The Coding Institute

Part B Insider

News & Analysis on Part B Reimbursement & Regulation

May 23, 2008
Vol. 9, No. 19
Pages 137-144

IN THIS ISSUE

REGULATORY NEWS

Lawmakers Agree to 2009 Budget Plan Without Medicare Cuts

▶ *Plan would create budget surplus by 2012 without Medicare cuts — but June '08 cuts are left hanging*

Lawmakers on Capitol Hill seem to have Medicare budget concerns on their minds this week, with a surprising budget plan that reveals no cuts to the Medicare program.

Both the House of Representatives and the Senate agreed earlier this week to a $3.07 trillion budget conference agreement for 2009.

Notably absent from the budget agreement were several steep Medicare cuts that President Bush had requested earlier this year when he proposed his $3.1 trillion budget. Instead, the agreement doesn't put into place the $178 billion in cuts that the president had asked to trim from Medicare over the next five years.

"This most likely means that President Bush's original plan to link Medicare drug premiums to the beneficiaries' salaries will no longer happen, which is great news," says **Heather Corcoran** with **CGH Billing** in Louisville, Ky. "This will open up some dialogue about logical places to save money in the budget, rather than taking from Medicare."

In addition, the figures outlined allow the federal budget to return to a surplus by 2012, and stay at a surplus in 2013.

"This is a significant achievement," said Senate Budget Committee Chairman **Kent Conrad (D-N.D.)** in a statement. "This is a fiscally responsible plan that returns the budget to balance."

As of press time, the Senate and House had not yet voted on the budget, but the vote was expected to take place within the next few days. Keep an eye on the *Insider* for more on the 2009 budget.

June '08 Pay Cut Still Not Resolved

The 2009 budget blueprint does not address what will happen to the 10.1 percent Medicare pay cut that's due to hit physicians on July 1.

Lawmakers intended to hammer out an agreement to halt the rate cuts by the Hill's Memorial Day recess, but were unable to reach a bipartisan consensus, said **Senate Finance Committee Chair Max Baucus (D-Mont.)** in a May 21 statement.

Baucus intends to craft his own legislation that boosts Medicare pay for an additional 18 months and expects to have it on the Senate floor for a vote by early June, according to his May 21 statement. ■

PART B PAYMENT

New CMS Pilot Program Bundles Physician's Pay With Hospital's

▶ *Certain cardiac, orthopedic services targeted first in the 4 participating states*

If you think consolidated billing has been difficult to keep up with, just wait for Medicare's latest plan.

CMS announced on May 16 that it plans to launch a new demonstration project that bundles payment for hospitals and physicians' services into one lump sum.

As part of the Acute Care Episode (ACE) demonstration, CMS will assign a global payment amount that combines reimbursement for the Part A and Part B Medicare services that providers deliver during an inpatient hospital stay.

One of the benefits of the plan, CMS says, is to promote "gainsharing," which lets physicians and hospitals share the financial benefits of implementing certain quality and efficiency improvements.

"The ACE demonstration reflects CMS' ongoing commitment to actively pursuing the best medical care for Medicare beneficiaries through value-based purchasing," said **Kerry Weems,** CMS' acting administrator, in a statement.

CMS will select one ACE demonstration site per market during the demonstration's first year, and the markets currently include Texas, Oklahoma, New Mexico and Colorado.

Orthopedics, Cardiology Affected

Of note, the procedures that CMS will test using the bundled payment methodology include 28 cardiac and nine orthopedic inpatient surgical services, which CMS selected "because profit margins and volume have historically been high," according to the agency's May 16 press release announcing the new plan.

How the plan will work at this point is unclear, but the carrier potentially will pay the hospital a single amount and the hospital will then carve out the physician's payment.

"If that ends up being the case, a physician should get an agreement in writing regarding how much they'll get paid," says **Barbara J. Cobuzzi, MBA, CPC-OTO, CPC-H, CPC-P, CPC-I, CHCC,** president of **CRN Healthcare Solutions,** a coding and reimbursement consulting firm in Tinton Falls, N.J.

