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Ask the Legal Advisory Board
From HIPAA’s Privacy Rule and anti-kickback statute, to compliant coding, to fraud and abuse, there are a lot of legal ramifications to working in healthcare. You almost need a lawyer on call 24/7 just to help you make sense of all the new guidelines. As luck would have it, you do! AAPC’s Legal Advisory Board (LAB) is ready, willing, and able to answer your legal questions. Simply send your health law questions to LAB@aapc.com and let the legal professionals hash out the answers. Select Q&As will be published in Healthcare Business Monthly.
Letter from Member Leadership

Be Inspired By a Man Who Set High Standards

I can hardly believe we are wrapping up the first quarter of 2016 already. We have seen a lot of emotion in these first three months at AAPC. It was with great sadness that we learned of the passing of a former president of the National Advisory Board (NAB), Terrence C. Leone, CPC, CPC-I, CPC-C, CIRCC, or Terry. Please take the time to read the article on page 10, in which some of his colleagues and friends share sentiments about him and the effect he had on their lives.

Reflect on a Successful Life
Although we are saddened to hear of his passing, we can use this time to evaluate where we are, and look to Terry for inspiration.

Here was a man truly dedicated to his family, and yet he found time to be dedicated to his career and AAPC, as well. Terry realized he wanted more for his career and our organization, and set a path to get there. He achieved so much in his life, including becoming the first male NAB president of an organization that was over 99 percent women, at the time.

Assess Yourself and Your Ambitions
Looking back at his successes as a family man, a professional, and a mentor, I think about where I am now and I begin to assess what I can do better. You, too, may be asking these questions:

• Where am I at completing goals I have previously set?
• Are those goals still attainable?
• Have I strayed off course?

If you’re unsure of where you are or the goals you want to set, there are two great ways to get you back on track:

1. Take a look at the AAPC website home page (www.aapc.com). You’ll be amazed at all the information and opportunities that are presented to you on the first page alone. When you dig deeper, you’ll find course offerings to suit your individual needs.

2. Read Healthcare Business Monthly. This month, the topics range from hierarchical condition categories, to transcription and procedure coding, to ICD-10. Perusing these pages is a great way to expand your horizons.

Be Passionate
Whatever you are doing now or decide to do in the future, be passionate about it and put your heart into it. Terry did, and it made a difference.

As always, thank you for your time in reading this message. Please let your NAB representatives know if you have any questions or concerns.

Take care,

Jaci Johnson Kipreos, CPC, COC, CPMA, CPC-I, CEMC
President, National Advisory Board

Whatever you are doing now or decide to do in the future, be passionate about it and put your heart into it.
Fee Schedule Corrections

“Relative Value Units: The Basis of Medicare Payments” (January 2016, pages 50-51) states that the 2015 Medicare Physician Fee Schedule conversion factor is $33.9764. The correct number is $35.7547. As well, the correct amounts of physician expense relative value units for CPT® 17260 Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettage), trunk, arms or legs; lesion diameter 0.5 cm or less are 1.59 non-facility and 0.91 facility.

Kim Pollock, RN, MBA, CPC, CMDP

Be Certain to Observe Scribe Guidelines

Although there are many great ideas in “Get the Message to Your Clinicians” (February 2016, pages 42-43), I would caution readers regarding saving time for the providers by having medical assistants document for them. This is considered “scribing,” and there are strict Medicare guidelines regarding this. Before a practice considers using staff to document in the electronic health record, they should familiarize themselves with these requirements.

Sue Vermette, CPC

For more information about scribes and the rules that regulate their use, see “The Medical Scribe: A Hot Commodity” (December 2015, pages 50-52).

Chat Room

Let’s Hear It for Our National-level Members

If you post on AAPC’s Facebook page, many AAPC members and employees read your threads. Our staff enjoys reading your posts and feedback, and especially loves when you spread positive messages to fellow members. We were excited to read a couple of posts from members Robin Moore, CPC, Toledo, Ohio, local chapter president, and Dolores Dumont, Hollister, California, which gave shout outs to our national-level superstars and a very special staff member, Karen Park.

Robin Moore
January 15 at 11:15am
Can I just say thank you to AAPC! What other organization can you reach out to the top members on the National level and not only get a quick response, but get an of course what ever you need, I can do it!

Dolores Marie
January 19 at 10:30pm · Hollister, CA
I just wanted to give a SPECIAL THANK YOU to Karen at AAPC for working hard to help me after I had brain surgery for an aneurysm and missed my exam date due to being in Neuro ICU on my test date. She has been amazing!
I worked in production for more than 12 years, but when the company relocated their facilities to another country, I decided to change careers. I enrolled in an occupational program and started a year-long course in accounting. Half way through the program, my dad had a terrible car accident. The doctors who were involved in his care and rehabilitation would talk to me using words I did not understand, which was very frustrating. A few months later, my mother ended up in the hospital and needed my assistance in her recovery and treatment plan. It was then I decided to switch to the administrative medical assistance program.

Making the Switch to Coder

I completed the course and interned at a local doctor’s office. When interviewing for jobs, I brought samples of some of the medical terminology and coding practices I did in class. I landed my first job in the medical field as a data entry operator. We had one coder who worked at night, but she was rarely in the office. Our company acquired a new billing client and needed more coding services, so I began coding full time, coding mainly radiology and physician claims. At the same time, my boss bought the AAPC independent study program, which I studied at night. I passed my Certified Professional Coder (CPC®) in 2000, after only a year on the job.

Changing Gears to Hospital Coding

I was interested in learning hospital coding, so I applied for a job with a local hospital, did well entrance test, and was hired. My on-the-job training started in outpatient and emergency room abstract coding. I took an advanced hospital billing/Certified Coding Specialist (CCS) prep online, and I received my CCS credential in 2014. I was also able to make the transition from ICD-9 to ICD-10 after a lot of company-sponsored training. I now work remotely, full time in Arizona while caring for my mother.

Spreading Knowledge through Mentoring

My career goal is to develop a program or mentor people interested in coding as a profession. I want to help new coders understand how to start, what will be required, and if coding is the right career choice for them. I have been blessed with an awesome career and a great team of people to work with, and I want to share what I’ve learned with whomever is interested in medical coding.

LORIANN GILLETTE, CPC, CCS

#IamAAPC

Healthcare Business Monthly wants to know why you chose to be a healthcare business professional. Explain in less than 400 words why you chose your healthcare career, how you got to where you are, and your future career plans. Send your stories and a digital photo of yourself to: Michelle Dick (michelle.dick@aapc.com) or Brad Ericson (brad.ericson@aapc.com).
I learned of Terrance (Terry) Leone’s, CPC, CPC-I, CPC-C, CIRCC, passing on Facebook. On January 4, 2016, Rhonda Buckholtz, CPC, CPC-I, CPMA, CRC, CHPSE, CENTC, CGSC, CPEDC, COBGYN, posted, “This great man is no longer with us. Terry was a great leader, a passionate and compassionate past board president. I was proud to call him friend and mentor. May God bless his family.” I was shocked.

I didn’t get the opportunity to serve on the NAB with Terry, but he was the one who encouraged me to apply for the NAB. During the AAPC National Conference in 2008, the NAB hosted an event for anyone interested in learning more about it. It was during that event that I met Terry. His interest was genuine and his passion for our profession was evident. We talked about radiology, AAPC, and even our home towns. There were other members hovering around eager to speak with him. As I politely excused myself, he told me I would be great for the NAB. I did apply in 2008, and was selected as a member of the AAPC Chapter Association.

A Resounding Affect

I knew if Terry had such an affect on me, there were more accolades, memories, and stories to be shared by those who knew him well and served on the NAB with him. If you never had the opportunity to meet him, here is a glimpse into his character and influence as an AAPC member, NAB leader, healthcare business professional, and friend.

Nancy Clark, CPC, COC, CPB, CPMA, CPC-I
Elberon, New Jersey

Terry was one of the friendliest people I have ever known. I approached him at a conference with questions about becoming a NAB member. We spoke for over an hour, and I felt as though I had known him for years. He encouraged me to apply for the NAB. He told me how much he enjoyed meeting AAPC members, and how he thought I would, too. He was right. Terry encouraged me to begin one of the most remarkable experiences of my life. For that, I will always remember him. AAPC has lost one of its true stars.

