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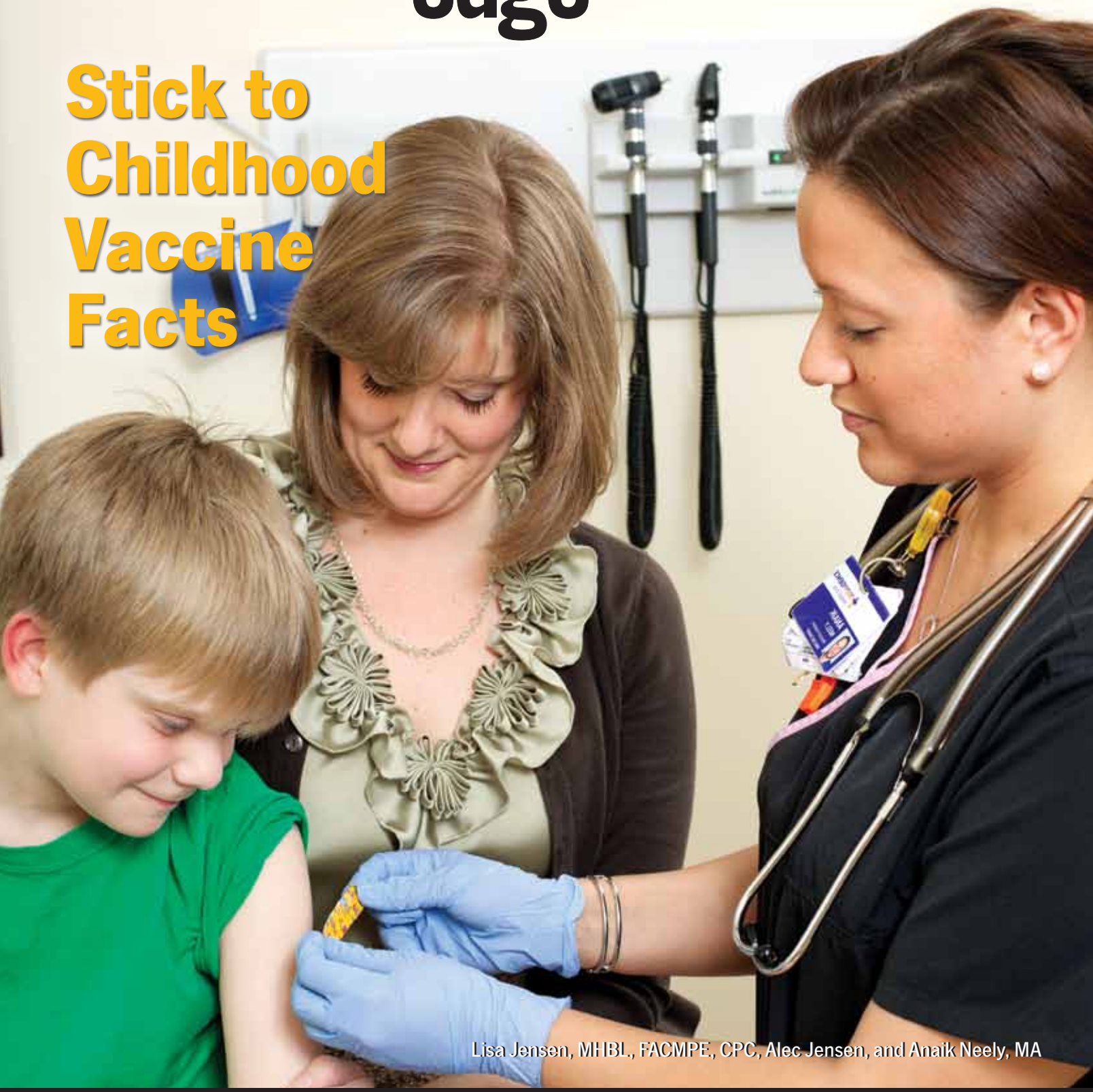
Stick to Childhood Vaccine Facts



Lisa Jensen, MHBL, FACMPE, CPC, Alec Jensen, and Anaik Neely, MA

Plus: Infusion Confusion • Silent PPOs • TMJ • Hospitalists • Modifiers Matter

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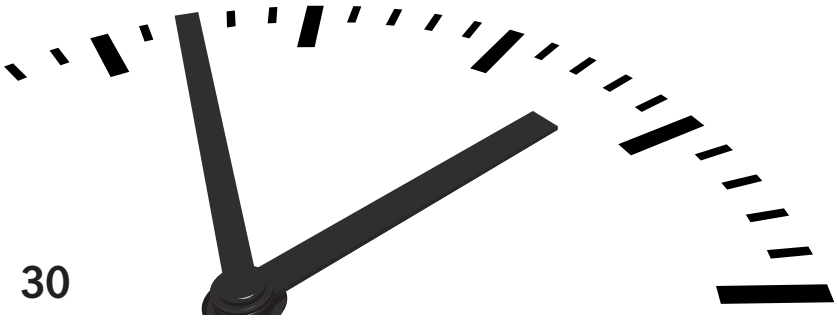

Features

On the Cover: Lisa Jensen's, MHBL, FACMPE, CPC, 8-year-old son, Alec Jensen, receives immunization from Medical Assistant Anaik Neely at Providence Medical Group Bethany Clinic, Portland, Ore. Cover photo taken by Tim LaBarge (http://timlabarge.com).

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Special Features

Education

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- **Claims Adjustment**
- **Aiding and Abetting**
- **ESRD**
- **New CT Codes**
- **DVT and Venous Emboli**

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

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

advertising index

AAPC CODING edge
July 2011

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Stand, Supported in the Storm

It has been a turbulent spring for AAPC members. Not only have codes and billing rules remained unpredictable, but harsh weather throughout the country has made this a long and late season.

As I write this, we hear more about record precipitation and flooding, tornado outbreaks, and other events that – although localized – impact us all. I especially send my condolences to our members and their families in tornado-ravaged Alabama, Missouri, Arkansas, Mississippi, Massachusetts, and other affected states. These tragedies, along with floods in the Mississippi Basin and other disasters, remind us of how important it is to reach out to our colleagues and their loved ones.

You're Not Alone

This concern and support that AAPC members have for each other underlines how important our local chapters are. Most members have a nearby chapter where they can network, receiving support and assurance while learning from others who face the day-to-day challenges of coding. Our local chapters are unique professional and personal resources for you.

Members give back to their peers. We hear it all the time: The apprentice who is helping others pass their exams; the member who donates an organ to a colleague; and the chapter helping strangers in need. We know what it is like to face the unpredictable.

Prepare for What's on the Horizon

For AAPC members, the profession has always been stormy. We are in the midst of major changes to our profession as more practices and facilities begin to adopt electronic health records (EHRs). We see the squall line of changes resulting from the year's end adoption of 5010 standards. And we scan the horizon knowing the cyclone of ICD-10 certainly will sweep through in 2013.

We began to prepare years ago, offering information on EHR and 5010 adoption at our conferences, through webinars, and in our publications. Our members make local presentations and help others learn to understand and manage the future.

AAPC offers several means to prepare shelter for the transition to ICD-10. Presentations provided to local chapters, online webinars, local boot camps, and other trainings are a primary focus now. We want all members to greet ICD-10 with confidence and expertise. You can learn more by going to our online ICD-10 page at **www.aapc.com/ICD-10/** to see what resources are available, try the ICD-9 to ICD-10 code conversion tool (ICD-10 Code Translator), and see the scope of support available to you from your organization.

Nothing Ventured, Nothing Gained

We adapt with change and adversity. We adjust and overcome. Just as the victims of tornadoes and floods will rebuild and renew, AAPC and our members will do what coders do best – meet the challenges of upcoming change with excitement and make ourselves better coders, auditors, and billers.

Your friend,

Reed E. Pew
Chairman and CEO

CMS Releases Quarterly HCPCS Level II Drug/Biological Updates

Effective July 1, the following HCPCS Level II code is *no longer payable* for Medicare:

J7184 Injection, von Willebrand factor complex (human), Wilate, 100 i.u. vwf:rco

Effective July 1, the following HCPCS Level II codes are *payable* for Medicare:

Q2041 Injection, von Willebrand factor complex (human), Wilate, 1 i.u. vWF:RCo

Q2042 Injection, hydroxyprogesterone caproate, 1 mg

Q2043 Sipuleucel-t, minimum of 50 million autologous CD54+ cells activated with PAP-GM-CSF, including leukapheresis and all other preparatory procedures, per infusion

See Transmittal 2227, Change Request (CR) 7303 for details: www.cms.gov/transmittals/downloads/R2227CP.pdf. (Note that Transmittal 2227 replaces the April 29 Transmittal 2207 release.)

Get E/M Facts Straight

Evaluation and management (E/M) services guidelines have a lot of documentation gray areas that can cost you in improper payments. To help you weed through the guidelines, capture proper E/M code selection, and gain insight into the causes of errors; CMS made available a new publication, "Comprehensive Error Rate Testing (CERT) – Evaluation and Management (E/M) Services: Overview." It is a fact sheet that provides education on E/M services to Medicare fee-for-service providers, and includes information on the documentation necessary to support E/M services claims submitted to Medicare.

One key note of the fact sheet states the coder's mantra: "If It Wasn't Documented, It Wasn't Done!" This section briefly explains how to achieve proper documentation: "Documentation should support the level of service reported. … In general, documentation of each patient encounter should include:

- Reason for encounter and relevant history, physical examination findings, and prior diagnostic test results;
- Assessment, clinical impressions, or diagnosis;
- Plan for care; and
- Date and legible identity of the observer.

Document the total length of time for the encounter if the level of service is based on counseling and/or coordination of care. Describe the counseling and/or activities to coordinate care."

The CERT fact sheet also provides information on:

- Components of an E/M Service
- Determination of the Correct Level of Code
- Guidelines
- Resources

You can find the Medicare Learning Network® fact sheet at: www.CMS.gov/MLNProducts/downloads/Evaluation_Management_Fact_Sheet_ICN905363.pdf.

NCD for PTA with CAS Unchanged

Physicians and hospitals submitting claims for percutaneous transluminal angioplasty (PTA) concurrent with carotid artery stenting (CAS) need to know that the national coverage determination (NCD) 20.7 for PTA of the carotid artery concurrent with stenting remains unchanged by the Federal Drug Administration's (FDA's) new approval of RX Acculink Carotid Stent System for patients who are not at high risk for carotid endarterectomy (CEA).

NCD 20.7 covers patients at high risk for CEA. Patients at normal or standard risk for CEA are not covered in FDA-approved post approval studies because the NCD requires patients to be at high risk for CEA. Medicare continues to cover patients at normal or standard risk for CEA only in Category B IDE trials in accordance with the Category B IDE clinical trials regulation (42 CFR 405.201).

For more information, see *MLN Matters* article SE1119 at www.cms.gov/MLNMattersArticles/downloads/SE1119.pdf.

July Updates to OPPS Category III CPT®

The July 2011 revisions to Integrated Outpatient Code Editor (I/OCE) data files, instructions, and specifications are provided in Transmittal 2234, Change Request (CR) 7443, "July 2011 Integrated Outpatient Code Editor (I/OCE) Specifications Version 12.2."

For the July 2011 update, CMS is implementing 14 Category III CPT® codes in the Outpatient Prospective Payment System (OPPS) that were released in January by the American Medical Association (AMA). Of these codes, 12 are separately payable under the hospital OPPS.

See the CR, posted on the CMS website (www.cms.gov/transmittals/downloads/R2234CP.pdf), for the Category III CPT® codes, status indicators, and APCs to be implemented as of July 1, as well as payment rates (found in Addendum B of the July 2011 OPPS update).

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Love Confessions of a Coder

Recently, I was asked why I loved coding. Several reasons came to mind, but my first response was that I didn't always love it. My love affair with coding didn't begin until I experienced firsthand what accurate and complete coding can do for just one claim. I remember it like it was yesterday …

Unsatisfied Coding Experiences

I began my career on the administrative side of health care in the accounts receivable (A/R) department. My experience with medical codes was that they were a means to an end—the desired end being a paid claim. Back then, more often than not, the first submission of a claim resulted in repeated denials and follow-up—more aptly named clean-up. It was no wonder I didn't like coding. It didn't really matter what the diagnosis or CPT® codes were—the details were not nearly as important as getting the claim paid.

One Claim Hooked Me

Then, one day while following up on a repeatedly denied claim, I had a coding epiphany. This claim had been denied, "fixed," re-filed, and denied several times. While reviewing the claim, I found that it had a valid CPT® code, there was a concussion diagnosis code to support provided services, and there was a modifier. It seemed, however, a lot of modifiers were tried—a new one every time the claim was resubmitted. With my infinite all-things-A/R knowledge, I concluded that the modifier must be the problem.

I contacted the payer to discuss the claim, and on the other end of the line was a certified coder. She explained to me that the service was supported medically by the diagnosis code; no modifier was needed on the claim, and adding one would not help with adjudicating the claim. The claim was being denied because the payer would not pay for any more concussion care due to a sports injury. Eureka! Now, we were getting somewhere; and I was going to win by getting the claim paid.

I quickly explained that, per documentation, this patient's concussion was due to an auto accident, not a sports injury. They were receiving the claim because the patient didn't have auto insurance coverage. The payer's claims representative, in turn, explained to me that if I corrected the claim by adding an E code to relate the injury to the auto accident, the claim would be accepted and should be adjudicated appropriately.

E code? What was an E code and where did I get one? The rep kindly took the time to explain what E codes were, where to find them, and when to use them. She also explained the relationship between diagnosis codes, procedure codes, and a speck of information regarding modifiers.

I went back to work, correcting the claim by digging into the documentation and relating the injury to the medical condition and how it occurred, applying the correct codes, and resubmitting the claim. I anxiously followed that claim, waiting to see if it would be paid. Four weeks later it was, with no further follow-up needed. I was hooked!

