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News & Analysis on Part B Reimbursement & Regulation

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RED FLAGS RULE

No Red Flags Program? You Could Be Losing Thousands

▶ *Tip: Institute your Red Flags program ASAP.*

You may think the government is implementing the Red Flags Rule in the distant future — but the Federal Trade Commission (FTC) will begin enforcing it on May 1 — and it can't come soon enough for some practices.

Under the Red Flags Rule, your practice will be required to spot the "red flags" that can signal identity theft. Just last week, a Long Island medical office employee was charged with stealing patients' identities from medical files and using the information to go on a spending spree.

Point of contention: In preparing their Red Flags programs, some practices plan to check patients' identification cards, and some choose to make photocopies or scan the photo ID cards to ensure that patients who present are using their own insurance cards. However, several practices report that they've heard that they should not keep copies of patients' IDs in their systems due to privacy concerns with their HIPAA policies.

Reality: In a Feb. 4 letter to the AMA, the FTC noted that requesting a photo ID at patient visits is "consistent with the objectives of the Red Flags Rule."

Good idea: "It is our recommendation to American Medical Billing Assn. (AMBA) members to have their providers check a photo ID for each encounter," suggests **Cyndee Weston,** AMBA's executive director. "I don't think the ID must be copied each time, but a picture in the patient's medical record for future identification purposes would be beneficial," she advises. Many providers already take a digital picture of the patient for the medical record, which is a "best practice suggestion."

What about HIPAA? "Once you've copied the license or scanned it into your system, you've entered HIPAA territory," says **Barbara J. Cobuzzi, MBA, CPC,CPC-H, CPC-P, CHCC,** senior coder and auditor for The Coding Network, and president of CRN Healthcare Solutions. "You now have to have very strong HIPAA protocols to protect that."

Keep in mind: The case of the Long Island woman should be a reminder that practices should include employee background checks in their Red Flags program, Cobuzzi says.

For tips on how to identify a "red flag" involving a patient's ID, turn the page. ■

RED FLAGS RULE

Act Quickly If Your Practice Identifies a Red Flag

▶ *Identity theft is nearly a $50 billion industry.*

You've implemented a Red Flags program at your practice — but do you know what to do if you identify an issue?

Your practice should not only determine how you'll identify red flags, but also create steps to deal with them.

For instance: If you decide to copy patients' ID cards at their visits (*see page 81 for more information*), you'll need to do more than just make copies or scan the cards. Your employees should be on the lookout for discrepancies.

"We've identified the following as a red flag regarding patient IDs," says **Cyndee Weston,** executive director of the American Medical Billing Association: "A photograph or physical description contained on the identification presented is not consistent with the appearance of the person presenting the ID or there are obvious differences between the age, gender, or ethnicity."

If there is a breach, offices should be asking these questions, Weston advises:

- How do we control a breach?
- How do we determine what happened and what information was subject to the improper use?
- How do we mitigate the breach (including recovering lost data for internal purposes)?
- What do we need to do to ensure this doesn't happen again?
- Do we have to notify anyone?
- If so, who must we notify and through what means?
- If we don't "have to" notify, should we notify anyway?
- Is there anyone else we need to notify (clients, regulators, etc.)?

"Practices should take a proactive approach and react accordingly," Weston advises.

Don't be daunted: Some patients may balk at your tighter patient identity protocols, but you should remind them that your goal is to ensure that no one else is using their identity to get medical care.

"Medical identity theft is not just financial theft, but also affects the patient's medical records, blood type, diagnoses, etc., and the resolution of that information can take a long time," says **Barbara J. Cobuzzi, MBA, CPC,CPC-H, CPC-P, CHCC,** president of CRN Healthcare Solutions. "Lack of identification of this theft can lead to medical crisis or even death — for example, being given the wrong blood type because the medical records carry the thief's blood type."

Be aware: Identity theft isn't just a rare occurrence in medical practices. "The FTC conducted a survey and found that 4.5 percent of the 8.4 million victims of identity theft in 2007 were related to medical services," Weston says.

"My statistics show that in 2007, identity theft cost $49.3 billion, the mean per fraud victim cost was $5,720 and it took an average of 25 hours to resolve issues related to the theft," Weston says. "Only 15 percent of victims find out due to a proactive action taken by a business and 85 percent find out in a negative manner." ■

COMPLIANCE

OIG Advisory Opinion Process Can Be Long, Arduous — And Costly

▶ The Advisory Opinion will give you peace of mind, so proceed with requesting one if you think you're on shaky ground.

Last week, we showed you a few of the ins and outs of requesting an Advisory Opinion — now get ready for the realities of using the OIG's process.

Legal ramifications: Several subscribers wrote to us and asked whether the OIG could use the information in an Advisory Opinion request to impose penalties on the practice.