Julie Croly, CPC, CPC-I, CPC-P
Honolulu, Hawaii

Terry gave each of us on the NAB who served with him a pewter tree. It stood for the strength of coders, the NAB, and AAPC. The branches stood for how we “branch out” to help our fellow coders,
Memorial

If you never had the opportunity to meet him, here is a glimpse into his character and influence as a NAB leader and friend.

and the overall strength and growth of the profession. From the day he gave me mine, I have displayed it proudly on my desk.

I try not to focus on the sadness of his passing, but how he touched so many people by being such a wonderful person, colleague, and friend.

Terry’s pewter trees represent the strength and growth of fellow coders.

Gail Donlin, CPC
Burlington, Vermont

I first met Terry when he came to my facility to audit our radiology coding. It was from that meeting, we developed our working relationship; and it was through his efforts, I was elected to the NAB. We both shared a love of radiology coding, especially interventional radiology. He was my mentor and my friend.

David Dunn, MD, FACS,
CIRCC, COC, CCVTC, CCC, CCS, RCC
Nashville, Tennessee

I thought very highly of Terry, knowing him for the past eight or nine years. He was a family man in the true sense and I respected him for that. I worked with Terry on the NAB and found him very loyal to AAPC. He worked very diligently during his tenure on behalf of the NAB. Terry encouraged me to run for NAB president and because of Terry and his mentoring, I ran and thoroughly enjoyed myself — all because of Terry.

When my son was considering Cornell, Terry was very helpful in our planning for a trip to visit the college, which is relatively close to where Terry lived. He even said if my son went there, he would be happy to help if an emergency arose, as getting to Ithaca from Nashville does take time. Terry once told me he went to a hospital in Buffalo where a friend’s son was being prepared for an emergency appendectomy and stayed until the parents could travel there. I will truly miss Terry Leone.

Linda Duckworth, CPC, CHC
Lone Jack, Missouri

I had the pleasure of serving on the NAB with Terry for two years. I appreciated his sense of “calm during the storm.” If we, as a board, had issues to address that would uncover varying — and sometimes strong — opinions, we could count on Terry to appreciate both sides and value our input. I felt that he was a strong leader and a wonderful representative of coders of all specialties across the country. Most of all, he was a kind man and a cherished friend.

Linda R. Farrington, CPC, CPMA, CPC-I, CRC
Colorado Springs, Colorado

It was a pleasure working with Terry on the NAB. He was a class act. I observed many times where Terry put others first. He was a kind man and a thoughtful leader. He will be missed in our coding community. May his wife and family find peace and comfort.

Rita Genovese, CPC, PCS
Philadelphia, Pennsylvania

The one thing that stands out in my mind when I think of Terry is his smile and the warmth he projected towards everyone. He was approachable and always willing to answer any question asked of him. He was genuine and a true gentleman.

Melody S. Irvine, CPC, CPMA, CEMC, CFPC, CPB, CPC-I, CCS-P, CMRS
Loveland, Colorado

I immediately felt a bond with Terry when I met him because he reminded me so much of my brother. I used to tease him of his fast talking, New York accent. I also vividly remember the day he called and asked me to serve on the 2011–2013 NAB in the officer member relations position. He said, “Mel, we need your sense of humor on the board.” He respected my opinions, and more importantly, we could always make each other laugh. He was compassionate about his family and the coding field. I will miss you Terry and your great smile, and you will always have a special place in my heart for
Terry’s pewter trees represent the strength and growth of fellow coders.

the opportunities you shared and gave to me.

Jaci Johnson Kipreos, CPC, CPMA, CEMC, COC, CPC-I
San Diego, California

As the current NAB president, I have often looked back at some of Terry’s articles from Healthcare Business Monthly (then, Coding Edge) for support and guidance. He offered a lot of wisdom during his tenure on the NAB. We were fortunate to have him as a part of this organization. His voice will certainly be missed.

Jonnie Massey, CPC, CPC-P, CPC-I, CPMA, AHFI
Sacramento, California

I served on the NAB with Terry and came to know him as a friend. We exchanged birthday wishes and found time to catch up at conferences. Terry always made time to talk to everyone. He had a warm and inviting smile. It was important for him to be with the chapter members at conferences. You’d find him walking around the conference and talking to the attendees. He wanted to make sure everyone felt welcomed and appreciated. Terry’s heart was as big as his smile. He had a way of lighting up the room. Terry spoke often of the importance of his family and taking care of them. I had the pleasure of meeting his family at one of the conferences; he was very proud of them. I will always respect Terry’s values and his respect for others, and have fond memories of Terry. My heart goes out to Terry’s family and friends. He will be greatly missed.

Michael D. Miscoe, Esq., CPC, CASCC, CUC, CCPC, CPCO, CPMA
Central City, Pennsylvania

While it’s both polite and common to say nice things following anyone’s passing, Terry is truly deserving of any accolade. Terry helped shape AAPC into the professional organization it is today. His passion for coding was infectious, and his dedication to AAPC and its members was noteworthy. I had the honor of serving with him on the 2007-2009 NAB when he was president-elect. That experience and his example helped kindle my own passion to continue his work in advancing the profession of coding. His dedication to learning, professionalism, and service is something we can all strive to emulate. His passing is a great loss to the family of coders that he leaves behind. He will be sorely missed.

Suzanne Quinton, CPC, COSC, CPC-I
Broken Arrow, Oklahoma

I served with Terry on the 2007-2009 NAB and, although I didn’t get to know him well on a personal level, he was a tremendous asset to the board. He was well respected in his field, and his opinions and ideas were well perceived by everyone. He was somewhat quiet, compared to the excitement level of Susan Ward, Cyndi Stewart, Yvonne Dailey, Jonny Massey, and myself, but he was a game player when it came to performing skits. We were a particularly close group of board members; the loss of Terry has been felt far and wide.

Terri Scales, CPC, CCS-P
Indianapolis, Indiana

From 2009 to 2011, I got to know the wonderful man that was Terry Leone. Terry and I served on the AAPC NAB together. The coding world had a great leader who took us over the 100,000 member threshold. I remember the AAPC National Conference where Terry was introduced as our new NAB president. He was so excited to encourage our members to stay strong through a changing time in healthcare. Coders were being challenged by the introduction of the electronic health record. He reassured us that our chosen careers were more important than ever and that AAPC credentials were the strongest and most respected in healthcare. He was right! Terry will always be remembered as a strong leader to AAPC and its members.

Toni L. Slocum, CPC, CPC-P, AHFI
Portland, Oregon

I was honored to call Terry my friend and that was due to him. Once
you met him, that was it; he always made you feel like you were a friend. Terry and I spent a good amount of time talking about our mutual love of the New York Yankees and my favorite: listening to him tell me stories about his family. Although I never met them, he spoke so highly and lovingly about them; it was as if I knew them, too. Terry was truly a gentleman’s gentleman, and the world will be a little less wonderful without him.

Arlene Smith, CPC, CEMC, COBGC
Tacoma, Washington

I served on the NAB from 2007-2009 with Terry. I remember him as warm, friendly, and always ready to listen. We worked together behind the scenes at conferences, and he made those long days fun. Such a wealth of coding knowledge, I enjoyed attending his presentations at conferences after our time together on the NAB ended. He always greeted me with a smile and remembered me from my time on the NAB with him. He will be greatly missed.

Angelica Stephens, RHIT, CPMA, COC, COSC, CPC, CCS-P
Albuquerque, New Mexico

I did not have the opportunity to meet Terry, but I can assure you that he will never be forgotten. As a radiology coder, I refer quite often to his article “Seven Tips for Diagnostic Radiology Coding Success.”* He touched our lives in many different ways.

*Cynthia Stewart, CPC, COC, CPMA, CPC-I, CPMA
Olsburg, Kansas

I had the pleasure of knowing Terry both professionally and personally. I met Terry while serving on the NAB and was his president-elect while he served his term as president of the NAB. Terry was very passionate and outspoken about AAPC, its members, and their needs. He could often be found at conference in a quiet corner speaking with members, many of whom he had just met. It was his goal to meet as many members as possible in the short time allowed during conference. Terry was always willing to help or offer advice when assistance was needed. He was a caring and compassionate colleague with a unique sense of humor and a boisterous laugh. His absence will be felt for many years to come.