Love in Its Purest Form

Why do I love coding? That's easy. To me, coding is like an art form—not like the Cubist exaggerations of Picasso, but more like paint-by-numbers, where everything is in the right place. When done accurately and completely, coding tells a story of what happened to a person and what was done to help that person. When I code, I create a work of art of which even Michaelangelo would be proud.

Coding Gets Another Dimension

I am excited by the level of information the ICD-10 code set will bring to this art form. With more than 69,000 codes, ICD-10-CM holds a broader palette of choices, providing the detail, depth, and clarity necessary to complete the picture.

Best Wishes,

Cynthia L. Stewart

Cynthia Stewart, CPC, CPC-H, CPMA, CPC-I, CCS-P
President, National Advisory Board

Letters to the Editor

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

IPPE/AWV Allow for Same-Day Sick Visit

"Preventive Visits from Head to Toe," by **Joyce Will, CPC,** (April 2011) states that new patients cannot be billed with the initial preventive physical exam (IPPE) or annual wellness visit (AWV) due to history and exam elements overlapping. Although both IPPE and AWV require a complete personal/family/social history (PFSH), the exam is not comprehensive; therefore, there would be no overlap on the exam.

Christine Dunleavy, CPC, CEMC

CE: You are correct. The Centers for Medicare & Medicaid Services (CMS) guidelines stipulate:

"When the physician provides a *significant, separately identifiable* medically necessary E/M service in addition to the IPPE or AWV, CPT® codes 99201-99215 may be reported depending on the clinical appropriateness of the circumstances. CPT® modifier 25 [*Significant, separately identifiable evaluation and management service by the same physician on the same day of a procedure or other service*] must be appended to the medically necessary E/M service identifying this service as a significant, separately identifiable service from the IPPE or AWV code reported (G0402, G0438, or G0439, whichever applies).

NOTE: Some of the components of a medically necessary E/M service (e.g., a portion of the history or physical exam) may have been part of the IPPE or AWV and should not be included when determining the most appropriate level of E/M service to be billed for the medically necessary, separately identifiable E/M service."

Although the history and exam components should not be counted twice, per CMS, a significant, separately identifiable evaluation and management (E/M) service may be reported in addition to the IPPE/AWV, as long as the documentation requirements are independently met for both services.

For example, a patient presents for a subsequent AWV. During the visit, the patient mentions he has had pain when breathing deeply for the past two days. The physician listens to the patient's chest, hears diminished breath sounds on the right side, and orders a chest X-ray that shows pneumonia. The physician prescribes antibiotics and schedules a follow-up visit for the patient. In this case, the appropriate E/M code can be billed with modifier 25 appended, in addition to G0439 *Annual wellness visit, includes a personalized prevention plan of service (PPS), subsequent visit.*

Joyce Will, CPC

Patient Status Is Linked to Physician Relationship

Caral Edelberg's, CPC, CPMA, CAC, CCS-P, CHC, article "Educate Yourself on Proper E/M Auditing" (May 2011, page 26) provided a valid point: "the educated auditor must consider all relevant guidelines." Her next statements concerning "patient status," however, must be clarified to ensure accurate coding.

The statement "the status of each patient … is determined relative to the practice, not to the physician" is incorrect, even when qualified with regard to "provider networks" (provider networks may have bearing on claim adjudication, but not on coding patient status assignment). Proper patient status assignment is directly related to the individual physician's prior relationship to the patient (within the past three-years) and specialty. Consideration of the current practice affiliation is a secondary selection issue. This is particularly true for an established physician joining a new practice.

Some coders/consultants have perpetuated a coding fallacy that, if the provider has a new practice tax identification (ID) and possible need for new medical records, the provider can report all patients as "new." Although I do not believe this was the author's intention, I would like to clarify that if a previous patient was provided a face-to-face service within the last three years, and follows his or her physician to a new practice, that patient should be reported as an established patient.

My suggestion to all coders and providers is, if you can answer "no" to both of the following questions, the encounter status will likely support a new patient status:

1. Relationship: Did the physician provide this patient with a face-to-face service in any setting within the past three years?
2. Specialty and Practice: Did another physician of the same specialty within the same group practice provide a face-to-face service in any setting within the past three years?

E/M auditing is a challenge; more importantly, the accurate audit or selection of E/M codes is based on a series of "if-then-when" considerations, making every patient encounter a new adventure in coding.

Curtis Udell, CPC, CPAR, CMPA

Upholding Ethical Standards of the CPC® Designation

As a Certified Professional Coder Instructor (CPC-I®), I have had many students inquire about the apprentice status after passing their CPC® examination.

The CPC-A is the designation of passing the CPC® examination, but without the work experience of coding for at least two years, or coding education of 80 hours plus one year's work experience (actual coding experience). A recent student asked me why she would have the "A" after her credential if she knew enough to pass the CPC® examination. Many students are good test takers. If they have good instruction and pass the CPC® examination but don't have the work experience, then the work world needs to know that pertinent point.

If CPC® instructors allowed all of their students to pass with the designation of CPC® (without apprentice designation), without actual coding work experience, the CPC® credential would not be credible in the workforce. AAPC has put into place the criteria needed to have the apprentice designation removed when a coder has adequate training. If actual work experience is not obtainable, AAPC has virtual training that will assist a CPC-A to gain the experience he or she

needs to remove the "A." With good ethical advice from CPC® instructors, the work world will know that the CPC® credential stands for coding credibility from AAPC.

Let's stand together to enforce the credibility of what the CPC® stands for, as well as for all of the hard work that coders across the world have achieved. The AAPC Code of Ethics should be part of our daily lives as instructors, students, and coders.

Jacqueline Nash-Bloink, MBA, CPC-I, CPC, CMRS

Watch Your "Bs" and "Ds" While Getting Your ZZZs

"Six CPT® Changes: Reflect the Latest in Sleep Medicine" by **I. A. Barot, MD,** (March 2011) was a wonderful article regarding the latest changes in sleep medicine. The two figures showing the location of EEG leads were very informative.

I did find a small typo, however: "sleep-disordered breathing (SBD)" should have been "sleep-disordered breathing (SDB)."

Rahul Srivastava, CPC

Can't find your hardcopy of *Coding Edge*?

Read it online! Back issues are available in the member area of the AAPC website (www.aapc.com).

What Are the Supervision Requirements for My Facility?

Ask your legal questions.

The non-physician practitioners (NPPs) at my specialized health system are documenting the name of the physician who supervised them on a particular day. Sometimes the supervising physician will leave our facility without co-signing the charts. Here are my questions about this.

Question: *Is it appropriate for any physician in my clinic on the day of an NPP's service to be the supervising physician?*

Answer: The Centers for Medicare & Medicaid Services (CMS) *Medicare Claims Processing Manual*, Publication 100-02, chapter 15, section 60.2, clearly states that any physician within the clinic may provide direct supervision:

"In highly organized clinics, particularly those that are departmentalized, direct physician supervision may be the responsibility of several physicians as opposed to an individual attending physician. In this situation, medical management of all services provided in the clinic is assured. The physician ordering a particular service need not be the physician who is supervising the service."

Question: *What, if anything, needs to be documented in the electronic health record (EHR) to support another physician supervising the services when the original documentation indicates the absent physician was in supervision?*

Answer: It sounds like the EHR is set up automatically to add the physician that initiated the plan when the NPP documents services as incident-to. If this is so, make sure that this physician's information is populating Box 17 on the 1500 or its equal on the electronic claim as the ordering physician, and that the supervising physician is listed in Box 24J as the rendering physician on the 1500 or its electronic equal. We also recommend changing the EHR process so that the supervising physician's name is not auto-populated into the EHR.

... consider, however, the type of service the auxiliary personnel is providing because not all services require that incident-to rules are met.

Per *Medicare Claims Processing Manual*, Publication 100-04, chapter 26, section 10.4:

"**Item 24J** - Enter the rendering provider's NPI number in the lower unshaded portion. In the case of a service provided incident to the service of a physician or non-physician practitioner, when the person who ordered the service is not supervising, enter the NPI of the supervisor in the lower unshaded portion."

Question: *If it's appropriate to use a substitute physician, can the physician sign for all other types of auxiliary personnel services (i.e., medical assistant (MA), registered nurse (RN), registered respiratory therapist (RRT), audiologist, physical therapist (PT))?*

Answer: Based on the information provided, the quick answer is "yes." You also should consider, however, the type of service the auxiliary personnel is providing because not all services require that incident-to rules are met. These include auxiliary services such as venipuncture, electrocardiograms (EKGs), immunizations, etc. Check the benefit category each service falls into before applying incident-to rules.

Robert A. Pelaia, Esq., CPC, CPCO, is senior university counsel for health affairs at the University of Florida College of Medicine in Jacksonville, Fla. Pelaia is certified as a Health Care Law Specialist by the Florida Bar Board of Legal Specialization and Education.

Cynthia Stewart, CPC, CPC-H, CPMA, CPC-I, CCS-P, is the president of AAPC's National Advisory Board (NAB). She has over 25 years of experience in the medical profession. She is a revenue cycle systems manager of coding and charge entry with St. Vincent Health in Indianapolis.

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By Linda R. Farrington, CPC, CPC-I

Make Modifiers Matter

Appropriate modifier use can favorably affect payment.

A thorough understanding of modifiers is essential to accurate coding and reimbursement. To illustrate this, let's look at a few examples of how common surgical modifiers are used.

Example 1: A patient is admitted to the hospital on Monday and undergoes right carotid endarterectomy. A left endarterectomy is planned for two days later. Documentation for the follow-up procedures states:

Postoperative Diagnosis: Bilateral severe carotid occlusive disease; status post right carotid endarterectomy

Operative Procedure: Staged left carotid endarterectomy

The documented procedure is reported 35301-58-LT *Thromboendarterectomy, including patch graft, if performed; carotid, vertebral, subclavian, by neck incision-Staged or related procedure or service by the same physician during the postoperative period-Left side.*

By appending modifier 58, you tell the payer that this is a planned, staged procedure. According to the *Medicare Claims Processing Manual*, you also may use modifier 58 to describe a subsequent procedure during a post-op period that is "more extensive than the original procedure." When you apply modifier 58, a new post-op period begins and the reimbursement is based on 100 percent of the relative value unit (RVU).

Example 2: A gunshot victim has wounds to an artery and a vein of the same leg. One vessel is repaired directly. The other vessel requires a graft.

Postoperative Diagnosis: Gunshot wound with injury to popliteal artery and popliteal vein of right leg

Operative Procedure:

1. Repair of popliteal artery with GORE-TEX® graft
2. Direct repair of popliteal vein

Proper coding is 35286-RT *Repair blood vessel with graft other than vein; lower extremity-Right side*, and 35226-59-RT *Repair blood vessel, direct; lower extremity-Distinct procedural service-Right side.*

The diagnoses will differ for each procedure because there are specific injury codes for each vessel. In this case, however, the reported CPT® codes describe "mutually exclusive" procedures, according to the National Correct Coding Initiative (NCCI) at www.cms.gov/NationalCorrectCodInitEd/. Modifier 59 may be applied by the same provider, on the same patient and date of service, to describe a different session, different procedure/surgery, different site/organ system, separate incision/excision, separate lesion or—as in this case—a separate injury (or area of injury in multiple injuries). Multiple surgery rules still apply (payment for the second procedure will be reduced by 50 percent), but without modifier 59 one of the procedures would be denied completely.

Modifier 59 is commonly misused and is often an audit target. As explained by *Modifier -59 Article & General Correct Coding Policies*, chapter I.E, pages I-15: "Modifier -59 is an important NCCI-associated modifier that is often used incorrectly. For the NCCI its primary purpose is to indicate that two or more procedures are performed at different anatomic sites or different patient encounters. It should only be used if no other modifier more appropriately describes the relationships of the two or more procedure codes."

Example 3: Patient presents to the emergency department (ED) during an acute myocardial infarction. He is taken to the operating room (OR) urgently for triple vessel coronary artery bypass grafting (CABG). During the hospital stay, a large abdominal aortic aneurysm (AAA) is discovered. The aneurysm is repaired two months later (within the global period of the CABG). Documentation for the AAA repair states:

Postoperative Diagnosis: Infrarenal abdominal aortic aneurysm

Operative Procedure: Resection, infrarenal abdominal aortic aneurysm (18 mm Dacron tube graft)

Proper coding is 35081-79 *Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, abdominal aorta-Unrelated procedure or service by the same physician during the post operative period.*

By appending modifier 79, you tell the payer that—although this procedure was performed during the post-op period of another procedure—the AAA repair is completely unrelated to the procedure that preceded it. Claims filed with modifier 79 are excluded from prepayment audit. A new post-op period begins and payment is based on 100 percent of the RVU. If you were to bill this procedure without a modifier, the claim would be denied.

Compare modifier 79 with modifier 78 *Unplanned return to the operating/procedure room by the same physician following initial procedure for a related procedure during the postoperative period.* The *Medicare Claims Processing Manual* defines an operating/procedure room as "a place of service specifically equipped and staffed for the sole purpose of performing procedures. The term includes a cardiac catheterization suite, a laser suite, and an endoscopy suite. It does not include a patient's room, a minor treatment room, a recovery room,

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AUGUST WORKSHOP

MODIFIERS – THE REST OF THE STORY

Status, decisions, distinct, significant. Supported? Necessary, must use, can't abuse. When? How? Why?

Up to 6 CEUs | Author: Jennifer R. Swindle, RHIT, CPC, CEMC, CFPC, CPMA, CCS-P, CCP

A patient has a screening mammogram and a diagnostic mammogram on the same day, can both be billed? A primary care and specialist both see a patient on the date of admission and both report an initial hospital service to Medicare, what critical distinction is needed? A patient receives a joint injection in the ortho office, is a visit also reportable?

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Advanced E/M Chart Auditing	Modifiers – The Rest of the Story	RACs, MRACs, MICs, and ZPICs What Codes Are Being Targeted Now?