"Because the physicians aren't employees of the hospital, they could end up operating like subcontractors in such a scenario."

To read more on the demonstration program, visit the CMS Web site at www.cms.hhs.gov/apps/media/press_releases.asp, and scroll down to the May 16 news release. ■

COMPLIANCE

Take Initiative: 5 Steps Can Help You Handle Medicare Audits

▶ *Be proactive to avoid audits — but if all else fails, remain professional*

This year, hundreds of practices will get the news that no one wants — Medicare is reviewing their claims as part of an audit.

Today we've got five ways for you to stave off audits — and when necessary, prepare for them — that can help you get on the right track.

1. Keep up with Medicare regs. Medical practices are often too busy to stay on top of all of their carriers' many policy changes, which can spell trouble from a compliance standpoint. If you fail to keep up with your payer's requirements, you could be coding incorrectly, and you might end up being an audit target.

For example: During a recent recovery in Connecticut, three separate providers made identical errors that caused Medicare to accuse them of overbilling a particular service. "It would be surprising to see the same deliberate fraudulent overbilling in three different provider systems, which leads me to believe there's a good chance that the rules changed and the practices just weren't aware of it," says **David C. Harlow, Esq.,** of **The Harlow Group, LLC** in Newton, Mass.

2. Ensure that your documentation is correct. In some cases, the physician may circle a level of service on his claim form that he performed, but he didn't document properly to justify the code.

"I have shadowed physicians in the past while they've treated patients, and the key thing I noted was that many times, doctors are doing all of this work but fail to document the services they did," said **Annette Grady, CPC, CPC-H, CPC-P, CCS-P, OS,** an independent healthcare advisor and instructor, during her May 20 Coding Institute audioconference, *Everything You Need to Know About Responding to a Chart Review*. "The sad part about that is I knew the work was performed, but the documentation didn't support that the service was provided," she says.

"If you end up in an audit and you're trying to make excuses for documentation gaps, you're fighting a losing battle," Harlow says. "The goal is to have your documentation in good shape up front. It's not only complete documentation that you need — it's also accurate documentation," Harlow says.

3. Find out why you're being audited. If an auditor contacts your practice and requests a meeting to discuss your records, ask why.

"It makes sense to try and get a handle on exactly what sort of information they may be looking for," Harlow says. "It is appropriate to ask "What is the scope of the audit you're doing? What are you looking for? Is this purely post-payment review, or is there another area that you're looking at?" Harlow says. If there's a chance that your practice is the target of a criminal investigation, you should ask your attorney to come to the audit, Harlow says.

4. Gather your documentation. Often, the auditor simply wants to review your documentation to ensure that it meets the service you billed. "For instance, an audit was done in 2003 where the government found that about 35 percent of claims including modifiers 25 and 59 didn't support the service," Grady says. "So now they sometimes request documentation during a prepayment review to ensure that those modifiers have been reported appropriately."

4. Keep a record of what the auditors review. "If the auditors take copies of your documentation, you should get a set of copies of the same materials so you know what they've taken with them to examine, whether it's paper or electronic copies," Harlow says. "That way, you can huddle with advisors later to ensure that everything is complete and accurate."

If you find that any of the information that the auditors took with them requires further explanation, "do so proactively, rather than waiting for them to ask," Harlow says. ■

DOCUMENTATION

Documentation Addendums Are Acceptable — Most of the Time

▶ *Ensure that the physician isn't amending the record just to get the claim paid*

Imagine this: Your physician documents a visit with a patient but leaves out critical information about the services that the doctor provided. Now you're unable to report the appropriate code for the visit.

How can you remedy this? In many cases, the doctor can simply write an addendum to the medical record — but be sure that your addendum meets the requirements.

Ensure clarity: "The critical issue when amending a patient's medical record is that the physician needs to ensure that any subsequent treating provider reviewing the patient's medical record can determine precisely what the amendment is and when it was made," says **Mark. C. Rogers, Esq.,** with **The Rogers Law Firm** in Boston.