Beverly Welshans, CHC, CPMA, CPC, CPC-I, COC, CCSP
Buffalo, New York

For me, Terry was synonymous with AAPC. I first encountered Terry in 2001 when he was traveling from Rochester to Buffalo to get the Buffalo chapter off the ground. He devoted countless hours to establishing the chapter, and always provided emotional and financial support. Terry encouraged me to run for the NAB, and serving under him was a pleasure. Over the years, I frequently reached out to him for expert advice on radiology compliance. I had several opportunities to see him with his family at AAPC conferences, and he appeared to embrace them with the same dedication and enthusiasm that he did AAPC. He will be sorely missed.

Carrying on Your Legacy

As I read through the memories shared by past and current NAB members, I wonder if Terry knew the impression he left on AAPC and the members he encountered along the way. My guess is he saw himself as “one of us” and not fully realizing the catalyst he had become. Thank you, Terry, for being a steadfast leader, a mentor, a consummate educator and, above all, a friend. Your contributions will not be forgotten.
The month of May is quickly approaching, and we all know what that means: flowers blooming, birds chirping, and May MAYnia. It’s almost time to show off your local chapter and dazzle your members. Take the opportunity to network, have some fun, and showcase all AAPC has to offer its members, including:

- Two new credentials: Certified Inpatient Coder (CIC™) and Certified Risk Adjustment Coder (CRC™)
- Bigger and better national and regional conferences
- ICD-10 training and low cost continuing education units

Let the Ideas Flow
Here are some ideas for getting local chapter members excited about May MAYnia:

- **Make a day of it and offer a seminar.** Some chapters change the date of their regular chapter meeting and have May MAYnia on a Saturday or Sunday. In giving members the whole day for education, you can offer more CEUs than a regular meeting and extra time to network with other healthcare business professionals.

- **Have some fun and host a night of games.** Make a jeopardy board and ask coding/billing questions or play Pictionary and race to draw pictures of the human anatomy. Whatever you do, create excitement for members with fun, competitive energy.

- **Get well-educated speakers.** Bring in knowledgeable experts to enlighten members with important education in healthcare. For example, a physician might speak about a new procedure or a coder might speak about a particular topic in which he or she is an expert.

- **Promote healthcare in your community.** Invite a nonprofit organization to speak about a healthcare issue they advocate. In 2012, the Orange Park, Florida, local chapter invited a speaker from “Take it to Heart,” who discussed heart disease in women and the steps women can take to reduce the risks. It was very informative, and they made it fun by holding a raffle and handing out T-shirts.

Get Creative
Make sure to give your members as much notice as possible and really hype up the event. Encourage them to bring friends and colleagues. The more, the better. AAPC will provide fantastic prizes for the meeting, as well.

May MAYnia is the event of the year. Whatever you decide to do, make it big and make it fun for your members.

Whatever you do, create excitement for members with fun, competitive energy.
Wanting to Advance Your Career?

AAPC’s CIC, COC, and CRC certifications are the ONLY specialized inpatient, outpatient, and risk adjustment credentials offered in the business of healthcare.

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*Percentages based on 2014 Salary Survey

Visit aapc.com/compare and discover which credential is right for you.
Yates Memorandum:
Follow-up Implications for Coders

"Corporate Wrongdoing Falls on the Individual," (February, pages 44-47) provided an excellent analysis of the Department of Justice’s (DOJ) recent memorandum, which contained guidance to U.S. attorneys for identifying individuals responsible for corporate misconduct. The approach is to essentially leverage what is called “cooperation credit” for disclosures that will help the DOJ identify who is responsible for corporate misconduct. Unfortunately, some are reading more into this article than was intended.

Your Responsibility, Plain and Simple
When investigating corporate entities for civil or criminal misconduct, the DOJ is looking to identify and prosecute the individuals in the corporation who are responsible for the misconduct. The key, however, is that the DOJ is looking for the responsible corporate decision-makers or the individuals actively participating in the misconduct. The low-level employees who are passive in the misconduct and required to do what they are told are not likely targets. As such, if you are a front-line coder, or even a coding department supervisor, you're not likely the person the DOJ is going to focus on unless you are actively involved in the misconduct and/or financially benefitting from the misconduct. A recent case out of Illinois illustrates active involvement: The coder for an in-home visiting physician group was convicted of making false statements related to healthcare matters based on creating information necessary to submit a claim for services that she knew never happened.

Regardless of personal liability, when you do have concerns about what you’ve been told to do, you’re responsibility is limited to raising those concerns, and the basis for them, to management or to your compliance department. Do so in writing and retain a copy. Keep copies of any responses or given directives. Not only will these documents establish that you’re not the decision-maker the DOJ is looking to prosecute, but the documentation is exactly the kind of evidence the corporation must disclose to qualify for “cooperation credit.” As a coder or biller, if you are directed to generate claims for services you know were not provided, you must refuse to cooperate in the creation or submission of those claims.

Advice for Decision-makers
If you’re a decision-maker and have made a decision to code or bill in a particular way, even after concerns are raised, and those decisions ultimately are alleged to be inaccurate, be sure to maintain documentation for the basis of your decision. Both civil and criminal liability requires not only wrongdoing, but evidence of intent to defraud. In response to a concern raised by a coder or other employee you supervise, be certain to obtain an independent, written opinion from your compliance department or external compliance contact. The basis for your decisions and the standards you relied on should be maintained in your organization’s (or your own) compliance binder, and are key to demonstrating your lack of intent.

Bottom Line
In the end, if you’re in a position where you are told to do something you’re not entirely comfortable with, and you’re not actively involved in the misconduct and not the decision-maker, you are not the person “responsible” for the misconduct. As a result, you are not the person the DOJ will likely focus on. For simple code selection disputes, you have an obligation to at least raise your concerns with your compliance department, or if you have no compliance department, then with your supervisor or management. If you’re asked to prepare and submit claims for services that you know were not provided, you must affirmatively refuse to do so.

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DMEPOS Coding and Billing Updates in 2016

Along with the durable medical equipment, prosthetics/orthotics and supplies (DMEPOS) fee schedule adjustments are several coding changes.

Coding DMEPOS

The following new HCPCS Level II codes are effective January 1, 2016:

- **A4337** Incontinence supply, rectal insert, any type, each
- **E1012** Wheelchair accessory, addition to power seating system, center mount power elevating leg rest/platform, complete system, any type
- **E0465** Home ventilator, any type, used with invasive interface (e.g., tracheostomy tube)
- **E0466** Home ventilator, any type, used with non-invasive interface (e.g., mask, chest shell)
- **L8607** Injectable bulking agent for vocal cord medialization, 0.1 ml, includes shipping and necessary supplies

HCPCS Level II codes deleted from the DMEPOS fee schedule, effective January 1, 2016, are: E0450, E0460, E0461, E0463, and E0464.

Code E0465 replaces E0450 and E0463 and code E0466 replaces E0460, E0461, and E0464.

Billing DMEPOS

For gap-filling pricing purposes, the 2015 deflation factors by payment category are:

- Oxygen - 0.459
- Capped Rental - 0.462
- Prosthetics and Orthotics - 0.463
- Surgical Dressings - 0.588
- Parental and Enteral Nutrition - 0.639
- Splints and Casts - 0.978
- Intraocular Lenses - 0.962

The 2016 fee schedule update factor is -0.4 percent. For example, the maintenance and servicing fee is adjusted by the -0.4 percent to yield a maintenance and servicing fee of $69.48 for oxygen concentrators and transfusing equipment in 2016.

See MLN Matters® article MM8999 Revised for the 2016 update to labor payment rates, effective for claims submitted using HCPCS Level II codes K0739, L4205, and L7520, with dates of service from January 1, 2016, through December 31, 2016.

Source:

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CPT® 2016: Urinary Interventional Coding


For 2016, the biggest CPT® coding changes affecting interventional radiology occur within the subspecialties of urinary, biliary, and neurologic intervention. This month, let’s focus on percutaneous urinary interventional coding, and in upcoming articles we’ll cover biliary and neurologic intervention codes.

New Codes for 2016
There are 12 new urinary intervention codes for 2016. The new codes describe:

**Diagnostic nephrostogram**

50430 Injection procedure for antegrade nephrostogram and/or ureterogram, complete diagnostic procedure including imaging guidance (eg, ultrasound and/ or fluoroscopy) and all associated radiological supervision and interpretation; new access

50431 Existing access

**Percutaneous nephrostomy and nephroureteral catheters**

50432 Placement of nephrostomy catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation

50433 Placement of nephroureteral catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation, new access

50434 Convert nephrostomy catheter to nephroureteral catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation, via pre-existing nephrostomy tract
Nephrostogram is bundled with the new nephrostomy catheter, nephroureteral catheter, and ureteral stent placement codes.