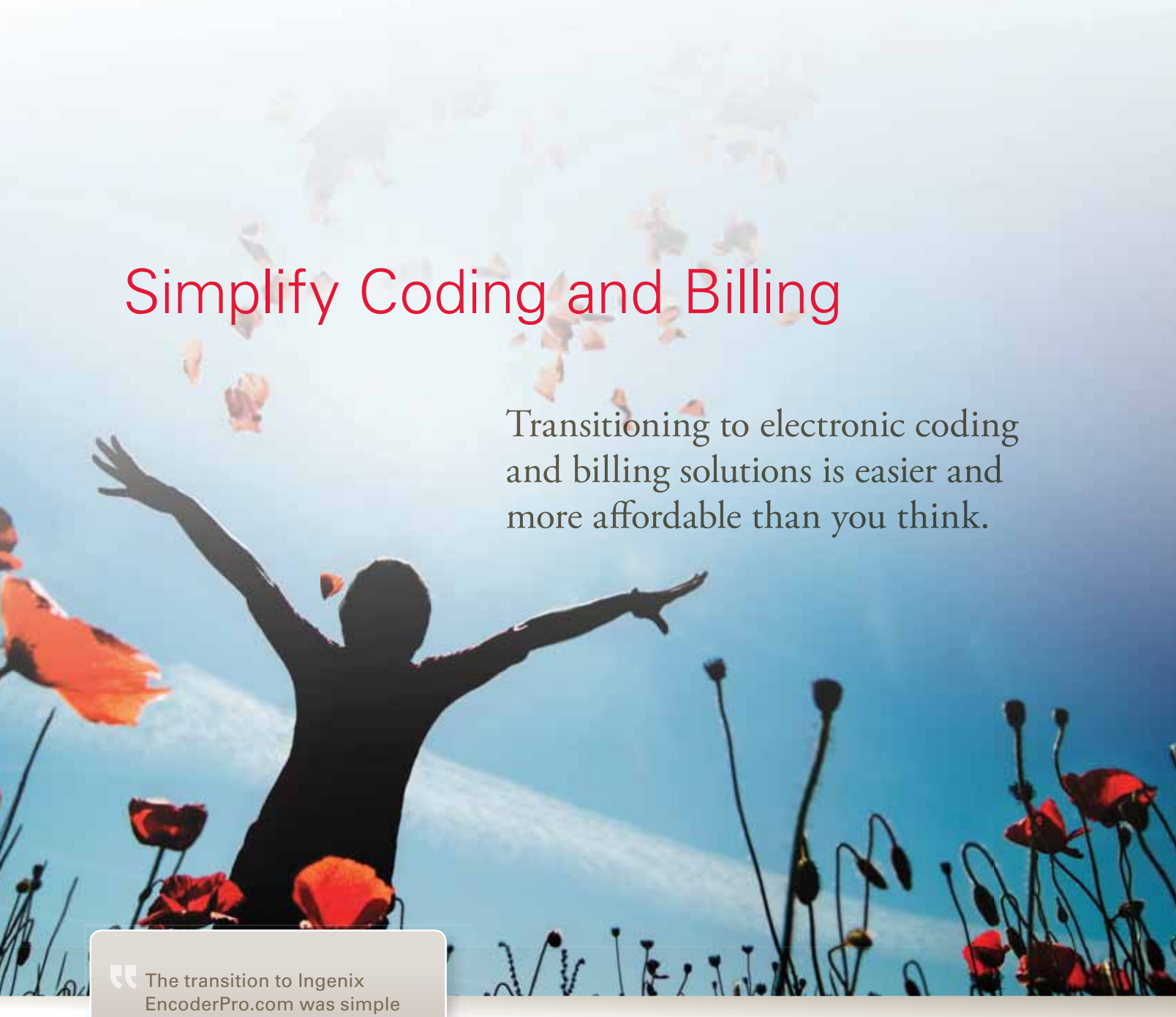
Modifier 59 is commonly misused and is often an audit target.

or an intensive care unit (unless the patient's condition was so critical there would be insufficient time for transportation to an OR)."

Claims submitted with modifier 78 are excluded from prepayment audit. Only the intra-operative portion of the procedure is paid. If the procedure reported has no global days, the reimbursement is based on 100 percent of the RVU. These values—the intra-operative portion and the global days—can be found by reviewing the Medicare Physician Fee Schedule **(www.cms.gov/PhysicianFeeSched/)**, under the columns titled "INTRA OP" and "GLOB DAYS," respectively. By contrast, a procedure billed without modifier 58, 78, or 79 during a postoperative period of another procedure by the same provider will be denied.

The correct and judicious use of modifiers can reap significant financial rewards. For a more in-depth look at modifiers, register to attend "Modifiers: The Rest of the Story" at **www.aapc.com/modifiers.**

Linda R. Farrington, CPC, CPC-I, has over 30 years experience in health care, specializing in cardiovascular and thoracic (CVT) surgery and risk adjustment. She served as local chapter president and secretary, presented audio conferences and workshops, and served on the AAPC National Advisory Board (NAB) from 2007-2011. Ms. Farrington is a consultant for Ingenix and is the owner/instructor of Medisense, teaching coding courses in Colorado Springs.



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By Maryann C. Palmeter, CPC, CENTC

Eliminate INFUSION Confusion

Proper coding of drug administrations in non-facility settings starts with good documentation.

For infusion/injection administration, "good" documentation begins with a physician's order that provides the name of the drug, dosage, and reason for its administration. From a best practice perspective, documentation also should include a record that lists the drug source, lot number, expiration date, and patient on whom the drug was administered. How each substance was administered (route) and the site of each administration also must be documented.

The time each substance was administered also should be included in the documentation to properly sequence multiple administrations. CPT® and Medicare do not specifically require start and stop times for drug infusions, but documenting these times will save the coder the need to calculate infusion time based on volume, rate, and intravenous (IV) calibration. Coders must not assume infusion time based on a physician's order alone because there is always the possibility that the infusion had to be stopped or discontinued. Also, the physician's order may not take into account IV calibration.

Know the What, How, Where, When, and Why

Coding for the administration of injections and infusions requires you to know five key pieces of information:

1. **What** – Tells the substance/drug/agent administered so you can select the proper subheading (e.g., hydration, therapeutic, chemotherapy) for the administration.
2. **How** – Tells by which route the substance entered the bloodstream (e.g., intra-arterially, subcutaneously, via IV infusion, etc.), and helps to further define code selection.
3. **Where** – Tells the site injected (e.g., right deltoid) or where the IV line was placed (e.g., left hand). This also helps with modifier application and coding of multiple administrations.
4. **When** – Tells us at what time each substance was administered and total infusion time. This helps with code selection, unit selection, and sequencing.
5. **Why** – Supports medical necessity and helps with sequencing (i.e., the primary reason for the encounter).

Look at What Is Bundled and What Isn't

Services performed to facilitate the infusion or injection—such as the use of local anesthesia, IV start; access to an indwelling IV, subcutaneous catheter or port; flush at conclusion of infusion; and standard tubing, syringes, and supplies—are not to be reported separately.

If the physician practice purchased the drugs/substances, the corresponding HCPCS Level II codes may be reported in addition to the administration codes.

Per CPT®, if a significant, separately identifiable evaluation and management (E/M) service is performed it may be reported in addition to the administration codes. Some private payers have rules that contradict CPT®, however, so be sure to research specific payer contracts and policies.

For Hydration See CPT® 96360-96361

Hydration is administered only by IV infusion and is used to report the administration of prepackaged fluids and electrolytes (e.g., normal saline, D5W), not drugs or other substances. A minimum of 31 minutes is required to report the first hour of hydration.

Hydration is bundled when performed concurrently with other infusion services; however, hydration may be reported if provided secondary or subsequent to a different initial service administered through the same IV access. Hydration may also be billed separately if provided prior to the primary substance. (See definition of *Sequential* in the accompanying Key Definitions sidebar.)

Hydration Table

If hydration is a secondary or subsequent service during same encounter and through same IV access, start with procedure code 96361.

Time in Minutes	Procedure Codes and Units
Less than 31	Do not report
31 - 90	Report 96360 x 1
91 - 150	Report 96360 x 1 and 96361 x 1
151 - 180	Report 96360 x 1 and 96361 x 2
181 - 240	Report 96360 x 1 and 96361 x 3

Consider Therapeutic, Prophylactic, and Diagnostic Infusions/Injections Key Points

There are some key points to consider regarding therapeutic, prophylactic, and diagnostic infusions/injections (CPT® 96365-96379). For example, codes describing these procedures are not used for:

- hydration or vaccines/toxoids
- allergen immunotherapy
- antineoplastic hormonal or nonhormonal therapy
- hormonal therapy that is not antineoplastic
- chemotherapy

- highly complex drugs
- highly complex biologic agents
- therapeutic, prophylactic, and diagnostic infusions/injections, which require direct physician supervision for patient assessment, provision of consent, safety oversight, and intra-service staff supervision

Do not report 96372 *Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular injection* if the substance was administered without direct physician supervision. You might instead refer to 99211 *Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician …* Note, however, that Medicare also requires direct physician supervision to bill 99211. If the physician does not provide direct supervision, neither 96372 nor 99211 may be billed to Medicare. If the administration code cannot be billed, neither can the drug/substance administered.

Infusions require:

- special consideration to prepare, dose, or dispose of;
- practice training and competency for the staff who administer them; and
- periodic patient assessment with vital sign monitoring.

Apply Chemotherapy and Other Highly Complex Drugs or Biologic Agents Rules

CPT® 96401-96549 apply to parenteral administration of nonradionuclide antineoplastic drugs, antineoplastic agents provided for treatment of noncancer diagnoses, substances such as certain monoclonal antibody agents, and hormonal antineoplastics.

Per CPT®, because of the complex nature of the drugs involved, the administration requires advanced practice training and competency for staff who provide them, and special consideration for preparation, dosage or disposal. Physician work and/or clinical staff monitoring of the patient goes well beyond that of therapeutic drug agents because there is a greater risk of severe, adverse patient reactions. Do not report preparation of the chemotherapy/complex drug/biologic agents when performed to facilitate the infusion or injection.

Direct physician supervision is required for patient assessment, provision of consent, safety oversight, and intra-service supervision of staff.

Report each parenteral method of administration employed when chemotherapy/complex drug/biologic agents are administered by different techniques. When independent or sequential administrations of

Key Definitions

To code administrations properly, it is important to understand these key terms.

Push – Also known as a *bolus*, is medication administration from a syringe directly into an ongoing IV or intra-arterial infusion or saline lock. Per CPT®, if a health care professional administers a substance/drug intravenously or intra-arterially, and is continuously present to administer and observe the patient, the administration is treated as a push. Continuous presence must be documented. If the infusion time is 15 minutes or less, the administration is treated as a push.

Concurrent · Multiple drugs or substances infused simultaneously through the same line. Multiple substances mixed in one bag are considered one infusion, not a concurrent infusion.

Piggyback · Infusion of medication given on top of the main solution that allows for the intermittent infusion of different medications at specific times. See also *Concurrent*.

Sequential · Initiation of different fluid or drug administered immediately following the primary substance. It may also be referred to as *secondary. Note: Sequential can also refer to drugs/substances administered before the primary substance.*

Some private payers have rules that contradict CPT®, so be sure to research specific payer contracts and policies.

medications are administered as supportive management, report in addition to chemo/complex/biologic agent codes. CPT® does not include a code for concurrent chemotherapeutic infusion because chemotherapeutics are not usually infused concurrently. If a concurrent chemotherapy infusion were to occur, CPT® instructs us to use the unlisted chemotherapy procedure code 96549 *Unlisted chemotherapy procedure*.

Example: A patient presents for chemo treatment. He is provided an antiemetic to help with anticipated nausea, and is also given a B12 injection for anemia. IV infusion of antiemetic drug X in left arm, start 14:50/end 15:25. IV infusion chemo drug A same site, start 15:30/end 16:45. At 16:55 patient receives B12 injection IM in right hip (ventrogluteal). Physician provides direct supervision.

- Start with the primary reason for the encounter (patient presents for chemo treatment, sequence accordingly).
- Code IV chemo infusion as the primary service.

Code IV chemo infusion based on time for single substance/drug (96413 *Chemotherapy administration, intravenous infusion technique; up to 1 hour, single or initial substance/drug)* for up to one hour. Total infusion time was one hour and 15 minutes. Per CPT®, do *not* report the additional hour code 96415 *Chemotherapy administration, intravenous infusion technique; each additional hour (List separately in addition to code for primary procedure)* unless the infusion interval is greater than 30 minutes beyond the hour increments. In this case, the infusion interval after the initial hour was only 15 minutes so you would not report 96415.

- Follow with IV infusion of prophylactic antiemetic drug X.

Report 96367 *Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); additional sequential infusion, up to 1 hour (list separately in addition to code for primary procedure)* because the infusion was provided subsequent to the chemo service and was administered through the same IV site. Remember, if injection or infusion is subsequent or concurrent in nature, even if it is the first such service within that group of services, report the subsequent or concurrent code from the appropriate section.

- End with therapeutic injection of B12 administered intramuscularly by coding 96372 *Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); substance or intramuscular* (physician provided direct supervision).
- Correct coding is: 96413 x 1, 96367 x 1, 96372 x 1.
- Don't forget to include the HCPCS Level II codes for the drugs administered.

Understand Correct Sequencing

For physician billing in a non-facility setting, report as the "initial" service the code that best describes the key or primary reason for the encounter, irrespective of the order in which the infusions or injections occur. This is different than for facility settings where sequencing rules require administrations to be coded in the following order:

1. Chemotherapy/Complex
2. Therapeutic, prophylactic, diagnostic
3. Hydration

For facility billing, infusions are coded before pushes and pushes are coded before injections.

Example: Patient presented for chemo treatment. IV infusion of chemo drug C, start 09:00/end 11:00. Piggyback infusion of Tx drug D, start 09:45/end 10:45. Prophylactic drugs A and B mixed together and administered via IV infusion prior to chemotherapy, start 7:55/end 8:55. All infusions are via same site and the physician provided direct supervision.

- Start with the primary reason for the encounter (patient presents for chemo treatment, sequence accordingly).
- Code 96413 x 1 for the first hour of infusion chemo drug C.
- Code 96415 x 1 for the second hour of infusion chemo drug C.
- Code 96367 x 1 for one hour infusion of pro drugs A & B mixed together.