Make sure you're amending for the right reasons: "My first question to the physician is, 'Why are you addending it?'" says **Margaret T. Atkinson, BS, CPC, RMC,** business manager at **Centennial Surgery Center** in Vorhees, N.J. "You should never consider whether the patient has coverage when making your decision on how to treat the patient, and you can't change the record to reflect information that will help get the claim paid if it's not true to what the doctor performed," she says.

Example: A gastroenterologist sees a patient and orders a colonoscopy screening. He notes the chief complaint as, "Patient's over 50 and presents for colonoscopy screening."

The coder reviews the chart and knows that Medicare will deny coverage because the patient has already had a screening colonoscopy within the last two years, so she alerts the physician to this.

The physician tells the coder that the patient had rectal bleeding, and that he'd like to amend the chart to include that as the chief complaint.

Solution: "In this case, I would ask the physician what the timing and duration was of the rectal bleeding," Atkinson says.

"If the rectal bleeding is resolved by the time of the visit, then that would be categorized as past, family and social history, so you couldn't amend the record to make it the chief complaint," Atkinson says. "But if it is a current condition, you can amend the record to reflect that."

Make sure the addendum is signed, dated: When you add information to the medical record, the physician should initial or sign the addendum, and include the date and time that he made the revision, Rogers says.

Keep in mind: The caregiver who performed the service should personally make the change to the record, Atkinson says. "The signature and date can't be performed by a representative or the coder," she says.

EMR tip: "If the physician is making entries on an electronic medical record, this approach may not be possible depending upon the software that is being utilized," Rogers says. "Nevertheless, every effort possible should be made to link the revision to the incorrect entry."

Potential pitfall: "I am aware of certain electronic medical record software that 'lock' entries and do not allow a direct amendment to the entry," Rogers says.

"The physician is required to revise the entry through an addendum; the addendum, however, is not available for review on future patient visits," Rogers advises. "Such a process absolutely creates a potential liability exposure to the physician and the institution in which he/she is practicing." ■

READER QUESTION

New CCI Verbiage Shouldn't Constrain Your Modifier Use, CMS Says

▶ *Version 13.3's introductory notes confused physicians, but we've got clarification*

Question: *In the introduction to Correct Coding Initiative (CCI) version 13.3 and the subsequent versions (including the most recent, 14.1), it says, "... a significant and separately identifiable E/M service unrelated to the decision to perform the minor surgical procedure is separately reportable with modifier 25." But in some cases, our doctor must perform a service for a related procedure during the same visit. Is the modifier no longer applicable for these services?*

Answer: The new language has been confusing for quite a few practices, but Medicare lays your fears to rest with specific guidance on this topic.

CMS "does not require that the significant and separately identifiable E/M service and the minor surgical procedure be reported with different ICD-9 codes," a CMS spokesperson told the *Insider* earlier this week. "Both may be related to the same medical problem."

The CMS spokesperson points to the following citation from chapter 12, section 40.1, of the *Medicare Claims Processing Manual:*

"Visits by the same physician on the same day as a minor surgery or endoscopy are included in the payment for the procedure, unless a significant, separately identifiable service is also performed. For example, a visit on the same day could be properly billed in addition to suturing a scalp wound if a full neurological examination is made for a patient with head trauma. Billing for a visit would not be appropriate if the physician only identified the need for sutures and confirmed allergy and immunization status."

Therefore, if you perform an E/M service and a procedure on the same date, you can continue to append modifier 25 (*Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service*) or modifier 57 (*Decision for surgery*) on the E/M code, as long as the physician's documentation meets the requirements of the codes and the modifiers on the claim. ■

Part B Coding Coach

Prepare Now So Pain Management Diagnosis Coding for 2009 Is No Pain, All Gain

▶ *You may have to leave your 784.0 comfort zone in October*

ICD-9 2009 may include more new codes than you've seen in a decade, and the almost two dozen new headache codes could make your head spin.