Reality: "If your Advisory Opinion concerns a proposed arrangement and the OIG issues an unfavorable opinion, the OIG generally assumes that the requester will not go through with the proposed arrangement," says **Mark Wachlin, Esq.,** a former OIG attorney who now practices with Dilworth Paxson, LLP in Philadelphia.

If your Advisory Opinion involves an existing arrangement and the opinion will be unfavorable, the OIG will normally call you and inform you that the opinion will likely be unfavorable. "The requester will then usually withdraw the advisory opinion request," Wachlin says.

"The regulations governing the advisory opinion process expressly state that in the event of withdrawal, the 'OIG reserves the right to retain any request for an advisory opinion, documents and other information submitted to it under these procedures, and to use them for any government purpose,'" Wachlin says. "In the final rule published in the *Federal Register*, 63 FR 38311, several commenters asked whether the 'any governmental purpose' language means that the OIG can use information submitted with requests as a basis for investigation." The OIG responded as follows:

"Our primary purpose under these regulations is to gather and assess information in order to render informed advisory opinions. However, the anti-kickback statute is a criminal statute, and therefore review of arrangements that potentially implicate the statute requires heightened scrutiny. As a law enforcement agency, the OIG cannot ignore information lawfully obtained to further legitimate governmental purposes."

Outcome: If the OIG issued an unfavorable opinion regarding an existing practice, it could pursue the requester or refer the matter to the Dept. of Justice, Wachlin says. "It is not, however, customary for this to occur. Indeed, in my three plus years at the OIG, I do not ever recall such a situation occurring."

Consider Financial Impact

If you request an Advisory Opinion, you won't get an answer overnight — and it won't be inexpensive.

"Getting an advisory opinion is not a straightforward and simple thing — there is a huge checklist of items that must be included with your request and the initial $250 fee," says **David C. Harlow, Esq.** with The Harlow Group in Newton, Mass.

First, you'll pay your attorney to prepare, review, and/or submit your request. Then, after you submit it, the OIG might recommend that its independent expert review it, "and they'll engage what could be a big consulting firm or a healthcare economics firm and that cost is passed along to you," Harlow says. "Plus, they charge for staff time reviewing your case."

Keep in mind: You can set a "trigger amount," which means the OIG will contact you if they've surpassed a particular dollar amount.

Timeliness: The OIG is supposed to respond to your request within 60 days, but that doesn't necessarily start the day you submit your paperwork. "The process could easily take six months or longer," Harlow says.

Alternative: In some cases, you might review previous Advisory Opinions and structure your arrangement to fit one that the OIG has already blessed, Harlow says. "Whether you want to follow this path could depend on your risk tolerance," Harlow advises. "The stakes are high — and include being barred from the Medicare program, so you don't want to guess wrong." ■

PART B REVENUE BOOSTER

Brush Up on Your ICD-9 Know-How With 3 Tips

▶ *Confused about fifth digits or V codes? Look no further.*

Insurers base your reimbursement on whether your claims show medical necessity — and you can't demonstrate that without accurate diagnosis codes. Refresh your ICD-9 coding skills with three tips that make ICD-9 coding a breeze.

Tip 1: Forget that fifth digit and forget reimbursement. If you omit a required fifth digit when submitting ICD-9 codes, such as those for arthritis (715.00-716.99), you can anticipate claim denials, delays, and potential payer rejections.

"The purpose of the fifth digit is to allow the physician to provide greater detail, and when required it must be billed in order to facilitate reimbursement," says **Susan Vogelberger, CPC, CPC-H, CPC-I, CMBS, CCP-P,** president of Healthcare Consulting & Coding Education, LLC in Boardman, Ohio. "A code is invalid if it has not been coded to the full number of digits required."

Fifth digits add additional information to the code, Vogelberger says, such as the location of anatomy for arthritis codes or the percentage of body surface with third-degree burns.

Best practice: If you've dealt with denials due to missing fifth digits, you should print the applicable ICD-9 codes, including the fifth digits, right on your superbill. For instance, you could include all of the carpal bone fracture codes, including the fifth digits, right on your superbill. If you don't have enough room on your superbill to list every last fifth digit, you should place a line or symbol after codes that require a fifth digit.

For example: Suppose you want to offer the physician the option of circling an upper end closed humerus fracture, but you want to remind him that a fifth digit is required.

Solution: "In one of my offices, we denote 812.0* and in my other office we denote 812.0X," says **Marlene Gould** with Verity Orthopedics and Spine Surgery in Orlando, Fla. This way, the person sending in the claims would be reminded to look up the appropriate digit to put on the diagnosis code.

Tip 2: When a V code is your only option, report it as the primary diagnosis. If you think that you should never report V codes (found near the back of the ICD-9 manual) as primary diagnosis codes, think again.

