of specimens drawn. When a single test, such as a comprehensive metabolic panel (80053), requires a series of specimens, treat the collections as a single encounter. You would report 36415 once per encounter, and the laboratory is responsible for billing the different testing codes.

However: Check with individual payers on whether to use 36415 when it is part of a larger E/M visit. Some carriers may not allow you to bill it separately. Instead, they claim that you should bundle the blood draw as part of the E/M service.

Inside: If your practice has its own laboratory to perform blood tests, you can report the test along with the venipuncture. The lab must have Clinical Laboratory Improvement Amendments (CLIA) certification and can only process CLIA tests.

Example: An office staff member draws a Medicare patient's blood and performs a complete blood count (CBC) with platelet and white blood cell (WBC) counts. Along with 36415, report 85025 (*Complete blood count*).

If the blood draw comes from a port, report 36540 (*Collection of blood specimen*), but only for services rendered in 2007. CPT 2008 contains a new code (36591) for blood draw from an implanted device and a new code (36592) for blood draw from a peripherally-inserted central catheter (PICC) or peripheral catheter. ■

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Part B Coding Coach

Cure Your Colonoscopy Denials by Following CMS Advice

▶ ***Guidance concerning what diagnosis codes you should report may surprise you***

If you're confused about what constitutes a screening versus a therapeutic colonoscopy and how to order your ICD-9 codes, you're not alone. Four scenarios break down CMS' stance on this tricky subject and help lead to picture-perfect colonoscopy claims.

Secure What a Screening Procedure Entails

Scenario 1: A Medicare patient with no gastrointestinal symptoms reports for a screening colonoscopy (or flexible sigmoidoscopy). The gastroenterologist performs the procedure and sees nothing out of the ordinary.

Solution: This is a screening procedure. CMS waives the annual Part B deductible for colorectal cancer screening tests.

For the procedure code, you should report G0121 (*Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk*) for an average-risk patient receiving a screening colonoscopy or G0105 (*Colorectal cancer screening; colonoscopy on individual at high risk*) for a high-risk patient. Use G0104 (*Colorectal cancer screening; flexible sigmoidoscopy*) if the physician performs a screening flexible sigmoidoscopy.

As for the diagnosis, your primary ICD-9 code should be a screening V code. The only code for individuals not meeting criteria for high risk is V76.51 (*Special screening for malignant neoplasms; colon*). In other words, you'll use V76.51 for low-risk patients. For high-risk patients, you might use V10.05 (*Personal history of malignant neoplasm; large intestine*), V10.06 (*... rectum, rectosigmoid junction, and anus*) or V16.0 (*Family history of malignant neoplasm; gastrointestinal tract*).

Know How to Code Contrast Screening

Scenario 2: A Medicare patient with no gastrointestinal symptoms reports for a screening colonoscopy (or flexible sigmoidoscopy). The gastroenterologist performs the procedure and sees an abnormality (such as a polyp or lesion), which he biopsies or removes.

Solution: This is a screening procedure that turned into a therapeutic procedure. You cannot report this procedure as a screening, nor can you waive the deductible.

In this case, you should use the code for the actual procedure and not the G screening code. For instance, if the physician discovers a polyp during the colonoscopy, you should report 45380 (*Colonoscopy, flexible, proximal to splenic flexure; with biopsy, single or multiple*). If the physician performs a flexible sigmoidoscopy, you'll report 45330-45345.

As for the diagnoses, the primary diagnosis should be the screening code: V76.51. Your secondary diagnosis code should reflect the abnormal finding — for instance, 211.3 (*Benign neoplasm of other parts of digestive system; colon*). "This way tells the payer that this

Part B Coding Coach

was a screening colonoscopy and that the physician found a polyp(s) during the exam," says **Debora K. Schulte, CPC,** a medical coder at UCSD Medical Group Business Services in San Diego.

Helpful hint: Enter a "2" in Box 24E of the CMS 1500 to link the biopsy or polypectomy with the polyp, CMS says.

Solve This Incidental Diagnosis Challenge

Suppose your gastroenterologist finds more than a polyp. How would you choose your ICD-9 codes?