Count drugs mixed together as one infusion; and code them as sequential even though they were administered prior to the chemo. Per *CPT® Assistant*, when administering multiple infusions, injections, or combinations, only one "initial" service code should be reported, unless administration occurred through separate IV sites—even if subsequent or concurrent in nature and even if it is the first such service within that group of services. Although this is the first prophylactic infusion, it would be coded as subsequent because chemo drug C is coded first per physician sequencing rules. Remember: *Subsequent* can mean administered before or after the initial drug.

- Code 96368 x 1 for one-hour concurrent infusion of Tx drug D (note *Piggyback*).
- Correct coding is: 96413 x 1, 96415 x 1, 96367 x 1, 96368 x 1.
- Don't forget to include the HCPCS Level II codes for the drugs administered.

Multiple Administrations

If the injection or infusion is subsequent or concurrent in nature, even if it is the first such service within that group of services, report the subsequent or concurrent code from the appropriate section. More than one initial service code is only appropriate when there are separate IV sites (e.g., IV right hand and IV left hand) or separate encounters (e.g., visit at 8 a.m. and separate encounter at 3 p.m. on the same day).

Append modifier 59 *Distinct procedural service* to identify the distinct procedural service when more than one initial service code is justified. Some payers may accept RT *Right side* and LT *Left side* modifiers, instead of modifier 59, to signify separate sides of the body.

Example encounter 1: Cancer patient receives IV infusion of antineoplastic drug, start 08:05/end 11:10.

Example encounter 2, same day: Patient returns for administration of hydrating solution provided via IV infusion for dehydration, start 14:20/end 16:30. New line started.

- Code 96413 for the first hour of IV infusion of the chemo drug (antineoplastic drugs are coded under chemo/complex/biologic agent subheading).
- Code 96415 for each additional hour.

There were two additional hours beyond the first hour so, two units are reported.

- The patient returned during a different encounter: Because new IV access had to be established to infuse the hydration solution, select code 96360 *Intravenous infusion, hydration; initial, 31 minutes to 1 hour* for IV infusion, hydration; initial for the first hour.
- Code 96361 x 1 for the additional hour of hydration.

According to CPT® instructional notes, if the hydration solution had been administered through the same IV access as a secondary or subsequent service to the chemo infusion, we would have coded *ALL* of the time for hydration with code 96361 *Intravenous infusion, hydration; each additional hour (list separately in addition to code for primary procedure)* instead of splitting out into initial and additional codes. The key here is different IV access. Because the patient returned and a new IV access had to be established, start with the initial hydration code and code any additional hours with add-on code 96361.

- Append modifier 59 to identify the hydration service codes as distinct, procedural services because the hydration was performed during a separate encounter.
- Proper coding for both encounters is: 96413 x 1, 96415 x 2, 96360-59 x 1, 96361-59 x 1
- Don't forget the HCPCS Level II codes for the drugs.

Maryann C. Palmeter, CPC, CENTC, is director of physician billing compliance for University of Florida Jacksonville Healthcare, Inc. and provides professional direction and oversight to the billing compliance program at the University of Florida College of Medicine - Jacksonville. She has over 28 years of extensive health care experience in both government contracting and physician billing. She is the education officer and a two-time past president of the Jacksonville, Fla. chapter. Palmeter is AAPC's 2010 Member of the Year, and was recently appointed to the National Advisory Board (NAB).

By G. J. Verhovshek, MA, CPC

Observe TMJ Coverage Guidelines Ever So Carefully

ICD-9-CM coding for TMJ is straightforward, but payer requirements vary widely.

The temporomandibular joint (TMJ) is where the jawbone (the mandible) is connected to the skull bone (the temporal bone). These joints on either side of the head, just below the ear, allow the jaw to open and close, and to slide from side to side. Like other joints, the TMJ may suffer injury and degradation due to trauma or stress (such as that caused by teeth grinding, or bruxism), and is susceptible to ankylosis, arthritis, dislocation, and neoplasia, among other conditions.

Temporomandibular joint disorder (TMD or TMJD)—also known as TMJ syndrome and Costen's syndrome—is a broad term to describe acute or chronic inflammation of the joint. Common symptoms include jaw and/or face pain, swelling, limited jaw movement, difficulty chewing, "popping" or clicking sounds, and locking of the joint. Because the joint is so close to the ear, tinnitus (ringing in the ears), headaches and dizziness also may occur.

If a diagnosis of TMD is not confirmed, report the applicable signs and symptoms codes (e.g., 719.48 *Pain in joint involving other specified sites*). A definitive diagnosis of TMD is classified to ICD-9-CM category 524.6 (fifth digit required):

524.60 Temporomandibular joint disorders, unspecified (includes temporomandibular joint-pain-dysfunction syndrome)

524.61 Adhesions and ankylosis (bony or fibrous) of temporomandibular joint

524.62 Arthralgia of temporomandibular joint

524.63 Articular disc disorder (reducing or non-reducing)

524.64 Temporomandibular joint sounds on opening and/or closing the jaw

524.69 Other specified temporomandibular joint disorders

A definitive diagnosis of TMD may be made through history and an evaluation of jaw movement, listening for jaw sounds, etc., and may include diagnostic studies such as computed tomography (CT) or magnetic resonance imaging (MRI). Note that TMD also may occur secondary to other injury, such as dislocation (830.0 *Closed dislocation of jaw*).

Check Payer Guidelines Before Billing

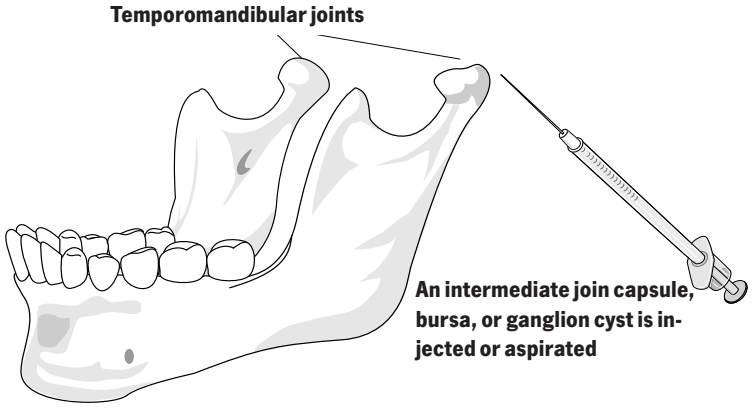
Treatment for TMD ranges from doing nothing (symptoms may resolve on their own) to full-blown surgery—including everything in between, from over-the-counter medications to bite guards, stress management, Botox® injections, physical therapy, and more. Coding for TMD treatment is complicated further by coverage and billing requirements that vary widely from payer to payer.

Medicare statute, per 1862(a)(12) of the Social Security Act, excludes payment "for services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth." As a result, Medicare generally does not cover TMD treatment—and neither do many other payers (TMJ disorders occupy a hazy middle ground between dental and medical benefits). In those cases when the insurer does cover TMD, they typically require preauthorization of services and for the provider to follow a strict treatment protocol (beginning with the most conservative treatments).

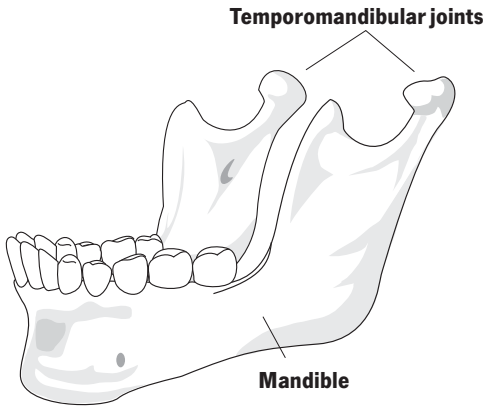
Policy Examples Show the Need for Vigilance

As an example of possible coding scenarios, UnitedHealthcare provides coverage determination guidelines that list TMD-related services, to include:

- Evaluations (consultations, office visits, examinations)
- Diagnostic testing (e.g., panoramic X-ray) (subject to company medical policy criteria)
- Dental casts
- Arthrocentesis (e.g., 20605 *Arthrocentesis, aspiration and/or injection; intermediate joint or bursa (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa)*)
- Arthroplasty (e.g., 21240 *Arthroplasty, temporomandibular joint, with or without autograft (includes obtaining graft)*, 21242 *Arthroplasty, temporomandibular joint, with allograft*, and 21243 *Arthroplasty, temporomandibular joint, with prosthetic joint replacement*)
- Arthroscopy (e.g., 29800 *Arthroscopy, temporomandibular joint, diagnostic, with or without synovial biopsy (separate*



An intermediate sized joint, such as the temporomandibular, or an intermediate bursa or ganglion cyst is accessed by needle and the capsule either aspirated of its fluid contents or injected with a therapeutic substance (20605).



Arthrotomy is an incision into a joint; CPT® code 21010 reports an arthrotomy into a temporomandibular joint.

Coverage may include bite splints or oral orthotic appliances, physical therapy, and/or TMJ surgery, while braces and orthodontic treatment are considered dental therapy and are not eligible under medical benefits.

procedure) or 29804 *Arthroscopy, temporomandibular joint, surgical)*

- Arthrotomy (e.g., 21010 *Arthrotomy, temporomandibular joint*)
- TMJ splints/biteplates
- Trigger point injections (e.g., 20552 *Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s)*)
- Corticosteroid injections
- Physical therapy

Coverage does not apply to all patients/plans, and UnitedHealthcare specifically excludes other treatment options—such as biofeedback, acupuncture, and TMJ implants—in all cases.

A clinical policy bulletin for Aetna likewise explains, "Most Aetna HMO plans exclude coverage for treatment of temporomandibular disorders (TMD). … For plans that cover treatment of TMD and TMJ dysfunction, requests for TMJ surgery require review by Aetna's Oral and Maxillofacial Surgery patient management unit. Reviews must include submission of a problem-specific history … and physical examination, TMJ radiographs/diagnostic imaging reports, patient records reflecting a complete history of 3 to 6 months of non-surgical management (describing the nature of the non-surgical treatment, the results, and the specific findings associated with that treatment), and the proposed treatment plan."

Aetna also lists potentially covered and always excluded services for TMD, but its list differs from UnitedHealthcare's. For instance, "Aetna considers relaxation therapy, electromyographic biofeedback, and cognitive behavioral therapy medically necessary for treatment of TMJ/TMD."

Blue Cross/Blue Shield of North Carolina's (BCBSNC) Corporate Medical Policy observes different criteria from either UnitedHealthcare or Aetna. BCBSNC "determine[s] medical necessity for evaluation and treatment of Temporomandibular Joint Dysfunction on an individual consideration basis." Coverage may include bite splints or oral orthotic appliances, physical therapy, and/or TMJ surgery, while braces and orthodontic treatment are considered dental therapy and are not eligible under medical benefits.

Know Payer Requirements

Check with the payer to determine if coverage is available and, if so, what is covered and in what order. Coding must reflect the service provided, as supported by documentation, but insurer reimbursement requires that the provider carefully observe applicable guidelines. For Medicare beneficiaries and others who may not be covered, carefully explain treatment options, their costs, and the patient's financial responsibility.

G.J. Verhovshek, MA, CPC, is managing editor at AAPC.

By Pam Brooks, CPC, PCS

Create Compliant Templates in Your EHR

Moving forward with implementation means your participation is vital.

If you thought the introduction of the electronic health record (EHR) would change coding, you were absolutely right. The days of sitting in the back office, appending ICD-9-CM codes to paper fee tickets and manually posting charges is, for some practices, in the distant past. Modern offices expect you to transform your coding knowledge into the fundamental tools used for EHR software development and compliance auditing. With a systematic plan, the right resources, and reasonably sophisticated EHR software, you can be a vital resource in their implementation.

Get Ahead of the Learning Curve

To participate in the development of compliant documentation templates, you must understand how an EHR is designed and how software is modified.

Overall, the EHR should interface with a billing or practice management software so patient demographics data attach to the medical record to avoid 'wrong patient' issues. Most EHR software is designed with pre-created templates used to capture patient medical data, document visits and procedures, order prescriptions, and document patient/provider communication—all seamlessly linked to the patient demographics. These templates are designed so providers can enter data through several methods. They can click check boxes or select radio buttons, and choose items from drop down menus to determine the information they want to document in the patient chart. The provider can type additional data within a text box, which displays this information exactly as it's entered. Other patient data, such as chronic conditions, past medical history, and medication lists can be pre-loaded.

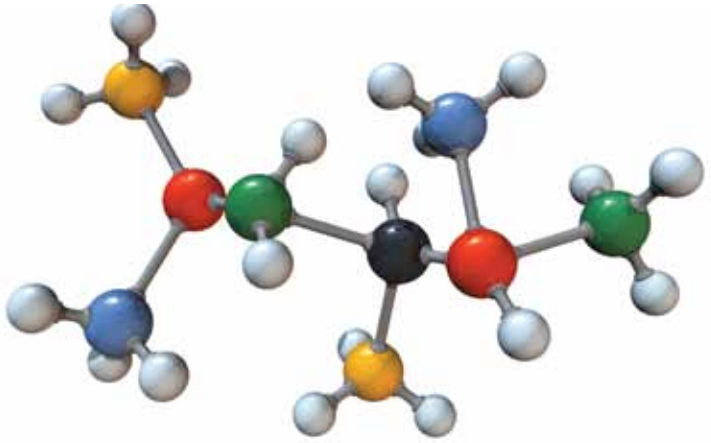
In some sophisticated software, templates can be set up to require some sort of action—almost like an internal email that alerts nursing staff to contact the patient regarding lab results. Other templates can be developed to order a prescription that automatically faxes to the pharmacy. These methods of selection and documentation are elements of a "user interface," which is a behind-the-scenes mapping of how and where the information is displayed. Taking the time to learn about the behind-the-scenes default "language" that is all part of the EHR package's user interface will help you determine whether there are options for clear and concise documentation, or if the documentation is limited to certain canned phrases and verbiage.