**Nephrostogram**

Nephrostogram (50430 and 50431) is performed to evaluate the renal collecting system for patency, stones, strictures, malignancy, and leaks. These abnormalities can occur anywhere in the collecting system, but most often are between the ureteropelvic junction and the bladder. The nephrostogram may be performed via a new access (placing a needle or catheter through the back into the pelvocalyceal system) or a pre-existing catheter (usually an existing nephrostomy catheter). Contrast is injected and imaging is performed and interpreted. The procedure is reported with 50430 when performed via a new access, or with 50431 when performed via an existing access. Because imaging guidance is performed, be sure the ultrasound, CT, or MRI tech does not charge a guidance code when the access uses one of these imaging guidance modalities.

Nephrostogram is bundled with the new nephrostomy catheter, nephroureteral catheter, and ureteral stent placement codes. The nephrostogram codes may be used as a base code for codes +50606, +50705, and +50706, but only if a catheter is not placed, replaced, or converted.

**Example:** A patient has an existing nephrostomy catheter. Diagnostic nephrostogram is performed (50431), demonstrating a mid-ureteral stenosis. Ureteroplasty is performed (+50706). No tubes are left in place at the end of the procedure.

The following codes do not involve placement of a ureteral stent:

- **50432** describes the initial placement of a percutaneous nephrostomy (PCN) catheter via a new access and includes 50430.
- **50433** describes the initial placement of a percutaneous nephroureteral (PNU) catheter via a new access and includes 50430.
- **50434** describes the conversion of an existing nephrostomy catheter to nephroureteral catheter (removal of the PCN catheter and placement of the PNU catheter over a wire) and includes 50431.
- **50435** describes the exchange of a PCU catheter for a new nephrostomy catheter or the exchange of a...
nephroureteral catheter for a nephrostomy catheter and includes 50431.

**Example:** The patient recently underwent nephrostomy catheter placement for ureteral obstruction and infection. Now that the infection has subsided, a diagnostic nephrostogram (50431) is performed, showing mid-ureteral stenosis. The nephrostomy catheter is removed over a wire and a nephroureteral catheter is advanced with the tip in the bladder and secured in position (Add 50434 for the conversion of a nephrostomy to a nephroureteral catheter. Delete 50431 as bundled with this conversion.).

**Initial Ureteral Stent Placements**

There are three new codes for initial ureteral stent placements: one via an existing access and two from a new access:

- **50693** describes the placement of a double pigtail ureteral stent via an existing access (prior nephrostomy catheter or nephroureteral catheter access) and includes placing an externally draining nephrostomy catheter (if done).

- **50694** describes the placement of a double pigtail ureteral stent via a new access without leaving a nephrostomy catheter at the end of the procedure.

- **50695** describes the placement of a double pigtail ureteral stent via a new access with separate placement of an externally draining nephrostomy catheter.

All three codes include an initial nephrostogram (50430, 50431) and all imaging guidance (fluoroscopy, ultrasound, CT, MRI) used during the procedure.

**Example:** A patient with an existing nephrostomy catheter presents for conversion to an internalized double pigtail ureteral stent (50693). At the end of the procedure, a new nephrostomy is placed over the guidewire due to excessive bleeding during the procedure (this is bundled with ureteral stent placement).
The new codes were well thought out to cover the majority of performed urinary cases, and all include both the surgical and supervision and interpretation (S&I) components of the procedure.

### New Add-on Codes

Codes +50606, +50705, and +50706 require a base code, which can be any of the catheter placement, conversion, or exchange codes described above, as well as diagnostic nephrostogram codes 50430 and 50431.

- **+50606** describes an endoluminal biopsy (brush, needle, or alligator forceps) of the urinary collecting system (renal calyx, renal pelvis, or ureter). If a duplicated collecting system (e.g., bilateral ureters, duplicated ureters) is also biopsied, report +50606 a second time for the separate procedure.

- **+50705** describes ureteral embolization and is usually performed to treat a fistula or urinary leak due to an invasive malignancy. Once embolized, a permanent nephrostomy catheter will be necessary for urinary drainage. Ureteral embolization is coded once per ureter.

- **+50706** describes ureteroplasty (balloon dilation) of the ureteropelvic junction (UPJ) or the ureter for treatment of a stenosis or occlusion.

The three add-on procedure codes can be submitted once per day, per collecting system and can be performed via any percutaneous access (including a renal access, an ileal conduit, a cystostomy, a ureterostomy, and via a trans-urethral approach).

**Example:** The patient has a nephroureteral catheter in place via an ileal conduit. The patient has a known filling defect in the region of the UPJ, and is here for biopsy. The catheter is removed over a guidewire and a sheath is placed up to the abnormality. A brush biopsy is performed and sent for pathology (+50606). A new nephroureteral stent is placed over the wire via the ileal conduit (50688 Change of ureterostomy tube or externally accessible ureteral stent via ileal conduit, 75984 Injection procedure for ureterography or ureteropyelography through ureterostomy or indwelling ureteral catheter).

### Deleted and Revised Urinary Codes

Also in this section of CPT®, six codes were deleted (50392, 50393, 50394, 50398, 74475, and 74480) and two were revised: 50390 Aspiration and/or injection of renal cyst or pelvis by needle, percutaneous and 74425 Urography, antegrade (pyelogram, nephrostogram, loopogram), radiological supervision and interpretation. Code 50390 is now used for placing a needle into a renal cyst to inject contrast or remove fluid. Code 74425 is still used to describe a nephrostogram, but only from a retrograde approach, as done via an ileal conduit, with injection code 50684 Injection procedure for ureterography or ureteropyelography through ureterostomy or indwelling ureteral catheter.

**Code 50390** is now used for placing a needle into a renal cyst to inject contrast or remove fluid. Code 74425 is still used to describe a nephrostogram, but only from a retrograde approach, as done via an ileal conduit, with injection code 50684 Injection procedure for ureterography or ureteropyelography through ureterostomy or indwelling ureteral catheter.

### What Stays the Same in 2016

Existing codes describe procedures:

- Via an ileal conduit approach (e.g., catheter exchange codes 50688/75984 and nephrostogram codes 50684/74425);

- Via a transurethral approach (e.g., transurethral ureteral stent exchange code 50385 Removal (via snare/capture) and replacement of internally dwelling ureteral stent via transurethral approach, without use of cystoscopy, including radiological supervision and interpretation and transurethral ureteral stent removal code 50386 Removal (via snare/capture) of internally dwelling ureteral stent via transurethral approach, without use of cystoscopy, including radiological supervision and interpretation); and

- Of non-externally accessible ureteral stents (e.g., percutaneous ureteral stent exchange code 50382 Removal (via snare/capture) and replacement of internally dwelling ureteral stent via percutaneous approach, including radiological supervision and interpretation and percutaneous ureteral stent removal code 50384 Removal (via snare/
With the new codes added in 2016, a comprehensive set of urinary codes is now available to describe almost every procedure performed in the urinary system.

Other procedures with existing codes include nephroureteral catheter exchange (50387 Removal and replacement of externally accessible transmephrine ureteral stent (eg, external/internal stent) requiring fluoroscopic guidance, including radiological supervision and interpretation), nephroureteral or nephrostomy catheter removal (50389 Removal of nephrostomy tube, requiring fluoroscopic guidance (eg, with concurrent indwelling ureteral stent)), and creation of an access site (50395 Introduction of guide into renal pelvis and/or ureter with dilation to establish nephrostomy tract, percutaneous) with dilation of a tract between the skin and kidney for stone extraction.

With the new codes added in 2016, a comprehensive set of urinary codes is now available to describe almost every procedure performed in the urinary system. The opportunity for coding specificity has never been better. **HBM**

David Zielske, MD, CIRCC, CC, CCVTC, CCC, CCS, RCC, is the founder and CEO of ZHealth, LLC, and ZHealth Publishing, LLC. He practiced as an interventional radiologist for 15 years and has 16 years of experience as a coding reviewer and educator. Dr. Zielske is Board Certified in Radiology with the Certification of Added Qualification (CAQ) in Interventional Radiology (ABIR) (1995, 2005). He was on the AAPC National Advisory Board from 2005-2009, and is a member of the Nashville, Tenn., local chapter.
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Better Bronchoscopy in 2016

Consider the changes and apply the rules for three new EBUS codes.