Scenario 3: A Medicare patient with no gastrointestinal symptoms comes in for a screening colonoscopy (or flexible sigmoidoscopy). The gastroenterologist performs the procedure and sees an abnormality (such as a polyp or lesion), which he biopsies or removes. He also determines the patient has diverticulosis and internal hemorrhoids.

Solution: Again, this procedure is a screening that turned into a therapeutic procedure. Therefore, you would report 45380 and not the G screening code.

As for the diagnoses, you would report the following sequence:

- V76.51 to show the intention was a screening test
- 211.3 for the polyp
- 562.10 (*Diverticulosis of colon [without mention of hemorrhage]*) for the diverticulosis
- 455.0 (*Internal hemorrhoids without mention of complication*).

Good idea: "In our practice, we post the first charge as a dummy charge (we call it ADX) with no dollar amount, just a diagnosis," says **Gaelin Simson,** a billing specialist in Lansing, Mich. Example:

CPT	**DX**
ADX	V76.51
45380	211.3

Watch Out for Screening, Surveillance Differences

Scenario 4: A patient came into our practice last year, and the gastroenterologist removed a huge polyp. The physician requested that the patient come back after one year. He returned, and the colon was negative. Should you bill 45378 with V12.72 or G0105 with V12.72?

Answer: First, you can only report G0105 (*Colorectal cancer screening; colonoscopy on individual at high risk*) every two years. If you try to report it again, you'll receive a denial.

If your gastroenterologist decides he wants to look at the colon during the in-between year, you should consider this a "surveillance" service. You should therefore report 45378 (*Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen[s] by brushing or washing, with or without colon decompression [separate procedure]*) and attach V12.72 (*Personal history of certain other-diseases; diseases of digestive system; colonic polyps*).

Hint: Don't confuse "screening," which in this case occurs every two years, with "surveillance." Surveillance relates to a particular problem the doctor wants to review. ■

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PHYSICIAN NOTES

OIG Semiannual Report Reflects $43 Billion in Recoveries

▶ *Audits covered everything from hospice to supplies*

The OIG has released its Semiannual Report to Congress, covering its activities between April and September of 2007. In the report, the OIG notes that its savings and recoveries over the six-month period totaled more than $43 billion.

For example, the OIG found that 64 percent of the surgical debridement services audited for service dates in 2004 did not meet Medicare requirements, resulting in $64 million in improper payments to debridement providers. Of those errors, 39 percent were billed with codes that did not accurately reflect the services provided, 29 percent had no or insufficient documentation and 1 percent were not medically necessary.

In the report, the OIG also referenced its audit of Part B mental health services performed in 2003, 47 percent of which did not meet program requirements, resulting in improper payments of $718 million. Miscoded services accounted for 26 percent of all mental health services in 2003, whereas 19 percent of services were undocumented. "Medically unnecessary services and services that violated the 'incident to' rule each accounted for four percent of all mental health services," the report indicated.

To read the OIG's entire Semiannual Report, visit www.oig.hhs.gov/publications /docs/semiannal/2007/Semiannual Final2007.pdf.

<u>In other news:</u>

• **If you were hoping that the NPI Enumerator could help you solve your Medicare claim problems** or fix technical issues with the NPI Crosswalk, you're out of luck. Those are two areas that the NPI Enumerator doesn't address, CMS says in a recently revised MLN Matters article (SE0751).

The Enumerator helps healthcare providers apply for their NPIs and update their information in the NPPES, but does not help you fill out the paper or electronic form.

A list of what the Enumerator can and can't do is in article at www.cms.hhs.gov/MLNMattersArticles/downloads/SE0751.pdf.

• **CMS quells chiropractors' concerns with the new MLN Matters article SE0749,** "Addressing Misinformation Regarding Chiropractic Services and Medicare." Released on Dec. 14, the article dispels seven common misconceptions about billing Medicare for selected chiropractic services.

For example, chiropractors who are non-participating in Medicare may think that they don't have to meet Medicare's documentation standards when treating Medicare patients, but the article notes, "The participating status of the provider is irrelevant to the documentation requirements."

You can read the article in its entirety online at www.cms.hhs.gov/MLNMattersArticles/downloads/SE0749.pdf. ■

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