Practices can use V codes for primary diagnoses under certain circumstances. Although it used to be difficult to collect reimbursement from some carriers when you reported only V codes, many are coming around.

Example: If a patient returns for follow-up care after a fracture, it is incorrect to report the fracture code again, because once it has been reduced and casted or splinted, it is no longer considered a fracture. Therefore, you should report a V code instead, such as V54.12 (*Aftercare for healing traumatic fracture of lower arm*).

Tip 3: When you have a workers' comp case, append an E code. Suppose a patient falls off of scaffolding at his construction job and fractures two metacarpal bones and three phalanges. Your hand surgeon sees the patient, and you report 817.0 (*Multiple fractures of hand bones; closed*) for the fractures, but the patient's workers' comp insurer denies the charge. Why? Because you forgot to add the appropriate E code to describe how the work-related diagnosis occurred.

You should use E codes to describe external causes of injuries or accidents. You should never bill E codes as your primary code, and you should list the E codes last. It may be necessary to assign more than one E code to fully explain each cause.

In the example above, the coder should report 817.0, followed by E881.1 (*Fall from scaffolding*) and E849.3 (*Place of occurrence; industrial place and premises*).

Don't forget: Workers' comp laws vary from state to state, so you should ask the insurer for its guidelines and requirements before you bill. ■

READER QUESTION

Mind This Year's CPT Deletions for Accurate Botox Coding

▶ *Tip: Report chemodenervation guidance once per day, not per injection or injection site.*

Question: *What is the correct way to report Botulinum toxin injections?*

Answer: For Botulinum toxin injections into facial muscles, use 64612 (*Chemodenervation of muscle[s]; muscle[s] innervated by facial nerve [e.g., for blepharospasm, hemifacial spasm]*). For injections to the cervical spine muscles, use 64613 (*... neck muscle[s] [e.g.,for spasmodic torticollis, spasmodic dysphonia]*). For extremity or trunk muscles, use 64614 (*... extremity[s] and/or trunk muscle[s] [e.g., for dystonia, cerebral palsy, multiple sclerosis]*).

Per the AMA, chemodenervation coding should be reported with a maximum of one unit of service per day, regardless of the number of injections performed. Note that the Medicare Physician Fee Schedule takes a slightly more liberal approach and allows the chemodenervation injection codes to be reported bilaterally if appropriate.

Additionally, some Medicare carriers have addressed reporting chemodenervation injection coding based on one unit of service per "contiguous body part." It is best to review your payer coverage policies.

Some providers may need to use needle guidance, either electrical stimulation or EMG needle, for chemodenervation injections on some patients.

For electrical stimulation guidance, report the add-on code +95873 (*Electrical stimulation for guidance in conjunction with chemodenervation [List separately in addition to code for primary procedure]*). Report +95874 (*Needle electromyography for guidance in conjunction with chemodenervation ...*) for EMG needle guidance.

The Dec. 2008 *CPT Assistant* clarified that coding for these needle guidance services is limited to a maximum of one unit of service per day of chemodenervation injection services. It is not appropriate to report the chemodenervation needle guidance services based on the number of injections and/or injection site(s). ■

Comments? Questions? Concerns?
Contact **Torrey Kim, CPC**
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Part B Coding Coach

5 Answers Capture Suture Removal and Related Work

▶ Tip: Your E/M usually requires 2 components — which means more than problem-focused.

If you pigeonhole encounters involving suture removal as 99212s, you could be cutting yourself short — or you could be overcharging your service.

To tell whether you need to code more or less for laceration follow-up care, answer these five questions.

1: Did You or a Co-Physician Do the Repair?

Yes: If your physician or a doctor within your group places the sutures, you cannot bill for their removal, confirms **Tracy Russell, CBCS,** at Carroll Children's Center in Westminster, Md. The laceration repair code includes uncomplicated, related postoperative follow-up visits and suture removal.

No: If another physician places the sutures and your doctor removes them, you can bill for the wound check and removal.

2: Are You Providing a 2-Day Post-ER Check?

"For lacerations done in the ER, we are often called upon to 'evaluate' the wound in two days," explains **Charles Scott, MD, FAAP,** a pediatrician at Medford Pediatric and Adolescent Medicine in New Jersey.

This ER-physician ordered two-day wound check involves checking for infection and for proper wound healing, and usually requires an expanded problem-focused history and examination. "I code an E/M — usually 99213 because I not only look at the laceration site, but I also need to assess the area's functionality," Scott relays. This involves such concerns as:

- Does the leg move properly or the finger bend well?
- Could there have been a tendon injury below the surface?
- For an eyebrow, what about the extra ocular muscle function?
- Is sensation intact?