CPT® 2016 introduced three new codes to describe endobronchial ultrasound (EBUS). Here’s what you need to know to report these services correctly.

**Reporting EBUS**

EBUS combines a bronchoscope with ultrasound to visualize the bronchi and adjacent structures, and to obtain tissue for biopsy.

In past years, CPT® designated add-on code 61620 to describe EBUS during diagnostic or therapeutic bronchoscopy. For 2016, 61620 was deleted and replaced by two, new standalone codes to describe EBUS for the purpose of obtaining transtracheal and transbronchial sampling:

- **31652** Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with endobronchial ultrasound (EBUS) guided transtracheal and/or transbronchial sampling (eg, aspiration[s]/biopsy[ies]), one or two mediastinal and/or hilar lymph node stations or structures
- **31653** Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with endobronchial ultrasound (EBUS) guided transtracheal and/or transbronchial sampling (eg, aspiration[s]/biopsy[ies]), 3 or more mediastinal and/or hilar lymph node stations or structures

You may report a single unit of either 31652 or 31653 (but not both), per session.
You may report a single unit of either 31652 or 31653 (but not both), per session, depending on the number of lymph node stations or structures from which tissue is obtained.

depending on the number of lymph node stations or structures from which tissue is obtained. As an example of proper 31652 use, *CPT® Changes 2016: An Insider’s View* offers, “In a patient with known or suspected lung cancer, endobronchial ultrasound is used to identify and aspirate/biopsy on mediastinal and one hilar lymph node station.”

Note that sampling by EBUS differs from transbronchial lung biopsy(s) (+31632 Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial lung biopsy(s), each additional lobe (List separately in addition to code for primary procedure) and transbronchial needle aspiration biopsy(s) (+31633 Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial needle aspiration biopsy(s), each additional lobe (List separately in addition to code for primary procedure)), neither of which include an ultrasound component.

**Note:** For 2016, CPT® includes moderate sedation, when provided, with 31632.

**Call on 31654 for Peripheral Lesions**

*CPT® 2016* also created an add-on code to describe EBUS for a diagnostic or therapeutic intervention of peripheral lesions.

+31654 Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchoscopic endobronchial ultrasound (EBUS) during bronchoscopic diagnostic or therapeutic intervention(s) for peripheral lesion(s) (List separately in addition to code for primary procedure(s))

When appropriate, you may report a single unit of +31654, per session, in addition to primary procedures 31622-31626, 31628-31629, 31640, 31643, or 31645-31646.

*CPT® Changes 2016: An Insider’s View* provides as an example scenario, “A patient presents with a 1.5-cm peripheral lung lesion. The lesion is identified with transendoscopic ultrasound probe guidance.”

For instance, when reporting 31625 Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial or endobronchial biopsy(s), single or multiple sites, if one or more biopsies are taken using EBUS, you would report +31654, as well.

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**Barbara J. Cobuzzi, MBA, CPC, CHC, CPC-P, CPC-I, CENTC, CPCO** is vice president of Stark Coding and Consulting, LLC., in Shrewsbury, N.J. She is an approved ICD-10 instructor, and a past member of the AAPC National Advisory Board and executive board. Cobuzzi owned a medical billing company for 13 years before becoming a full time consultant. She is a speaker for many local and national organizations and a member of the Monmouth, N.J., local chapter.
Dr. Z presents an abundance of information in a clear, organized, and very entertaining way. The days fly by and I leave feeling excited about the knowledge I have learned. Thank you Dr. Z.

-- Laura Ross, Revenue Integrity Auditor

Dr. Z is an excellent teacher. I enjoy his style of teaching. He teaches anatomy, procedure details, devices and revenue cycle.

-- Marsha McRorie, Clinical Specialist

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Before denials and resubmissions take a toll on your practice, have a game plan that gets you paid.

Fighting with an insurance company to get claims paid can be difficult. Accounts receivable staff must be on top of their game because incoming payments are needed to pay the light bill, the doctor’s malpractice premium, our salaries, and other necessary practice expenses.

Build a Winning Team

To champion your cause, you must have the right people in the right place to handle the claim. This team must understand the denial and know the best way to resubmit the claim. Beyond their skills and knowledge, they also must have:

- Resourcefulness - To get help from others when needed
- Persistence - To be a problem solver
- Tenacity - To finish with a resolution
- Ownership attitude - To care as if these payments belonged to them

MVPs (most valuable players) will:

- Ask the claims examiner the right questions;
- Review the entire billing record, not just the one denied charge; and
- Know and understand payer rules.

Face Your Opponent

To begin a successful fight, you must first understand the denial. The five most common denials involve: bundling, non-coverage, insufficient information, failure to prove medical necessity, and eligibility of the patient.

Bundling

When you report a code combination that may not be billed together, that’s bundling. To avoid this type of error, check National Correct Coding Initiative (NCCI) edits before submitting claims.

In the event you receive a denial based on unbundling, check the NCCI tables:

- If they show your combination of codes can never be billed together, the denial was correct.
- If they show your combination of codes may be billed with an appropriate modifier, determine if a modifier would be appropriate and, if so, which one. Resubmit the claim as a “corrected claim.”
- If they show your combination of codes does not have a bundling issue, send an appeal asking for reconsideration, with a copy of the documentation.
Denials

Non-covered Denials

“Non-covered” can mean a lot of things: The service may not be a covered benefit for the particular patient; the service may be covered, but not the CPT® code billed; or the diagnosis code may not support either the service or the coding.

If the payer doesn’t cover the diagnosis code, review the patient’s chart. If another diagnosis was documented, you can bill a corrected claim.

Example: Depo-Provera® 150 mg (J1055 Injection, medroxyprogesterone acetate for contraceptive use, 150 mg) is administered with an original diagnosis of Z30.13 Encounter for initial prescription of injectable contraceptives. After re-examining the chart, it is found that the patient received the Depo-Provera® for N80.0 Endometriosis of uterus. Submit a corrected claim, with the appropriate diagnosis code tied to the procedure code.

Remember: Never make any changes to the documentation after the original claim is filed.

If the payer doesn’t cover the CPT® code, review the patient’s documentation. If the wrong code was selected, you can bill a corrected claim.

Example: A patient has a wellness visit, which was documented, along with instructions to change her blood pressure medication. Code 99212 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making; … Typically, 10 minutes are spent face-to-face with the patient and/or family was erroneously selected and billed with ICD-10-CM Z00.01 Encounter for general adult medical examination with abnormal findings. Change the CPT® to the age-appropriate wellness visit code, and submit a corrected claim.

If the service is truly a non-covered service under the patient’s policy, the service should be billed to the patient. It may be helpful to have a signed Advanced Beneficiary Notice of Non-coverage (ABN) form on file for the patient. Unfortunately, not all carriers use or recognize an ABN.

Claim Needs More Information

Most injury-related claims are denied until the payer can determine the cause of injury. Payers send out communication to the provider, as well as to the patient, asking for details about the injury. Was the injury related to the patient’s employment or a motor vehicle accident? Is there another agency that should be responsible for this claim?

The details of the accident can be provided through accurate diagnosis coding. By selecting a diagnosis from Chapter 20, External Causes of Morbidity (V00 – Y99) on the original claim, in addition to a diagnosis from the Chapter 19: Injury, Poisoning and Certain Other Consequences of External Causes (S00 – T88), most denials of this nature can be avoided.

Other types of claims that “need more info” may be for college-aged dependents. The payer will want proof that the dependent has remained a full-time student. In this case, the patient’s parents need to obtain this information, such as a statement from the college’s registrar.

Using unlisted codes also requires more information. These codes are used when there is not an adequate CPT® code to describe the services rendered. Usually, the operative note documentation will suffice, as long as the payer can identify what part of the surgical note applies to the unlisted code.

Claim Lacks Medical Necessity

If the service is purely cosmetic, the patient is responsible for payment. The claim should not be adjusted based on the payer’s denial due to lack of medical necessity.