All EHR software arrives "out of the box" with default data lists that are used to populate the templates to drop pre-determined verbiage into a formatted document based on the provider's selection. These data lists can include CPT® and ICD-9-CM codes, and place of service (POS) indicators, as well as more customized and editable lists such as office locations, special charges, and fee schedules. Data is typically selected through a drop-down menu.

In all cases, successful EHR implementation depends on the ability to understand, customize, test, and audit the capability and compliance of the EHR software. Coders, today, need to understand the concepts of a user interface, billing rules, and clinical documentation standards, and be able to translate coding and documentation guidelines for successful and compliant software development.

Test the EHR Before Going "Live"

A good software package will provide you with a test environment. When the practice decides to "go live" with a new EHR, there is a period during which the electronically-generated medical record should be systematically audited within a test environment to



identify errors or bugs. These problems should be corrected prior to using the EHR in a "live" environment.

By comparing the computer generated notes against an approved audit tool, you can see where the software might be "double-dipping" (counting the same elements twice), pulling forward (bringing arbitrary documentation from another, unrelated note), or creating "bugs," such as documenting both male and female system reviews for all patients. The completed EHR should meet all of the criteria for a legal medical document. This kind of testing is most effective if planned and implemented in a methodical manner, using test patients that you create, name, and run through the workflow process with varying visit types and medical scenarios.

Using a spreadsheet or database to capture and compare this analysis process is helpful, and can keep the project organized. Some scenarios to consider include:

- Are the templates for physical examinations age/sex appropriate?
- Are there opportunities to document all elements of the history of present illness (HPI)? The review of systems (ROS)?
- Are the examination templates set up to record based on 1997 or 1995 guidelines?
- Can your medical record be locked for security after a certain length of time? What is your addendum process?
- Can you import data such as lab results that are relevant to your current note? Is your note readable? Do consecutive notes appear to be copied, or cut and pasted?
- Do surgical/procedural templates allow for informed consent documentation?
- Is there space to document adverse effects or complications?
- Does your finger stick glucose lab template always default to a diabetes diagnosis? This should not be the case: Not everyone is diabetic!
- Does your wart destruction template allow for both benign and malignant lesion reporting?

Much of this developing and testing should be handled by your practice's information technology (IT) department, but savvy coders, such as yourself, may want to develop super-user status. You can participate in pre-implementation activities, where you act as patients while the providers learn the software. During this time, make recommendations regarding coding compliance to the physicians, as well as the IT team.

EHR Software Works Best when Customized

The features that make an EHR easy to use, such as pre-filled templates, automatic code drop, and predetermined diagnosis codes are the very things that cause compliance concerns. Think of the EHR as a tool that has to be sharpened and honed. It's very effective if used correctly, but you have to learn how to use it safely, or you're going to get hurt.

Most EHR software comes with pre-loaded E/M templates, which vendors probably will tell you are of the "plug and play" variety. Information systems experts and coders know that this is not necessarily the case. The Centers for Medicare & Medicaid Services (CMS) has not changed the E/M guidelines since 1997; however, the way the EHR captures data to support the levels of service has most definitely changed. Usually, the EHR configures the E/M templates in a manner similar to an audit tool, with a section for each of the key components: the chief complaint; HPI; ROS; past, family, and social history (PFSH); exam; and medical decision making (MDM). By working systematically, you and your IT staff can approach the development and custom-

One common issue in an EHR is that old diagnosis codes that are related to previous encounters remain in the patient's list of chronic conditions, so the invalid codes can inadvertently be chosen again and again to appear on a claim form.

ization of these templates in a way that ensures easy use and compliance within the final documentation.

Most EHR programs also have the capability to import documents. Scanning allows you to import a photo image of a document, to be stored in the patient's chart. Establishing a direct interface between a lab or radiology department to import diagnostic results is a very efficient way to receive medical information into the patient chart. Having a consistent method of importing and cataloging these documents is important because it allows records to be easily identified and located at a later date. To meet compliance and patient care standards, all imported documentation must be reviewed and noted by the ordering physician before being stored in the electronic chart. Take it upon yourself to ensure that this is being done effectively and consistently.

Much of the custom work will be the IT department's responsibility, with you acting as the compliance consultant. In smaller practice settings, your software vendor can be extremely helpful with the implementation process. Some EHR products offer users groups, which are online chat rooms offering a place for IT people, coders, and practice managers to post questions and discuss known issues. The bigger software companies provide seminars, conferences, and workshops on best-practice concepts and new initiatives. There is also an EHR discussion thread on the AAPC website where coders who are using the same EHR can "meet" and discuss.

Additional EHR Concerns to Address

Who Did What? Most EHRs have some "auditing" capability, where a behind-the-scenes look can identify which employee or clinician entered or edited which pieces of information. This allows you to see who is accessing the medical record (for instance, in case of privacy concerns), who is actually placing orders for medications and diagnostics, and where data entry errors might be occurring (to identify training opportunities). All EHRs should have signature and date recording ability for physicians and performing clinicians to meet the regulatory requirements of a legal medical record. This is one area where you can assist in workflow planning for compliance.

Procedure Templates: Most EHR software allows for easy documentation of office and surgical procedures. Templates should be designed to capture common elements of any given procedure, including anesthesia, informed consent, procedural elements, and follow-up instructions. When using these templates in a test environment, make sure the resulting procedure note makes sense, and your software default choices match the procedure that actually took place. For example, if your provider performs and documents a lesion excision, make sure your resulting note doesn't document lesion destruction.

Annual Updates: Many of the EHR's data lists, such as CPT® and ICD-9 codes, can be updated annually by the vendor, but often the vendor can provide only new codes. Frequently, the deleted and revised codes have to be edited individually and manually by you, or someone in IT, to ensure providers do not select invalid or deleted codes. One common issue in an EHR is that old diagnosis codes that are related to previous encounters remain in the patient's list of chronic conditions, so the invalid codes can inadvertently be chosen again and again to appear on a claim form. Claim edits should be set up to prevent this from happening.

As you move forward with your implementation, other issues may present themselves. It's critical for documentation compliance that you perform concurrent audits to review the EHR for completeness and accuracy as codes change, software is upgraded, and new providers begin to use the EHR. Having a comprehensive plan for EHR implementation that includes your participation in creating compliant EHR templates is essential. This implementation must include a comprehensive workflow evaluation to ensure that the EHR system your practice is using is configured in the best possible format as a legal medical record. CE

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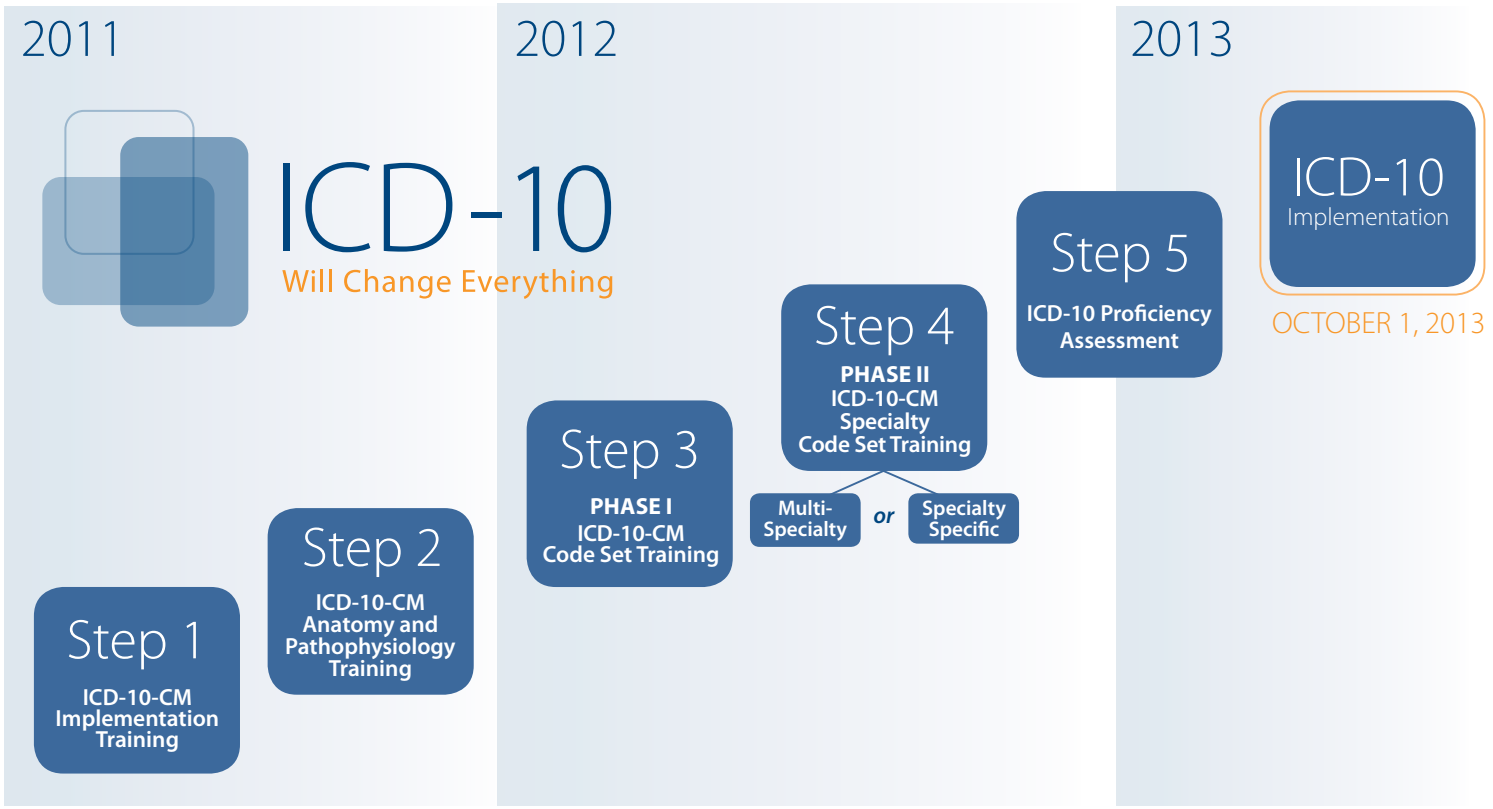
Coder's Roadmap to ICD-10

ICD-10 TIMELINE



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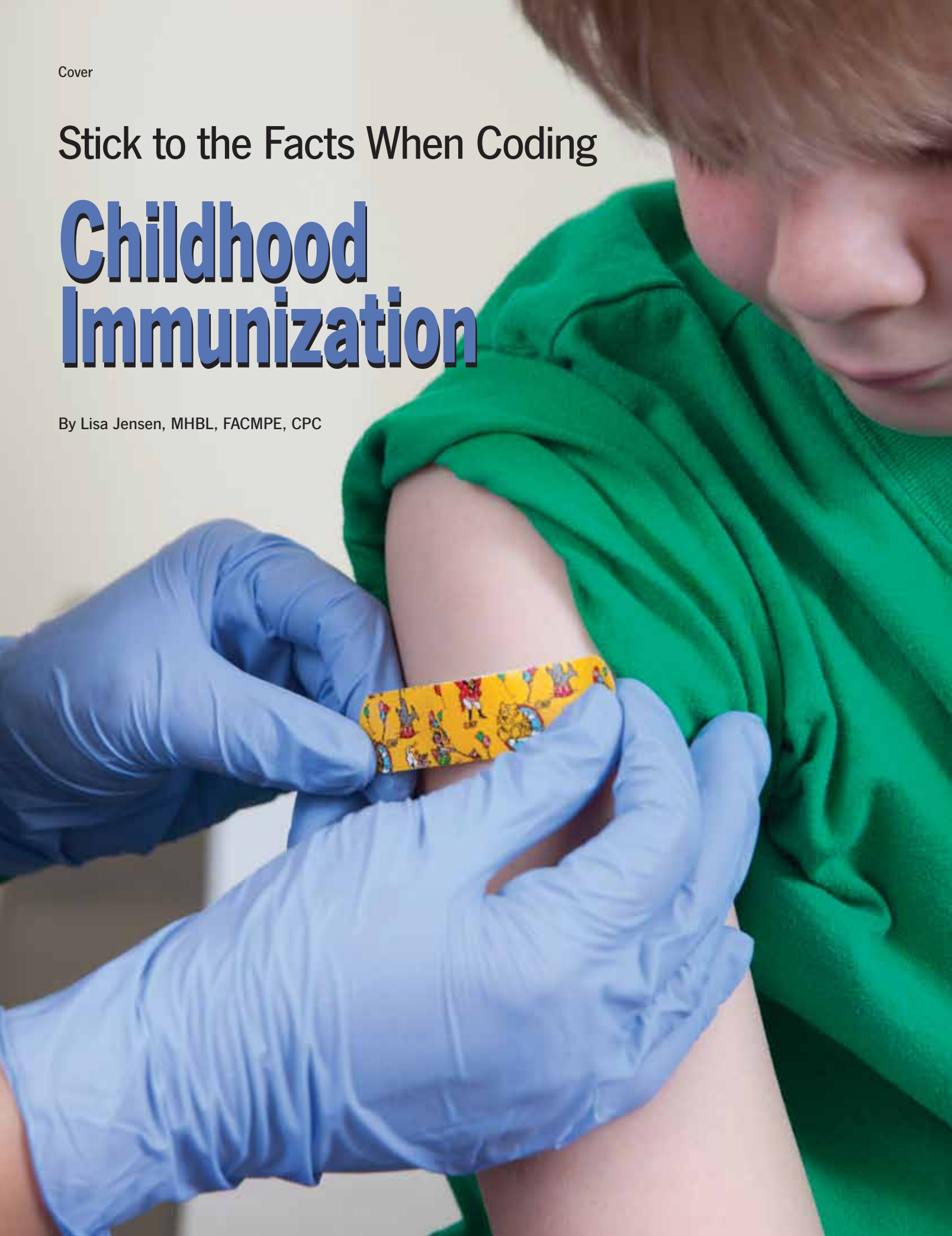
Stick to the Facts When Coding

Childhood Immunization

By Lisa Jensen, MHBL, FACMPE, CPC



With so much information to sift through, counseling and coding become more challenging than ever.