But don't reach for the aspirin just yet — here are insider tips to help you prepare and ease your pain before it even starts.

Code 784.0, Meet 339.XX

The lowdown: CMS just released the preliminary 2009 ICD-9 new diagnosis code list. The changes aren't official yet, but this rundown will give you a leg up on the changes that will most likely take effect Oct. 1, 2008.

The biggest shake-up: ICD-9 2009 may change your options so that 784.0 (*Headache*) will no longer be your go-to headache code. According to ICD-9 2008, this catchall code covers facial pain and any "not otherwise specified" head pain. But a new 2009 339.XX series could cover other headache syndromes, which will make your diagnosis coding that much more accurate.

"My physicians are more specific in their notes, so I welcome the more specific coding," says **Angie Medrano, CPC,** coder with **Children's Hospital Neurology Foundation** in Boston.

"I do find more specific codes helpful, especially when it is called for in the payer policies," says **Lonna Maile,** coding manager with **Hawaii Pacific Health.** The challenge for coders is educating the physician on the need for accurately documenting diagnoses to the highest specificity, Maile says.

Helpful advice: You'll need to work with your pain management specialist to be sure documentation matches up with the new coding choices, or you could be stuck reporting "unspecified" codes when your payers' policies require something more specific.

Tip: Once the codes become official, consider giving your pain management specialist a list of the new codes so he'll know what information you need to choose the most specific code. Here's how the ICD-9 2009 headache codes likely will appear.

Break Up Cluster Headaches

New subcategory 339.0X (*Cluster headaches and other trigeminal autonomic cephalgias*) will cover a variety of cluster headaches and headaches affecting one side of a subject's head. These include the following:

- 339.00 — *Cluster headache syndrome, unspecified*
- 339.01 — *Episodic cluster headache*
- 339.02 — *Chronic cluster headache*
- 339.03 — *Episodic paroxysmal hemicrania*
- 339.04 — *Chronic paroxysmal hemicrania*
- 339.05 — *Short lasting unilateral neuralgiform headache with conjunctival injection and tearing*
- 339.09 — *Other trigeminal autonomic cephalgias*.

Note: Code 339.00 also includes cluster headache not otherwise specified (NOS), ciliary neuralgia, histamine cephalgia, lower half migraine, and migrainous neuralgia, while

Part B Coding Coach

339.03 includes paroxysmal hemicrania not otherwise specified, says **Stephen D. Silberstein, MD, FACP,** past president of the **American Headache Society**, director of the **Jefferson Headache Center** and neurology professor at **Thomas Jefferson University Hospital** in Philadelphia, during his presentation, "Headache Classification 2007" (www.cdc.gov/nchs/ppt/icd9/att1_headache_mar07.ppt).

Remember: You use NOS codes when the medical record is insufficient for you to choose a more specific code, according to the HIPAA-mandated ICD-9 Official Guidelines. The abbreviation NOS is the equivalent of "unspecified."

Also helpful: Codes 339.01-339.04 include the new terms "episodic" and "chronic."

"Chronic" denotes pain persisting for more than three months. When you're coding for headaches, it has this meaning for secondary headache disorders, Silberstein says.

Watch out: For primary episodic headache disorders, such as migraines, Silberstein says, use the classification "chronic" whenever the headache occurs on more days than not for greater than a three-month period.

"Episodic," on the other hand, indicates that the headache occurs on less than 15 days per month, he says.

Exception: Trigeminal autonomic cephalalgias (TACs) are the exception, Silberstein says. The chronic classification isn't used for TACs until a patient has unremitting headaches for more than a year.

Take the Tension Out of TTH

ICD-9 2009 may also offer three new codes you can use for tension-type headaches (TTH):

- 339.10 — *Tension type headache, unspecified*
- 339.11 — *Episodic tension type headache*
- 339.12 — *Chronic tension type headache.*

Note: These codes will exclude tension headaches due to psychological factors classified under 307.81 (*Tension headache*), Silberstein says.