If the service was medically necessary, the problem could be the frequency in which the service was billed. For example, patients who have diabetes mellitus will customarily have an HgA1C checked every 90 days. Billing the test in shorter intervals than 90 days will cause a medical necessity denial. If the physician has a medical reason to check the levels more often than 90 days, an appeal may be submitted, with the chart documentation.
Denials

Patient Eligibility
Claims denied due to patient eligibility are the patient’s responsibility, and are out of bounds until sufficient and correct insurance information is obtained.

The Winning Way to Overturn Denials
Knowing the best way to overturn a denial is instrumental in expediting payment. A claim should not be resubmitted simply to try and force a different outcome. Billing claims multiple times never gets results. A corrected claim is always appropriate when diagnosis codes or CPT® codes need to be changed or modifiers need to be added. Be sure to identify the claim as “corrected;” failing to do so may result in another denial because the payer may see this second claim attempt as a duplicate.

Beat the buzzer: Allowing several months to pass before you correct the claim issue could result in a timely-filing denial.

Step Up Your Appeals Process Game
An appeal is appropriate if you’re dissatisfied with the initial determination on a claim. Filing an appeal should include all pertinent medical documentation. The different levels of appeals vary from payer to payer. Medicare’s level of appeals includes:

- Redetermination must be done within 120 days from the date of the initial determination.
- Reconsideration by a qualified independent contractor is a review, which must be done within 180 days from the date of the Medicare redetermination notice.
- A hearing by the administrative law judge (ALJ) has to be performed within 60 days from the receipt of the reconsideration notice, and there has to be at least $150 in controversy.
- Review by the Medicare Appeals Council (MAC) of the Departmental Appeals Board should be conducted within 60 days from the date of the ALJ decision receipt.

- Judicial review in U.S. District Court has to be requested within 60 days from the MAC decision and at least $1,460 remains in controversy.

Check with other carriers for their appeal levels. Also, get your providers engaged in the appeal process. They need to know when a portion of their claims are being denied. The provider may be able to equip you with an appeal letter explaining in detail what was performed, and why.

If all else fails, pick up the phone and call the payer. Hearing the problem over the phone may turn up new information. For example, a claim for 99232 Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of moderate complexity … Typically, 25 minutes are spent at the bedside and on the patient’s hospital floor or unit was denied as “bundled in with a previously paid service;” but there is no other service on this patient’s account to which bundling of the 99232 could occur. After contacting the payer, it is found to be a provider/group linkage issue. Sometimes telephone conversations are needed to work through these details.

Remember: Never make any changes to the documentation after the original claim is filed.

Wendy Grant-Denton, CPC, has been in the medical industry since 1977. She works as a revenue cycle manager and coding analyst for Community Health Systems. Grant-Denton is a member of the Little Rock, Ark., local chapter. She also served on the AAPC Chapter Association board of directors from 2009-2013.
Cerumen Removal Coding Depends on Impaction, Method

Factor in the components of the common family practice procedure.

Cerumen (ear wax) can build up in the ear canal, which may lead to symptoms of discomfort, dizziness, and impaired hearing for which patients seek medical care. In fact, the American Family Physician website tells us that cerumen removal is the most common ear, nose, and throat (ENT) procedure performed in primary care.

Coding for cerumen removal depends on two factors:
1. Whether the cerumen is impacted; and
2. If the cerumen is impacted, the method used to remove it.

Not Impacted = E/M Service

CPT® guidelines tell us, “For cerumen removal that is not impacted, see E/M service code …” such as new or established office patient (99201-99215), subsequent hospital care (99231-99233), etc. In other words: If the earwax isn’t impacted, removal is included in the documented evaluation and management (E/M) service reported and may not be separately billed.

Per the American Academy of Otolaryngology-Head and Neck Surgery (AAO-HNS), cerumen is impacted if one or more of the following conditions are present:
- Cerumen impairs the examination of clinically significant portions of the external auditory canal, tympanic membrane, or middle ear condition;
- Extremely hard, dry, irritative cerumen causes symptoms such as pain, itching, hearing loss, etc.;
- Cerumen is associated with foul odor, infection, or dermatitis; or
- Obstructive, copious cerumen cannot be removed without magnification and multiple instrumentations requiring physician skills.

The AMA’s CPT® Changes 2016: An Insider’s View confirms, “Impacted cerumen is typically extremely hard and dry and accompanied by pain and itching. Impacted cerumen obstructing the external auditory canal and tympanic membrane can lead to hearing loss.”

Method Determines Coding for Impacted Removal

If cerumen is impacted, it may be removed by one of two general methods: lavage (irrigation) or instrumentation. For removal by lavage, the correct code is 69209 Removal impacted cerumen using irrigation/lavage, unilateral. For removal using instrumentation (e.g., forceps, curette, etc.), turn instead to 69210 Removal impacted cerumen requiring instrumentation, unilateral.

CPT® Changes 2016: An Insider’s View specifies:

Code 69210 only captures the direct method of earwax removal utilizing curettes, hooks, forceps, and suction. Another less invasive method uses a continuous low pressure flow of liquid (eg, saline water) to gently loosen impacted cerumen and flush it out … Code 69209 enables the irrigation or lavage method of impacted cerumen removal to be separately reported…

You may report a single unit of either 69209 or 69210 (never both), per ear treated. As an example of proper reporting for 69209, CPT® Changes 2016: An Insider’s View provides the following:

A 7-year-old male child comes in for his well-child exam. He fails his hearing screen in the left ear. On examination, the physician is unable to see the tympanic membrane due to cerumen impaction. An order is placed for the nurse to irrigate the ear.
If cerumen is impacted, it may be removed by one of two general methods: lavage (irrigation) or instrumentation.

Bilateral Services

Both 69209 and 69210 are unilateral procedures. For removal of impacted cerumen from both ears, CPT® instructs us to append modifier 50 *Bilateral procedure* to the appropriate code. In the example above of the 7-year-old child, if irrigation occurred in both ears, appropriate coding would be 69209-50.

When billing Medicare payers, different bilateral rules apply for 69210. The 2016 Medicare National Physician Fee Schedule Relative Value File assigns 69210 a “2” bilateral indicator. This means, for Medicare payers, the relative value units assigned to 69210 “are already based on the procedure being performed as a bilateral procedure.” In contrast to CPT® instructions, the Centers for Medicare & Medicaid Services (CMS) allows us to report only one unit of 69210 for a bilateral procedure. CMS does allow us to bill a bilateral procedure for cerumen removal by lavage using 69209-50.

Finally, note that some payers may stipulate “advanced practitioner skill” is necessary to report removal of impacted cerumen (i.e., payers may require that a physician provide 69209, 69210). Query your individual payers to be certain of their requirements.

Resource

www.aafp.org/journals/afp.html
AAO-HNS: www.entnet.org/
In a Nutshell: Category II Codes

CPT® Category II codes are a mystery for many coders. Although use of Category II codes is optional and not required for correct coding, reporting these codes may have advantages.

The American Medical Association (AMA), which creates and maintains CPT®, states that Category II codes “are intended to facilitate data collection about the quality of care rendered by coding certain services and test results that support nationally established performance measures and that have an evidence base as contributing to quality patient care.” For example, Category II codes:

… describe clinical components that may be typically included in evaluation and management services or other clinical services and, therefore, do not have a relative value associated with them. Category II codes may also describe results from clinical laboratory or radiology tests and other procedures, identified processes intended to address patient safety practices, or services reflecting compliance with state or federal law.

Per the California Quality Collaborative, assigning CPT® Category II codes:

• Lessens administrative burden of chart review for many Healthcare Effectiveness Data and Information Set (HEDIS®) performance measures (HEDIS® consists of 81 measures across five domains of care);
• Enables internal performance monitoring of key measures throughout the year, rather than once per year as measured by health plans and pay for performance; and
• Identifies opportunities for improvement, so interventions can be implemented to improve performance during the service year.

Category II codes are supplemental, and never are used in place of Category I or Category III codes.

Resources


John Verhovshek, MA, CPC, is managing editor at AAPC and a member of the Hendersonville-Asheville, N.C., local chapter.

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Here is coding guidance to lift the weight from your shoulders.
The Centers for Medicare & Medicaid Services (CMS) and the American Academy of Orthopaedic Surgeons (AAOS) have opposing views on shoulder anatomy. AAOS recognizes the glenohumeral joint, the acromioclavicular (AC) joint, and the subacromial bursa as separate anatomic areas. CMS, by contrast, considers the shoulder to be a single anatomic region.