According to the April 2011 *Parents Magazine*, 40 percent of school age children are behind on their vaccines. Measles, mumps, whooping cough, and other diseases once nearly eradicated in the United States are again on the rise. The culprit is thought to be a loss of faith in the safety and efficacy of vaccines. News headlines and Internet chatter warn of vaccines leading to autism, asthma, attention deficit hyperactivity disorder (ADHD), diabetes, etc. On the other side of the debate are many studies pointing to evidence that vaccines and their components are safe and effective.

Parents trying to determine what is best for their child often turn to the child's pediatrician or other health care provider for advice. With all the conflicting information to sift through, providers often must spend a lot of time counseling parents prior to administering vaccines. Complete, proper coding ensures this time is fairly reimbursed.

Code Administration in Two Parts

The services associated with administration of vaccines are coded and billed in two parts: one code for the vaccine and another for the administration. You must report both parts of the service to ensure accurate coding and reimbursement.

For 2011, the American Medical Association (AMA) introduced two new codes in CPT® for vaccine administration:

90460 Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first vaccine/toxoid component

+90461 Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; each additional vaccine/toxoid component (List separately in addition to code for primary procedure)

The new codes differ from the previous (now deleted) codes 90465-90468 in several ways. Most importantly, the previous codes were reported *per immunization*, whereas the new codes require you to report *each component* separately. A component refers to all antigens in a vaccine that prevent disease(s) caused by one organism. Combination vaccines are those that contain multiple vaccine components.

Table 1 below shows the differences between the old and new administration codes.

These changes mean that vaccine administration coding will look very different than it has in the past. More claim lines will be required to report the same services, and counting the number of components will be different now when we count vaccines. For example:

- HPV vaccine would be one component and coded as 90460

Table 1

Element	90460-90461 (New Codes)	90465-90468 (Deleted Codes)
Routes of administration	Use for all routes of administration	Codes differed based on route of administration
Reported by	Component (antigen)	Immunization was single or combination
Age	18 years and younger	Younger than 8 years
Counseling provider	Required by physician or "other qualified health care professional"	Required by physician

Vaccine Timing Is Important

Each year, based on the most recent scientific data, disease experts recommend a vaccine schedule to best protect children in the United States. Changes, if needed, are announced in January. The schedule is approved by the American Academy of Pediatrics (AAP), the Centers for Disease Control and Prevention (CDC), and the American Academy of Family Physicians (AAFP).

The recommended vaccine schedule is influenced by several age-specific factors, such as risks for disease and complications, responses to vaccination, and potential interference with the immune system by passively transferred maternal antibodies. Taking these factors into account, vaccinations are scheduled for the earliest age group for which efficacy and safety have been demonstrated.

For many vaccines, three or four doses are needed to fully protect a child. To work best, the doses need to be spaced out. Although the vaccine schedule is considered ideal, there are exceptions for some children, including those who have an allergic reaction to an ingredient in the vaccine, a weakened immune system due to illness, a chronic condition, or are undergoing another medical treatment.

- Td would be two components and coded as 90460, 90461
- DTaP or Tdap would be three components (90460, 90461, 90461)
- DTaP-Hib would be four components (90460, 90461, 90461, 90461)
- DTaP-Hib-IPV would be five components (90460, 90461, 90461, 90461, 90461)

Counseling Is Critical

Counseling by a physician or other qualified health care professional (e.g., physician assistant or nurse practitioner) at the time of the administration is critical, and a requirement of 90460 and 90461. Let's define counseling.

CPT® requires each service billed to be fully and independently supported by medical record documentation, but does not go into specific detail about exact requirements to support the counseling of each component. Providers must provide face-to-face counseling, and then choose the format that works for them and their clinic, while still making it crystal clear which vaccine components were counseled on, and what that entailed.

For example, a note might include all vaccine components recommended at this visit, a notation that each component had counseling, and any issues discussed specific to those patient risk factors.

The documentation should support the time and effort associated with administering combination vaccines. Photocopying a statement, stamping a statement, or cutting and pasting templated documentation should be avoided. If you are concerned about your specific templates or documentation format, check with your payers to see what their payment policies are surrounding these new codes.

Some Administration Codes Carry Over

Vaccine administration codes 90471-90474 carry over from previous years, to be used for patients 19 years and older when the provider does not provide counseling, or if the health care professional providing the counseling does not meet state requirements for an "other qualified health care professional."

Providers must provide face-to-face counseling, and then choose the format that works for them and their clinic, while still making it crystal clear which vaccine components were counseled on, and what that entailed.

90471 Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid)

+90472 Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure)

90473 Immunization administration by intranasal or oral route; 1 vaccine (single or combination vaccine/toxoid)

+90474 Immunization administration by intranasal or oral route; each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure)

Counseling and Non-counseling Codes Can Be Mixed

If counseling is provided for some, but not all, vaccine/toxoid components to be administered, new administration/counseling codes 90460-90461 and carry-over administration codes 90471-90474 may be reported together to accurately reflect the services rendered. For example, if counseling is performed for HPV vaccine but not for an influenza vaccine provided at the same visit, report 90460 for the HPV and 90472 (or 90474, if the second, non-counseled vaccine is administered orally or intranasally) for the influenza vaccine.

Another circumstance might occur if counseling was provided at an earlier visit, the parent has new questions or concerns at the return visit, and the physician or other qualified health care professional is asked to address these concerns. It would be appropriate to report code 90460 at the administration of a series vaccine if counseling is clearly documented during a return visit.

As a complete coding example (including administration and vaccine reporting), consider the following case:

A patient presents for her two-month well-child visit and is vaccinated for DTaP-Hib-IPV (Pentacel), pneumococcal, and rotavirus.

Coding for this scenario is shown in **Table 2**.

Table 2

CPT® Descriptor	CPT® Code	Units
Preventive Medicine Service	99391	1
DTaP-Hib-IPV	90698	1
First vaccine component	90460	1
Each additional vaccine component	90461	4
Rotavirus vaccine	90680	1
First vaccine component	90460	1
Pneumococcal vaccine	90670	1
First vaccine component	90460	1

With the discussion of childhood vaccines becoming so much more challenging, use of new codes 90460 and 90461 to adequately report and represent the complexity of these services is very important. It is clear with the increase of preventable illness in children that the role of the vaccines is still essential to ensuring the health of our communities, and coding these correctly is important to supporting this effort. CF

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By Erin Goodwin, CPC, and G.J. Verhovshek, MA, CPC

Target Accurate Coding for Interstitial Device Placement

Keep healthy radiation therapy guidance claims by pinpointing location and method.

Radiation therapy must target cancerous cells precisely, while sparing as much surrounding healthy tissue as possible. Placing small metal "seeds" (typically made of gold or stainless steel), called fiducial markers, at the exact site of a malignancy allows the radiation oncologist to pinpoint that location when delivering radiation. In simple terms, the markers serve as landmarks. To ensure correct placement, the markers are implanted under imaging guidance.

Location and Method Matters

Placement of fiducial markers may be coded as a separately reimbursable procedure. Which code you select (and whether you may additionally report imaging guidance) will depend on the location and, in some cases, the method of placement.

For **intrathoracic (e.g., lungs or pleura) placement by a percutaneous approach**, select 32553 *Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), percutaneous, intra-thoracic, single or multiple*. Code 32553 is a standalone code, and does not include imaging guidance. You may report imaging guidance separately:

- For **ultrasonic guidance**, use 76942 *Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation.*
- For **fluoroscopic guidance**, use 77002 *Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device).*
- For **CT guidance**, use 77012 *Computed tomography guidance for needle placement (eg, biopsy, aspiration, injection, localization device), radiological supervision and interpretation.*
- For **MRI guidance**, use 77021 *Magnetic resonance guidance for needle placement (eg, for biopsy, needle aspiration, injection, or placement of localization device) radiological supervision and interpretation.*

If the marker is delivered by a bronchoscope via the airway, instead report 31626 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with placement of fiducial markers, single or multiple*. As a standalone code, 31626 includes fluoroscopic guidance and moderate sedation, when performed. This code is appropriate, for instance, when the physician places fiducial markers to help visualize lung wedge biopsy.

For the **abdomen, omentum, pelvis (excluding the prostate), peritoneum, or retroperitoneum**, select an appropriate code by method of insertion:

- For **laparoscopic placement**, select +49327 *Laparoscopy, surgical; with placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), intra-abdominal, intrapelvic, and/or retroperitoneum, including imaging guidance, if performed, single or multiple (List separately in addition to code for primary procedure)*. This is an add-on code reported with the code for the concurrent abdominal, intrapelvic, and/or retoperitoneal laparoscopic procedure.
- For **percutaneous placement**, report 49411 *Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), percutaneous, intra-abdominal, intra-pelvic (except prostate), and/or retroperitoneum, single or multiple.* This standalone code includes moderate sedation, when provided, but does not include imaging guidance. You may report guidance separately using 76942, 77002, 77012, or 77021, as appropriate.
- For **open placement by surgical incision**, report +49412 *Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), open, intra-abdominal, intrapelvic, and/or*

Don't Confuse Markers with Radioactive Seeds

Some types of cancer may be treated by implanting radioactive interstitial devices, which may be delivered by needle or catheter, at the site of cancerous cells. These radioactive "seeds" affect the malignant tissue directly. For example, 55875 *Transperineal placement of needles or catheters into prostate for interstitial radioelement application, with or without cystoscopy* describes placement of needles or catheters into the prostate to allow delivery of such radioactive devices. Do not confuse these interstitial devices with fiducial markers; fiducial markers do not deliver radiation, but act as guides in the delivery of external radiation therapy.

retroperitoneum, including image guidance, if performed, single or multiple (List separately in addition to code for primary procedure). This is an add-on code reported with the concurrent open abdominal, intrapelvic, and/or retroperitoneal procedure code. Code 49412 includes imaging guidance.

For example, the American Medical Association's (AMA's) *CPT® Changes 2011: An Insider's View*, describes a scenario in which a 67-year-old female "is found at the time of laparotomy to have an unresectable pancreatic adenocarcinoma in the head of the pancreas. Tracking fiducial implants are placed for later stereotactic radiation treatment." The planned laparotomy is reported as the primary procedure, with 49412 as an add-on to describe placement of the fiducial markers.

For **fiducial marker placement into the prostate**, report 55876 *Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), prostate (via needle, any approach), single or multiple*. This is a standalone code and does not include imaging guidance. You may report guidance separately using 76942, 77002, 77012, or 77021, as appropriate to the type of imaging used.

For **any location not described by one of the above codes**, turn to HCPCS Level II code C9728 *Placement of interstitial device(s) for radiation therapy/surgery guidance (e.g., fiducial markers, dosimeter), for other than the following sites (any approach): abdomen, pelvis, prostate, retroperitoneum, thorax, single or multiple*. This standalone code describes any approach, but does not include imaging guidance. You may report guidance separately using 76942, 77002, 77012, or 77021, as appropriate.

Fiduciary Marker Placement Coding at a Glance

APPROACH	SITE			
	Intrathoracic	Abdomen, omentum, pelvis (excluding prostate), peritonem, retroperitoneum	Prostate	Other location
Percutaneous	32553[2]	49411[2,3]		
Bronchoscopy	31626[3]			
Laparoscopic		49327[1]		
Open		49412[1]		
Any approach			55876[2]	C9278[2]

1. Add-on code: Report in addition to primary procedure
2. Report imaging guidance separately
3. Includes moderate sedation

Multiple Markers Won't Change Coding

Codes 31626, 32553, 49327, 49411, 49412, 55876, and C9278 all describe placement of one or more markers. Don't report multiple code units if the physician places more than one marker at a given location.

Marker Supply Isn't Included

Placement codes do not include supply of the markers (e.g., A4648 *Tissue marker, implantable, any type, each*). The supply would be reported by the facility, not the performing physician. In the hospital outpatient setting, Medicare states that the payment for placements includes the implantable devices. Private payers may provide separate payment for fiducial markers; check with your payer for instruction.

Which code you select (and whether you may report imaging guidance in addition) will depend on the location and, in some cases, the method of placement.

Erin Goodwin, CPC, is the director of radiation reimbursement at South Carolina Oncology Associates, PA. She has worked in oncology for over 13 years. She is an active member of her local AAPC Chapter, Capitol Coders, in Columbia, S.C. where she was the new member development officer in 2008.

G.J. Verhovshek, MA, CPC, is managing editor at AAPC.

Featured Coder

Expert

By Cynthia Stewart, CPC, CPC-H, CPMA, CPC-I, CCS-P

Mitigate the Impact of Silent PPOs

Don't wait for effective legislation to pass; quiet the threat to your bottom line now.

"Silent PPO" is the term used to describe when a non-contracted payer or plan administrator applies a contracted payer's fee schedule to services rendered by a provider, without the provider's prior knowledge or consent. Silent PPOs have been affecting providers' bottom lines since the early 1990s. Today, the practice of leasing or brokering a contracted payer's fee schedule extends beyond preferred provider organizations (PPOs) to include other parties, such as third-party administrators, managed care organizations or health maintenance organizations, self-insured employer's plans, and other Employee Retirement Income Security Act (ERISA)-protected health plans.

This is a very real concern for all providers; so much so, states are considering legislation to protect providers against the effects of silent PPOs. Whereas legislation could take years, however, there are steps practices can take to protect themselves today.

How a Silent PPO Happens

The practice of applying a contracted payer's fee to a non-contracted administrator's or payer's claim adjudication begins when a contracted network leases, for a fee, its contracted rates to a non-contracted network or administrator. Fees paid to the contracted network typically are based on a percentage of the savings to the non-contracted payer. When a current fee schedule lease agreement does not exist, the non-contracted payer may contact a silent PPO fee schedule broker to access its negotiated rates.