Be careful: Don't rule out a problem-focused visit.

Although cases requiring looking only at the wound are rare, if that's all Scott does, he uses 99212 (*Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a problem focused history; a problem focused examination; straightforward medical decision making ...*).

For the diagnosis code, use the open wound laceration by site code. Make sure to choose the appropriate digits to represent the location and status, such as:

- open wound of scalp (873.0, *Other open wound of head; scalp, without mention of complication*; or 873.1, *... Scalp, complicated*)
- forehead (873.42, *... face, without mention of complication; forehead*; or 873.52, *... face, complicated; forehead*)

Part B Coding Coach

• finger (883.0, *Open wound of finger[s]; without mention of complication*; 883.1, *... complicated; or 883.2, ... with tendon involvement*), etc.

3: Did You Assess Wound and Remove Sutures?

You might not be giving yourself due credit if you overlook the work you may provide in an encounter before performing the suture removal. *Remedy:* Look at the situation as two evaluation components:

1) wound assessment — Scott says this component involves the physician assessing:

• Is the wound healed and ready for suture removal?

• Is there functioning of the area?

• Is there an infection?

2) (after that assessment) the actual sutures removal.

"Each, in and by itself, would be a 99212 (unless you had a case involving extensive and complicated sutures)," Scott relays.

Adding the two components together, however, is usually a 99213 (*... an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity ...*).The complaint isn't a problem-focused issue (99212); rather the encounter involves two expanded components (thus 99213), Scott explains.

4: Does the Insurer Accept S0630?

The CPT manual does not offer a specific suture removal code. The HCPCS Level II manual does offer a less commonly accepted option. "I generally use S0630 (*Removal of sutures; by a physician other than the physician who originally closed the wound*) when we have already seen the patient for the injury," Russell reports.

Code S0630 accounts for the suture removal only, not a wound check. "If we are treating the patient's wound for the first time and taking out sutures, we will charge an E/M code with modifier 25 (*Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service*) along with S0630," recalls Russell.

You might, however, find you're better off sticking with a combined higher-level E/M code.

"Most payers include the suture removal in with the E/M code now," Russell notes.

Even if you're coding only for the suture removal, you still might want to omit the HCPCS S-code option. Russell finds that most payers do not pay.

5: Did You Use 2 Diagnoses?

You can support encounters in which the doctor assesses the wound and removes the sutures with a diagnosis that represents both components. Here's how:

• **Diagnosis 1:** "As long as you are still dealing with the wound, use the laceration diagnosis code," says **Bill Dacey, CPC, MBA, MHA,** principal in the Dacey Group, a consulting firm dedicated to coding, billing, documentation,and compliance concerns in Stanley, N.C.

Report 870-897 based on the wound's site. For instance, you would code an uncomplicated open wound on the eyebrow with 873.42 (*... forehead*), which includes "Eyebrow."

• **Diagnosis 2:** For the secondary diagnosis, indicate suture removal with V58.32 (*Encounter for removal of sutures*). ■

PHYSICIAN NOTES

OIG Imposes One of the Largest Ever Civil Monetary Penalties Against Nevada Radiology Practice

▶ *Plus: CMS establishes MLN Matters article to answer your PQRI questions.*

Think it's okay to provide diagnostic tests without physician orders? One Las Vegas radiology practice is paying dearly for making that mistake, among others.

The physician-owned practice will pay $2 million to resolve allegations that it submitted false claims to Medicare, the OIG announced in a March 25 press release.

The settlement — one of the largest ever negotiated under the OIG's Civil Monetary Penalties authority — will resolve the following allegations against the radiology practice:

• Improperly providing diagnostic tests to Medicare beneficiaries without the required treating physicians' orders

• Billing for certain tests under CPT codes not supported by the medical records

• Failing to satisfy "certain other Medicare billing and coverage requirements," the OIG noted in its press release.

"OIG will investigate and pursue enforcement actions against health practitioners who engage in a pattern of billing Medicare for services that were not ordered by the patients' treating physicians," said Inspector General **Daniel Levinson** in a statement.

In other news ...

• If your head is spinning with all of the changes between PQRI and e-prescribing, CMS has just the tool for you.

New *MLN Matters* article MM6394, dated March 20, offers a full breakdown of who is affected by the new PQRI and e-prescribing incentive programs, with a primer on applicable reporting periods and methods.

For example: The article notes, "For purposes of qualifying for the e-prescribing incentive payment for 2009, an eligible professional will be considered a successful e-prescriber if he/she reported the applicable e-prescribing quality measure in at least 50 percent of the cases in which such measure is reportable by the eligible professional during the reporting period."

To access the MLN Matters article, visit the CMS Web site at www.cms.hhs.gov/MLNMattersArticles/downloads/MM6394.pdf. ■

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