NCCI Doesn’t Allow Modifiers for Same-Shoulder Edits

Under the National Correct Coding Initiative (NCCI) edits used by Medicare, Medicaid, some workers’ compensation payers, and some other commercial health payers, providers may never use an NCCI modifier, such as 59 Distinct procedural service, XE Separate encounter, XP Separate practitioner, XS Separate structure, or XU Unusual non-overlapping service to bypass the procedure-to-procedure edits in place for shoulder surgery, unless the service is performed on the opposite shoulder. NCCI is required for use by Medicaid per the Affordable Care Act, and it has been adopted by 20 states for workers’ compensation. Many commercial carriers have also adopted NCCI, sometimes with modifications to reflect payer-specific medical policies and reimbursement methodologies.

1. Was the service performed on the shoulder arthroscopically?
2. Was the service performed on the distal clavicle?
3. Was approximately 1 cm removed?

If the answer is yes to all three of these questions, you may report 29824. If the answer is no to any question, a more appropriate code may exist. For example, bone removal of less than 8 mm is a debridement, such as CPT® 29822 or 29823 Arthroscopy, shoulder, surgical; debridement, extensive (see: AMA CPT® Changes: An Insider’s View 2002 and AAOS “April 2004 Bulletin”).

If the provider is addressing the AC joint, coding may be more challenging. If the surgeon notes creating a 1 cm space at the AC joint, he or she is referring to the distal end of the clavicle and the acromion. This is insufficient documentation to support either 29824 or 29826.

Subacromial Decompression with Partial Acromioplasty

CPT® 29826 requires both a subacromial decompression and a partial acromioplasty. If acromioplasty is not performed, report only a debridement. Keep in mind that 29826 is an add-on code requiring a primary procedure. When coding the acromioplasty, look for discussion about the morphology (specifically type I, II, or III) in the operative notes. This determines if the acromion is flat, curved, or hooked.
Returning to the AC joint: Was the creation of the 1 cm space in the AC joint due to a distal claviculectomy, acromioplasty, or both? If the bur was used to reshape the acromion by removing osteophytes or excess bone, this could be a form of debridement.

If the acromioplasty is the only service performed, report a debridement (29822 or 29823). If acromioplasty is performed with distal claviculectomy, it’s possible the two procedures created the 1 cm space. In this situation, it may be appropriate to report 29824 or 29826, but not both.

Encourage providers to describe the acromioplasty with morphology and the distal claviculectomy of approximately 1 cm separately, rather than to indicate the creation of a 1 cm space at the AC joint. This will reduce allegations of upcoding debridement, billing for services not rendered, or other false claim allegations.

**Example:** If a 1 cm space is created by removing 7 mm from the distal clavicle and 3 mm from the acromion, this is a debridement (29822) because the documentation does not meet the minimum requirements for the distal claviculectomy or the acromioplasty. If the 3 mm removed from the acromion is a true acromioplasty — achieved by converting the acromion to a type I morphology with a subacromial decompression — proper coding is 29822 and 29826. The 7 mm does not meet the requirements of the claviculectomy. Documentation must support both services.

**Rotator Cuff Surgery**

There are three possible codes for open rotator cuff surgery, depending on whether it’s an acute or chronic repair, or if it’s a reconstruction. CPT® 29827 is the only code for arthroscopic rotator cuff repair. If performing a revision or a reconstruction, modifier 22 Unusual procedural service may be used to indicate the extensive work involved in the revision or reconstruction. Check with your payer, however, as they may require a different code for the arthroscopic rotator cuff reconstruction (e.g., 29999 Unlisted procedure, arthroscopy).

**Debridement**

Debridement is reported as either limited (29822) or extensive (29823). To report the extensive debridement, documentation must indicate anterior and posterior sites, multiple sites (usually three or
CODING/BILLING

Arthroscopy

Coders and providers must be aware of the documentation requirements for proper coding of shoulder procedures.

more), and/or abrasion chondroplasty. In comparison, limited debridement involves only a couple of sites.

Example: A provider performs a subacromial decompression, biceps tenotomy, and debridement of the anterior labrum. Proper coding is 29823. If the provider only performs two of the procedures, proper coding is 29822.

SLAP Repairs

Providers must document the type of superior labrum from anterior to posterior (SLAP) to determine the correct code. There are four types of SLAP:

Type I is always 29822, which is a debridement.

Type II is either a debridement under 29822 or a SLAP repair under 29807 Arthroscopy, shoulder, surgical; repair of SLAP lesion. Base your coding on the documentation. If the provider documents a type III repair, report 29807. If debridement is documented, report 29822.

Type IV is coded 29807. Documentation must be specific to the type and procedure performed to determine proper coding.

Unlisted Arthroscopy

CPT® 29999 is often incorrectly reported for coracoid decompression, biceps tenotomy, and microfracturing.

The coracoid is connected to the acromion by the coracoacromial ligament. Release of the coracoacromial ligament is an inclusive component of 29826. The procedure does not require the release to be proximal to either the acromion or the coracoids; and because the code includes the coracoacromial ligament, it includes the coracoid process.

Subacromial decompression without acromioplasty is considered debridement. Coracoid decompression is, likewise, a form of debridement. Coracoid decompression is included in 29826 when acromioplasty is performed; otherwise, it is considered debridement under 29822 or 29823, depending on the extent of the debridement.

Biceps tenotomy (the removal of damaged tissue to promote healing) also meets the definition of debridement (29822 or 29823).

The release of the biceps tendon allows the inflamed tissue to leave the shoulder joint and fall into the upper arm.

Microfracturing is performed by drilling small holes (2-3 mm deep) into the bone to promote healing of healthy bone. Because anything less than 8 mm of a distal claviclecetomy is considered debridement, 2-3 mm of microfracturing meets the definition of debridement for 29822 or 29823 (depending on the extent of the debridement).

Check Bundling, Documentation

Many arthroscopic shoulder surgeries are reported as debridement with 29822 or 29823; however, when performed with another arthroscopic shoulder procedure on the same shoulder, the debridement is bundled into the primary surgical code(s) (if subjected to NCCI edits).

Bottom line: Coders and providers must be aware of the documentation requirements for proper coding of shoulder procedures.

Resources:
AAOS “April 2004 Bulletin:” www2.aaos.org/bulletin/apr04/code.htm

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Make the Most of Hierarchical Condition Categories

Part 3: Learn from commonly under-coded conditions and documentation.

Accuracy and specificity in diagnosis coding and medical documentation are critical in risk adjustment models. Over the past couple of months, we’ve looked at several under-coded conditions in the Medicare hierarchical condition category (HCC) risk adjustment model and discussed documentation strategies to improve coding. There’s one more batch of conditions we need to explore.

Vascular Disease

HCC 108

Peripheral vascular disease (PVD) refers to any disease or disorder of the circulatory system outside of the heart or brain. Approximately eight million people in the United States are afflicted with PVD. It’s most common in those over age 60, men, and smokers.

Approximately half of the people diagnosed with PVD do not have symptoms. The most common symptom is lower leg cramps with activity, which stop when rested. This is known as intermittent claudication, and it may occur in one or both legs. Other symptoms of PVD include color changes to the skin on the legs and feet; coldness; thin, shiny skin; hair loss on the legs; and weak pulses in the legs and feet.

To ensure correct code selection for PVD, look carefully at the documentation for the underlying cause (for example, arteriosclerosis or diabetes). Note also any manifestations of PVD, including: ulcers, gangrene, claudication, cellulitis, and amputation status.

Remember: Risk adjustment coding is all about painting the most accurate, clinical picture of your patient.

When documenting deep vein thrombosis (DVT), it’s important for the doctor to specify “acute” or “chronic.” There is a separate code for long-term use of anticoagulants; an additional code for anticoagulation therapy should be coded, as appropriate. An acute DVT is an emergency condition that is not usually treated in a doctor’s office. There is a “history of DVT” code for patients who have had a DVT in the past, but no longer have the acute condition (ICD-10-CM: Z86.718 Personal history of other venous thrombosis and embolism, ICD-9-CM: V12.51 Personal history of venous thrombosis and embolism).

Aneurysms without mention of rupture are also found in this category. Note that after an aneurysm has been documented as repaired, it’s no longer captured as an HCC. Do not report an aneurysm diagnosis when an ultrasound is performed to rule out aneurysm. In this case, the sign or symptom should be coded as the reason for the ultrasound.