The negative impact to the provider's bottom line may be made even greater if the non-contracted payer employs "cherry picking" when selecting payment rates, which involves brokering or leasing with multiple networks, and then applying the lowest discounted rate to the charge. In this way, the non-contracted payer consistently is paying the lowest amount for services rendered by the unsuspecting provider, reducing revenue and increasing what the provider believes to be valid contractual adjustments.

Further loss to the practice comes in the form of lost incentives to the provider for contracting with payer networks and plan administrators. A major incentive for providers to enter into any form of managed care network contracts is the promise of increased patient volume. To fulfill the promise of increased patient volume, contracted payer networks encourage patients to receive medical and health care services from in-network providers through financial incentives (lower co-pays, co-insurance, or deductibles). Non-contracted "networks," having no such agreement with the provider, are under no obligation to encourage their patients to receive care from a particular provider or group.

One additional negative impact to the provider's bottom line from this non-contracted reduced fee patient population is the increased cost of bringing each patient into the practice through advertising.

NCOIL Legislation May Bring Some Relief

There is no federal legislation—and inconsistent or no legislation at the state level—to protect providers from revenue draining silent PPOs. Ohio and Florida have passed legislation regulating PPOs. Many states, including Colorado, Indiana, and Connecticut, among others, have looked to the National Conference of Insurance Legislators (NCOIL) Rental Network (another name for silent PPOs) Contract Arrangements Model Act to help with creating legislation at the state level.

The NCOIL model legislation act outlines the responsibilities of both the entity directly contracting with the provider and the non-contracted entity.

Responsibilities of contracting entities include:

- having the provider contract with the payer state that the payer entity possibly may participate in an agreement with a third party.
- requiring that all third parties using the provider in-network contract fee also conform to all other terms, limitations, and conditions of the contract.
- making available to the provider a written or electronic list of all third parties the payer entity has given (or may give) rights to use the provider's contracted fee schedule. This list must be updated no less then every 90 days.
- giving contracted third party enough information regarding the provider's contact to remain compliant with terms, limitations, and conditions of the contract.
- requiring that third parties identify the source of the discount on the explanation of payment or remittance advice.
- notifying the third party of provider contract termination and requiring that the said party cease discounting the provider's services.
- discounting of provider's fees must cease with the date of service when the provider contract terminated.

Act Now to Protect Your Bottom Line

While waiting for effective legislation, mitigate the impact of silent PPOs to your practice's bottom line by reviewing each payer contract for "all payers" or similar language that permits this practice. Because this language may be incorporated by reference in the provider manual or other documentation in the contract, it is imperative to review these documents for "all payers" language, as well.

If your provider contracts incorporate "all payers" language, request a current list of all affiliated payers entitled to access the negotiated fee schedule to reduce unauthorized adjustments. Keeping this list current also may serve to protect your practice because a provider may breach a payer contract unintentionally by not honoring the contractual rate.

When considering contracting with a new payer network, review the contract language carefully for an "all payers" clause or similar verbiage. Request for the contract to state that the network will provide patient steerage in the form of lower patient out-of-pocket cost, and promotion of the provider though in-network provider list distributed to the networks patient population. Per Healthcare Financial Management Association, "Well-written agreements expressly provide that (patient) direction is the basis of this agreement, explain that it is a material term to the contract, and require that discounted rates be granted only where there has been prior patient direction."

The negative impact to the provider's bottom line may be made even greater if the non-contracted payer employs "cherry picking" when selecting payment rates.

Quick tips to reduce the blow to your practice's bottom line:

- ❑ Using a contracted network affiliated payer list, review each explanation of benefit and honor only authorized payer fee adjustments.
- ❑ Request updated contracted network affiliated payer list every three to six months.
- ❑ Employ "when in doubt, check it out" mentality by contacting the contracted payer network for updated affiliated payer information.
- ❑ Be wary of "valid agreement language" used by non-contracted payers. Who is the valid agreement with—the provider or the contracted payer?
- ❑ When contracting with new payers, stipulate that discounted rates will only be applied if patient steerage and provider promotion is employed.
- ❑ Consider contracting directly with the non-contracted payer. By contracting directly, the provider should receive the benefits expected through network contracting (e.g., patient steerage and provider promotion).
- ❑ Know your contract termination date(s), and inform the staff responsible for payment posting of termination date(s) to prevent ineligible discounts from being taken.

Cynthia Stewart, CPC, CPC-H, CPMA, CPC-I, CCS-P, is the president of AAPC's National Advisory Board (NAB). She has over 25 years of experience in the medical profession. She is a revenue cycle systems manager of coding and charge entry with St. Vincent Health in Indianapolis.

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KUDOS

This CPC-A is Paying It Forward

Congratulations to Margarita G. Sablan, CPC-A. Sablan is an intern under Linda Poulos', CPC, CPC-H, CPC-I, direction at Scripps Coastal Medical Center, San Diego, Calif. According to Poulos, Sablan took coding classes at the local community college, took her test, and passed on the first try. For that alone she deserves kudos. But she also deserves kudos for tutoring students at the same college from which she graduated. Poulos is proud to say, "Margie's students are taking the CPC class and passing."

Celebrate Our 13 New Chapters

Over the past six months we've established 13 new chapters to share a coding-enriched learning environment to members. Join us in welcoming the following new chapters:

- Idaho Falls, Idaho
- North Platte, Neb.
- Sharon, Pa.
- Laramie/Cheyenne, Wyo.
- Norfolk, Neb.
- Cumming, Ga.
- Aberdeen, S.D.
- Aurora, Ill. (reopened)
- Marion, Ohio
- Brainerd, Minn.
- Hamilton, N.J.
- Tawas City, Mich.
- London, Ky.

By Jacqueline Nash-Bloink, MBA, CPC-I, CPC, CMRS

Complete ICD-9-CM Coding Is Crucial to HCC Reimbursement

Replace bad coding habits with good ones to get the best possible reimbursement.

Hierarchical Condition Category (HCC) coding is a method of determining reimbursement based on the patient's diagnosis. Generally, the more severe the diagnosis, the higher the reimbursement. HCC coding differs from CPT®-based evaluation and management (E/M) coding, for which the review of systems (ROS), examination, and medical decision making (MDM) are vital when selecting levels of service, each of which is reimbursed at a rate either negotiated between the provider and payer, or based on Medicare's Resource Based Relative Value Scale (RBRVS).

HCCs: A Brief History

In 1997, as a result of the Balanced Budget Act and the start of Medicare Part C, Medicare beneficiaries were given a choice between the original, fee-for-service (FFS) system or an array of managed care corporations available in each state. Managed care companies (MCC) are given a fixed dollar amount per Medicare enrollee. The MCC may offer certain benefits to entice either the Medicare enrollee or a provider to belong to the program. Some MCC programs offer Medicare beneficiaries better (or additional) benefits than the FFS program. Providers are reimbursed on a different pay scale, as well. Often, the reimbursement will be better than what the Medicare FFS could offer.

MCC plans are reimbursed based the diagnosis codes the provider assigns for each patient enrolled in the plan that uses the HCC, or Risk Adjustment Factor, coding system. HCC coding is based on risk adjustment factors that are tied to ICD-9-CM diagnosis codes. The Centers for Medicare & Medicaid Services (CMS) fully implemented the risk adjustment system in 2007.

The HCC coding system uses approximately 3,100 diagnosis codes and places them in approximately 90 categories (the current ICD-9-CM has over 14,000 diagnosis codes). Each HCC code is given a value. The chosen HCC codes are severe, and usually chronic, diagnosis codes; although, there are some severe, acute codes, as well.

> Missing even one relevant diagnosis means the MCC will not be reimbursed the full amount allotted for the severity of illness for that particular patient.

Every Diagnosis Counts

Because payment is based directly on the ICD-9-CM codes assigned, complete provider documentation is essential. Missing even one relevant diagnosis means the MCC will not be reimbursed the full amount allotted for the severity of illness for that particular patient. The provider will not be fully reimbursed, either, due to inaccurate coding. And coding selected for the patient this year also will be used to calculate future CMS payments.

Consider this example of HCC coding:

Mr. X is a 68-year-old male seeing his primary care physician, whom he has been seeing for the last 20 years. The patient is a diabetic with neurological manifestation (peripheral neuropathy/polyneuropathy), and the primary reason for the visit is to discuss his medications with the physician. The patient also has dementia.

Good HCC coding would include all of Mr. X's diagnosis: 250.60 *Diabetes with neurological manifestations, type II or unspecified type, not stated as uncontrolled*, 357.2 *Polyneuropathy in diabetes*, and 294.8 *Other persistent mental disorders due to conditions classified elsewhere*. Incorrect coding would be anything less, such as the commonly used diabetes code 250.00 *Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled*. Such incomplete coding would affect reimbursement negatively.

Providers are under increased scrutiny from government agencies and private payers looking for inaccurate coding and lack of documentation. Providers must protect themselves with accurate coding and medical documentation—not only for the sake of reimbursement, but because it is ethical and legal.

Jacqueline Nash-Bloink, MBA, CPC-I, CPC, CMRS, is a health care consultant in Tucson, Ariz.

By Penny Osmon, BA, CPC, CPC-I, PCS, CHC

Hospitalists: Focus on Coding, Billing, and Documentation

This growing specialty must know the rules for accurate reimbursement.

A hospitalist is a physician whose primary focus is the general medical care of hospitalized patients. There are multiple employment models for hospitalists, including direct employment by a facility, independent contractor, or participation in a medical group practice that contracts with various facilities. Understanding the employment relationship is critical to appropriate billing and coding for hospitalist services. We'll focus on the independent group practice model.

A hospitalist cannot credential with Medicare or most commercial payers as a "hospitalist" because it is not a recognized specialty. Hospitalists become credentialed under the specialty of which they train. This is important when coding and billing for their services. As stated in *Medicare Claims Processing Manual* 100-04, chapter 12, section 30.6.5:

Physicians in the same group practice who are in the same specialty must bill and be paid as though they were a single physician. If more than one evaluation and management (face-to-face) service is provided on the same day to the same patient by the same physician or more than one physician in the same specialty in the same group, only one evaluation and management service may be reported unless the evaluation and management services are for unrelated problems. Instead of billing separately, the physicians should select a level of service representative of the combined visits and submit the appropriate code for that level.

This is a common scenario faced by independent hospitalist groups because they share hospital patients' care with their colleagues.

Most Common Services Billed

Because hospitalists spend all of their time in the hospital, the majority of services they perform and

It is critical that the admitting physician record a documented order for inpatient status.

bill are for evaluation and management (E/M) services. The most common services billed are:

- Initial Hospital Care (99221-99223)
- Subsequent Hospital Care (99231-99233)
- Observation or Inpatient Care Services (99234-99236)
- Initial and Observation Care (99217, 99218-99220, 99224-99226,)
- Hospital Discharge Services (99238, 99239)
- Critical Care Services (99291-99292)

When Does the Encounter Begin?

It is critical that the admitting physician record a documented order for inpatient status, thus beginning the hospital encounter. *Principles of CPT® Coding* tells us the initial hospital care codes (99221-99223) should be billed on the day of the actual face-to-face visit. CPT® instructs that if a patient is admitted from a different site of service on the same calendar day (e.g., the emergency department (ED) or observation status), all services are considered part of the admission. That leads to the question: Is an initial hospital care code the same as an admission?

Hospital Conditions of Participation (CoP) require a history and physical (H&P) to be completed no more than 30 days before, or 24 hours after, hospital admission. The initial hospital care codes take us one step further because three of the components (history, physical exam, and medical decision making (MDM)) are required. A simple H&P without documenting the MDM will not substantiate the initial hospital care code. (For additional information on CoP, see: http://edocket.access.gpo.gov/2006/E6-20131.htm) Ultimately, the H&P will support the 99221-99223, but MDM also must be documented for accurate and correct coding.

Quick Chart for Coding Initial Hospital Care E/M Services:

	99221	99222	99223
History	Detailed HPI 4+ ROS 2-9 PFSH (2 of 3)	Comprehensive HPI 4+ ROS 10-14 PFSH (3 of 3)	Comprehensive HPI 4+ ROS 10-14 PFSH (3 of 3)
Exam	Detailed	**Comprehensive**	**Comprehensive**
MDM	Straightforward/Low	Moderate	High
Time	Typically 30 min	Typically 50 min	Typically 70 min

Typically, one initial hospital care code is allowed per patient, per episode of care. In 2010, however, Medicare eliminated consultation codes for payment recognition, and inpatient consultations are now billed using initial hospital care codes. The admitting physician must append informational modifier AI *Principal physician of record* when billing the initial hospital care code to denote that he or she is the admitting physician of record.

Split/Shared Care in the Hospital

If a hospitalist group employs mid-level providers, such as a physician assistant (PA) or nurse practitioner (NP), the documentation requirements for accurate coding and billing. In the hospital (ED, outpatient, or inpatient), Medicare allows E/M services to be split or shared between a physician and a non-physician practitioner (NPP). Either the physician or the NPP may bill for the service under his or her own National Provider Identifier (NPI). Both the physician and the NPP must personally have a face-to-face visit with the patient and document one of the three required elements for initial hospital care,

Documentation to secure correct hospitalist observation billing includes a dated and timed order, the reason for observation, and notations that support personal provision of services by the physician.

or two required elements for subsequent hospital care.

Because Medicare reimbursement for an NPP is 85 percent of the Medicare allowed fee schedule amount, there is a financial advantage to billing under the NPI of the physician. The documentation must clearly indicate the personal provision of services by each provider. One Medicare contractor, Wisconsin Physicians Service (WPS), has the following non-qualifying documentation examples posted on its website to assist in guiding supporting documentation:

- "I have personally seen and examined the patient independently, reviewed the PA's history, exam and MDM and agree with the assessment and plan as written," signed by the physician
- "Patient seen," signed by the physician
- "Seen and examined," signed by the physician.
- "Seen and examined and agree with above (or agree with plan)," signed by the physician
- "As above," signed by the physician
- Documentation by the NPP stating "The patient was seen and examined by myself and Dr. X, who agrees with the plan," with a co-sign of the note by Dr. X
- No comment at all by the physician, or only a physician signature at the end of the note

Source: www.wpsmedicare.com/part_b/departments/medical_review/2009_1116_em.shtml

One example of qualifying documentation consists of capturing the physician's face-to-face presence with the patient. This can be as simple as, "Mr. Jones' lungs sound better today and he reports less shortness of breath at night. Reviewed and agree with NP's plan."