In other words: This list of tension-type headache codes in the potential new 339.XX range means your pain management specialist's documentation needs to offer enough information to code and differentiate accurately between "tension" headaches, which are in the Mental Disorders ICD-9 chapter, and the new "tension-type" headaches, which ICD-9 will likely place in the Nervous System ICD-9 chapter.

PTH Earns New Category

Post-traumatic headaches (PTH) represent another headache category you may see in ICD-9 2009. PTH can be part of post-concussion syndrome, Silberstein says, but it does not have to be.

So if the pain management provider documents PTH but doesn't document post-concussion syndrome, you may still be able to report one of the new PTH codes:

- 339.20 — *Post-traumatic headache, unspecified*
- 339.21 — *Acute post-traumatic headache*
- 339.22 — *Chronic post-traumatic headache.*

Don't forget that once you have specific codes for most of the possible headache variants, you need to be careful with how you handle headache coding. Make sure you always code to the highest level of specificity, and be sure your pain management provider's documentation supports reporting these new diagnosis codes for 2009. ■

PHYSICIAN NOTES

NPI-Only Date Is Here — Get Your Claims on Track

▶ *Plus: New DME competitive bidding program awardees announced for 10 communities, effective July 1*

Get ready for denials if you're not geared up for the National Provider Identifier (NPI) requirements that hit May 23.

"As of May 23, Medicare FFS will require and send NPI-Only in ALL provider identifier fields for all HIPAA and paper transactions where a provider identifier is required," CMS warned on the eve of the deadline. "If you send Medicare a transaction with a Medicare legacy identifier in any of the provider fields, your claim will be rejected," CMS said.

And you won't be off the hook for leaving referring physicians' NPIs off the claim. If the physician "does not furnish an NPI, the billing provider must attempt to obtain that NPI in order to enter it on the claim," CMS reminds providers. Use the NPI registry at https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do or contact the physician directly for the NPI number in question.

To use your own NPI in the secondary field, you must have "exhausted all possibilities of finding the NPI" of the referring or prescribing physician, CMS directs.

In other news ...

• **If you're one of the lucky participating states,** you can check out how your claims data compares to your peers in the same specialty and geographic location.

Empire Blue Cross/Blue Shield, a Part B carrier in New York and New Jersey, is offering practices a comparative distribution report (CDR) to benchmark their E/M use with other physicians'.

If you're in one of these two states, you can email your CDR request to eastclinicaleducation@wellpoint.com, along with your PIN, your practice address and phone, and the code family you're requesting.

• **Medicare has awarded 325 competitive bidding** program contracts for durable medical equipment.

In its May 19 announcement, CMS seemed to indicate that the program, which goes into effect on July 1 in 10 communities, will not drive small suppliers out of business, as previously speculated.

"Bids were evaluated to ensure there would be a sufficient number of suppliers, including small suppliers, to meet the needs of beneficiaries living in the competitive bidding areas," the release noted.

For more on the program, go online to the Web site www.cms.hhs.gov/DMEPOSCompetitiveBid. ■

PART B Insider

Published 44 times annually by *The Coding Institute*.
Subscription rate is $397.

Torrey Kim, CPC
Editor-in-Chief
torrey@partbinsider.com

Chris Owens, CPC
Managing Editor

Samantha Saldukas
President

Melanie Parker
Publisher

Bridgett Hurley, JD, MA
Vice President, Editorial & Development

The Coding Institute, 2272 Airport Road S., Naples, FL 34112 Tel: (800) 508-2582 Fax: (800) 508-2592

Part B Insider (USPS 023-079) (ISSN 1559-0240) is published weekly 44 times per year by The Coding Institute, a subsidiary of Eli Research, 2222 Sedwick Road, Durham, NC 27713. Subscription price is $397. Periodicals Postage is paid at Durham, NC 27705 and additional entry offices. POSTMASTER: Send address changes to Part B Insider, P.O. Box 413006, Naples, FL 34101-3006.

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