Time-based Coding in the Hospital

Time-based coding is under used in the hospital, but it may be appropriate because hospitalists provide varying levels of counseling and coordination of care to patients. By capturing the nature of these discussions, and documenting that greater than 50 percent of the total time was dedicated to these activities, time-based coding becomes a viable option. An example that supports this approach is, "Total floor/unit time was 45 min., and greater than 50 percent of that time was spent at the bedside discussing DNR orders with patient

and family members." CPT® defines total floor/unit time to include:

- Provider is present in the hospital unit and/or at the bedside of the patient
- Reviewing the patient's chart
- Examining the patient
- Writing notes/orders
- Communicating with other professionals and the patient's family on the floor

The Centers for Medicare & Medicaid Services (CMS) instructs in the *Medicare Claims Processing Manual* 100-04, chapter 12, section 30.6.15.1 (H) "The time approximation must meet or exceed the specific CPT code billed (determined by the typical/average time associated with the evaluation and management code) and should not be 'rounded' to the next higher level." It further states, "In those evaluation and management services in which the code level is selected based on time, prolonged services may only be reported with the highest code level in that family of codes as the companion code."

If a hospitalist performs and documents a subsequent hospital visit based on time and spends greater than 50 percent of the time in counseling or coordination of care, time-based coding is a mechanism to both capture the service and preserve revenue integrity.

Observation Opportunities

An observation encounter begins with a physician's dated and timed order clearly identifying the reason the patient has been given this status. Observation is an outpatient status (POS 22), not a place. The two key identifiers when billing observation services to Medicare are:

1. The length of stay

2. The number of calendar days

According to Medicare rules, if an observation stay is less than eight hours on the same calendar day, you must bill for the initial observation care only using Initial Observation Care codes 99218-99220, as appropriate. In this scenario, a discharge is not billed. When an observation stay is greater than eight hours and the patient is admitted and discharged on the same calendar day, Observation Same Day Admit/Discharge codes 99234-99236 are assigned based on supporting documentation. Observation stays that span beyond one calendar day are coded using the Initial Observation Care codes on day one and Observation Discharge code 99217 on day two. When an observation stay is greater than 48 hours, Subsequent Observation Care codes 99224-99226 are used for the interim days. Medicare has instructed that these codes be reported by only the admitting physician, although CPT® guides us to use these for all physicians caring for the patient during subsequent observation days. Check with third-party payers for guidance.

Use this quick chart to distinguish observation stay coding.

Same Calendar Day		Two Calendar Days
< 8 hours 99218–99220 ∅ Discharge code	> 8 hours 99234–99236 Provider must see twice	Day 1: 99218–99220 Day 2: 99217, or Day 2: Subsequent Observation: 99224–99226

Remember that all related outpatient E/M services on a given calendar day are included in the observation service. CPT® instructs, "When observation status is initiated in the course of an encounter in another site of service (e.g., hospital ED, physician's office, nursing facility) all evaluations and management services provided by the supervising physician in conjunction with initiating observation status are considered part of the initial observation care when performed on the same day."

Documentation to secure correct hospitalist observation billing includes a dated and timed order, the reason for observation, and notations that support personal provision of services by the physician. Document the total time spent to adhere to the Medicare eight-hour rule.

CMS Releases Guidance on Admission Decisions

CMS recently released *MLN Matters*® Number: SE1037, "Guidance on Hospital Inpatient Admission Decisions," to address how screening criteria (such as Interqual, Milliman, etc.) are being used to make medical necessity determinations on inpatient hospital claims. CMS clarifies that although contractors are required to use a screening tool as part of the medical review process for inpatient claims, a specific tool is not required and CMS contractors are not required to pay a claim based solely on the screening criteria to indicate that admission is appropriate. For additional information, see www.cms.gov/MLNMattersArticles/downloads/se1037.pdf.

Discharge Do's and Don'ts

As the hospital episode comes to an end, a hospitalist—as the attending physician—often is responsible for delivering final discharge instructions to the patient. Hospital Discharge Day Management codes 99238 (less than 30 minutes) and 99239 (greater than 30 minutes) describe face-to-face E/M services between the attending physician and the patient. Discharge day management visits are reported on the date of the actual face-to-face visit by the hospitalist, even if the patient is discharged from the facility on a different calendar date. This also holds true when pronouncing death. *Medicare Claims Processing Manual*, 100-04, chapter 12, section 30.6.9 (E) states, "Only the physician who personally performs the pronouncement of death shall bill for the face-to-face Hospital Discharge Day Management Service. … The date of the pronouncement shall reflect the calendar date of service on the day it was performed even if the paperwork is delayed to a subsequent date." The key to capturing work and revenue when reporting hospital discharge is documenting the total time spent conducting discharge activities.

Critical Care Cautions and Caveats

CPT® defines critical care services necessary when, "a critical illness or injury acutely impairs one or more vital organ system such that there is a high probability of imminent or life threatening deterioration in the patient's condition; and the physician must devote his/her full attention to the patient and, therefore, cannot provide services to any other patient during the same time period."

When providing critical care services, a hospitalist must devote his or her full attention only to the patient requiring the critical care services. Critical care cannot be provided as a split/shared service. Only one physician may bill for any one minute of critical care. Critical care does not have to be continuous, but documentation must capture the total time spent performing critical care, the interventions taken, and the high-complexity decision-making involved. You also must document the services performed that are not part of critical care, and the time spent performing them. For example, "Please note critical care time 45 minutes beyond all billable procedures spent entirely focused on this patient's care."

Critical care often is provided in a coronary care unit, intensive care unit (ICU), respiratory care unit, or ED. Payment may be made for critical care services provided in any location as long as the care provided meets the definition of critical care and is supported by the documentation. Critical care is payable on the same calendar day as another E/M service as long as the E/M service precedes any critical care services on the same day. ED services are never payable on the same day as critical care.

Hospitalists continue to be a growing specialty of medicine. Until "hospitalist" is a recognized specialty for billing purposes, however, you will need to navigate through the aforementioned coding, billing, and documentation rules for accurate reimbursement. CE

Penny Osmon, BA, CPC, CPC-I, PCS, CHC, is the director of educational strategies for the Wisconsin Medical Society. She has over 15 years of health care experience in Medicare compliance, coding, and practice management. She presents educational programs on revenue cycle, risk management, and health information management for physician practices throughout Wisconsin and the Midwest region with an emphasis on reducing waste, mitigating risk, and improving quality. She serves on the Wisconsin Medical Group Management Association Third Party Payer and Medicare and Medicaid Workgroups.

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By Christopher A. Parrella, JD, CHC, CPC, CPCO

CMS Mandates New HHA Face-to-face Encounters

Know the specifics so you'll be current with home health service requirements.

Effective April 1, the Centers for Medicare & Medicaid Services (CMS) implemented new face-to-face encounter requirements for home health services (MBPM30.5.1.1). This new rule requires the certifying physician document all face-to-face encounters conducted with patients.

NPPs also may perform face-to-face encounters, provided they inform the certifying physician regarding the clinical findings exhibited by the patient during the encounter. The certifying physician, however, must document the encounter and countersign the certification.

The following NPPs may perform face-to-face encounters:

- A nurse practitioner (NP) or clinical nurse specialist working in collaboration with the certifying physician in accordance with state law
- A certified nurse-midwife as authorized by state law
- A physician assistant (PA) under the supervision of the certifying physician

Encounter Documentation Requirements

The following face-to-face encounter elements are required:

- The date when the physician or NPP saw the patient and a brief narrative describing how the patient's observed clinical condition supports the patient's homebound status and need for skilled services.
- The certifying physician must document the encounter (handwritten, typed, or electronic health record (EHR)) either on the certification, which the physician signs and dates, or a signed addendum to the certification.

The certifying physician may choose to dictate the encounter. It also is acceptable for the physician/NPP to verbally communicate the encounter to the home health agency (HHA), where the HHA would then document the encounter as part of a certification form for the physician to sign.

Encounter Timeframes

The physician encounter must occur no more than 90 days prior to the home health start of care date, or within 30 days after the start of care.

In situations when a physician/NPP orders home health care for the patient based on a new condition inevident during a visit within 90 days prior to start of care, the certifying physician/NPP must see the patient again within 30 days after admission. Specifically, if a patient saw the certifying physician/NPP within 90 days prior to start of care, another encounter is necessary if the patient's condition changed to the extent that practice standards indicate the physician/NPP should examine the patient to establish an effective treatment plan.

Exceptions to the encounter mandates are:

- If the home health patient dies shortly after admission to the home health agency but before the face-to-face encounter occurs
- If the intermediary determines a good faith effort existed on the part of the HHA to facilitate/coordinate the patient encounter
- If all other plan of care requirements are met, the certification may be deemed as complete

Acute/Post-acute Stay Encounters

A physician, such as a hospitalist who tends to a patient in an acute or post-acute setting who does not follow the patient when discharged may still certify the need for home health care and establish and sign Plan of Care form 485. The acute/post-acute physician would then transfer the patient's care to a community-based physician, who assumes the patient's care in coordination with the HHA.

Resource Tip: For information on hospitalist coding, billing, and documentation rules, see the article "Hospitalists: Focus on Coding, Billing, and Documentation" in this issue of ***Coding Edge***.

Telemedicine Encounters

A face-to-face encounter can also be performed via a telehealth service in an approved "originating site." An originating site is considered to be the location of an eligible Medicare beneficiary at the time the furnished service (via a telecommunications system) occurs. Medicare beneficiaries are eligible for telehealth services only if they are presented from an originating site located in a Rural Health Professional Shortage Area (RHPSA) or in a county outside of a metropolitan statistical area (MSA).

Entities participating in a federal telemedicine demonstration project approved by (or receiving funding from) the Department of Health and Human Services as of Dec. 31, 2000 qualify as originating sites regardless of geographic location.

Originating sites authorized by law are:

- Office of a physician or practitioner
- Hospitals
- Critical access hospitals (CAHs)
- Rural health clinics (RHCs)
- Federally qualified health centers (FQHCs)
- Hospital-based or CAH-based renal dialysis centers
- Skilled nursing facilities (SNFs)
- Community mental health centers (CMHCs)

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Joyce Covington, CPC

Coder for Medical Group Services of Tampa, Fla., and teacher

Tell us a little bit about your career—how you got into coding, what you've done during your coding career, what you're doing now, etc.

I had no idea I would end up in coding. Like a lot of other little girls, I had planned on nursing as a career. At 16, every Sunday for two years, I was an American Red Cross volunteer at a local hospital. When I was 19, I enrolled at Erwin Tech for the Unit Clerk training class. Unfortunately, during this time, my younger sister had juvenile diabetes. I had to help with her care and I was unable to complete the class.

At 21, I joined the U.S. Air Force to obtain my nursing degree. This time I was unable to complete basic training due to an unknown knee condition (chondromalacia and synovitis) that caused my knees to swell, which required me to be on crutches for several weeks. The good news is, due to an Honorable Discharge and a disability rating of 10 percent, I then qualified for free schooling assistance with Hillsborough County.

I signed up for a class at MBC Medical Educational Center, run by Barbara LaProva, who cross-trained personnel for a more proficient doctor's office. It didn't take long for me to realize that, although I really enjoyed the nursing side of the medical field, I had an even stronger, more natural skill for the billing side.

Eventually, I left the private practice scene and got into corporate medical billing. I became the office manager at A&R Management Services in Seffner, Fla., which required me to become a Certified Professional Coder (CPC®). The owner sold the company to Medical Group Services where I now work as a coder with a great team. I also work part time as an instructor at Sanford Brown Institute, teaching medical billing and coding.

What is your involvement with the local AAPC chapter?

I am president of Tampa Bay Professional Coders. I have served as secretary and president-elect, and also have served on the local conference committee. The benefits of being a chapter officer have been wonderful, including the opportunity to go to national conference.

What AAPC benefits do you like the most?

I only recently saw that AAPC offers member perks and plan to take advantage of those. I use AAPC online chats and blogs, and I exchange coding information with members—the wealth of information is invaluable. *Coding Edge* and *Billing Insider* are especially educational, and all the available free continuing education units (CEUs) are nice perks.

What has been you're biggest challenge as a coder?

Finding the appropriate ICD-9 code for a diagnosis I've never heard of is challenging. Sometimes I wonder if the doctors just make up some of their diagnoses because they sound good! Also frequently challenging is when a client uses a diagnosis or procedure code that is outdated. Resolving these issues, however, is what coding is all about.

How is your organization preparing for ICD-10?

I work for a medical billing company that is very diligent in keeping coders well educated. As a team, we gather all the information out there. We attend webinars, read articles, attend lectures, and even speak about it at our local chapter meetings.

We also work towards educating our clients. Much like everyone else in this field, we are a "work in progress" as we move towards the October 2013 deadline.

If you could do any other job, what would it be?

That is a tough question. Most likely, I'd become a physicians' educator of better evaluation and management (E/M) documentation and compliance practices. With the emergence of EHRs making it easier to copycat medical records of visits and promote laziness when gathering factual information, physician education is needed more than ever. Hopefully, the detail that ICD-10 brings will curb some of that.

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

I love spending time with my family. I also enjoy attending bible studies with my girlfriends and other church-related activities.

I enjoy cooking, too. I love cooking shows (especially food competitions), and I am learning how to cook for my recently diagnosed diabetic husband. I learn a lot from those shows; and I like to try the new dishes on my husband and daughter, who really love my cooking. My husband and I also watch reality TV shows together. I admit I am a soap opera addict, as well. I will miss "All My Children" and "One Life to Live."

I also enjoy going to North Carolina for the holidays to see my in-laws. It is such beautiful country up there, and I enjoy the mountains and different wineries.

My only daughter is heading off to college; and since I find myself working two jobs, I don't have as much free time now. I am excited to see what God has in store for me next.

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