Artificial Openings for Feeding or Elimination

HCC 188

An ostomy is a surgically created opening connecting an internal organ to the outside of the body. This category includes “status
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HCCs

CODING/BILLING

Risk adjustment coding is all about painting the most accurate, clinical picture of your patient.

HCCs

To acknowledgement the importance of risk adjustment methodologies to the future of our industry, AAPC has created a new credential, Certified Risk Adjustment Coder (CRC™). A CRC™ proves, by rigorous examination and experience, that she or he knows how to read a medical chart and assign the correct diagnosis codes for a wide variety of clinical cases and services for risk adjustment models, such as the CMS-HCC Risk Adjustment Model and others.

Morbid Obesity

HCC 22

Morbid obesity is a growing public health concern in the United States. Per ICD-10-CM Official Guidelines for Coding and Reporting, a diagnosis of a clinical condition (i.e., overweight, obese, morbid obesity) must be obtained from provider documentation; however, the body mass index (BMI) may be coded from a dietician’s and/or other caregiver’s documentation.

Providers should be cautioned against defaulting to unspecified obesity for all patients because this is not a risk-adjusted condition and does not accurately reflect the clinical condition of patients with a BMI of 40, or higher. Some good documentation practices include: "diet discussed," "exercise encouraged," and "dietician referral and/or counseling." Under this category in ICD-10, there is an instructional note to use an additional code to identify the BMI (ICD-10-CM Z68., or ICD-9-CM V85.-), if known. **HBM**

Colleen Gianatasio CPC, CPC-P, CPMA, CPC-I, CRC, is a risk coding and education specialist for Capital District Physician’s Health Plan. She enjoys teaching PHCC, auditing, and ICD-10 classes. Gianatasio is president of the Albany, N.Y., local chapter and a member of the National Advisory Board.
2016 Brings Opportunity to Increase Revenue

Meet criteria to report two new codes for prolonged clinical staff observation services in the outpatient and office settings.

Prior to 2016, observation care services provided by clinical staff under the supervision of a physician or other qualified healthcare professional were considered part of office or outpatient services. This year, two new add-on codes are available for reporting prolonged clinical staff observation services in the outpatient and office settings:

- **+99415** Prolonged clinical staff service (the service beyond the typical service time) during an evaluation and management service in the office or outpatient setting, direct patient contact with physician supervision; first hour (List separately in addition to code for outpatient Evaluation and Management service)
- **+99416** each additional 30 minutes (List separately in addition to code for prolonged service)

These codes may be reported when the primary service provided to the patient by the physician or other qualified healthcare professional in an office or outpatient setting results in clinical staff providing observation care beyond the typical time ordinarily included within the evaluation and management (E/M) service.

**Note the Difference**

Prolonged service codes +99354 Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service; first hour (List separately in addition to code for office or other outpatient Evaluation and Management service) and +99355 Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service; each additional 30 minutes (List separately in addition to code for prolonged service) require direct patient contact (face-to-face) between the physician and the patient. The new prolonged services codes are useful when the patient requires further clinical observation, but face-to-face time with the physician or other qualified healthcare professional isn’t necessary.
Prolonged Services

Follow Examples for Applying Codes

A 21-year-old male comes to his primary care physician’s office complaining of painful abdominal cramps and persistent diarrhea for the past two days. He has not been able to hold down any food or drink in 24 hours. The physician performs a detailed history, detailed examination, and medical decision-making of moderate complexity. The physician diagnoses the patient with viral enteritis and decides to begin oral rehydration. The clinical staff monitors and observes the patient for three hours.

Although the patient is still under the care of the physician, direct face-to-face time with the physician or other qualified healthcare professional is no longer required — the clinical staff is under the supervision of the physician or other qualified healthcare professional.

The total time of the primary service is used to determine when the prolonged service time begins, as shown here:

<table>
<thead>
<tr>
<th>Total Duration of Prolonged Services (in Excess of Primary E/M Service)</th>
<th>Code(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 45 minutes</td>
<td>Not reported separately</td>
</tr>
<tr>
<td>45-74 minutes (45 minutes to 1 hour 14 minutes)</td>
<td>+99415 x 1</td>
</tr>
<tr>
<td>75-104 minutes (1 hour 15 minutes to 1 hour 44 minutes)</td>
<td>+99415 x 1 and +99416 x 1</td>
</tr>
<tr>
<td>105 minutes or more (1 hour 45 minutes or more)</td>
<td>+99415 x 1 and +99416 x 2 (or more, for each additional 30 minutes)</td>
</tr>
</tbody>
</table>

In the above example, the E/M service is reported with 99214 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision-making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family. Prolonged services begin after the 25 minutes of face-to-face time that is customary for the physician to spend with the patient during the primary service. CPT® +99415 is reported after clinical staff has spent at least 70 minutes face-to-face with the patient (45 minutes after the initial 25 minutes).

Reporting Criteria

The following criteria must be met to report +99415 and +99416:

1. The place of service must be in an office or outpatient setting.
2. Face-to-face time with the clinical staff must be beyond the typical face-to-face time of the E/M service on a given date (Note: Time does not have to be continuous).
3. The physician or qualified healthcare professional must be present to provide direct supervision of the clinical staff.
4. +99415 is for the first hour of prolonged clinical staff service on a given date (Note: A service of less than 45 minutes total is not reported separately).
5. +99415 is for each additional 30 minutes.
6. Prolonged services of less than 15 minutes beyond the first hour or less than 15 minutes beyond the final 30 minutes is not reported separately.
7. +99415, +99416 may not be reported for more than two simultaneous patients.
8. Facilities may not report +99415 and +99416.

Resource

Vital Definitions

Clinical staff includes a person who works under the supervision of a physician or other qualified healthcare professional and who is allowed by law, regulation, and facility policy to perform or assist in a specified professional service, but who does not individually report that professional service. Other policies may also affect who may report specific services.

Direct supervision means the physician or other qualified healthcare professional must be present at the site where the service is provided and is readily available to furnish assistance or direction.
Don’t Overlook Obstetric Panel Alternative

CPT® 2016 introduced a new obstetric panel code, 80081 Obstetric panel (includes HIV testing), which is identical to the long-standing obstetric panel 80055 Obstetric panel, with one exception: The newer code includes HIV testing.

Required components for both codes include:

- Blood count, complete (CBC), and automated differential WBC count (85025 or 85027 and 85004)

OR

- Blood count, complete (CBC), automated (85027) and appropriate manual differential WBC count (85007 or 85009)

- Hepatitis B surface antigen (HBsAg) (87340)

- Antibody, rubella (86762)

- Syphilis test, non-treponemal antibody; qualitative (eg, VDRL, RPR, ART) (86592)

- Antibody screen, RBC, each serum technique (86850)

- Blood typing, ABO (86900)

AND

- Blood typing, Rh (D) (86901)

To these tests, 80081 adds HIV-1 antigen(s), with HIV-1 and HIV-2 antibodies, single result (87389). CPT® also specifically instructs, “When syphilis screening is performed using a treponemal antibody approach [86780], do not use 80081. Use the individual codes for the tests performed in the obstetric panel.”

Remember: When reporting a panel code, each test listed in the panel description must be performed. If any single test defined as part of a panel is not performed, seek out a different panel code (e.g., If an obstetric panel is performed without an HIV test and all other tests are performed, continue to report 80055). If no panel code properly describes the tests performed, report the code(s) to describe the individual tests performed, rather than the panel code.

You may not report two or more panel codes including the same tests (for instance, you would never report 80081 and 80055 together); however, you may report test(s) performed in addition to panel components. The American Medical Association’s (AMA) CPT® Changes 2016: An Insider’s Guide is careful to note, “The panel components are not intended to limit performance of other tests. If tests are performed in addition to the tests listed for a panel, the additional tests are reported separately in addition to the panel code.” This instruction is supported by guidelines within the CPT® codebook.

Raemarie Jimenez, CPC, CPB, CPMA, CPPM, CPC-I, CANPC, CRHC, CCS, is vice president, AAPC Member and Certification Development.
Q When reporting radiology services, are transcription services considered to be included in the technical component (TC) or the professional component (PC)?

A When defining professional and technical components for radiology services, the Centers for Medicare & Medicaid Services (CMS) stipulates:

• The PC of a service is for physician work interpreting a diagnostic test or performing a procedure, and includes indirect practice and malpractice expenses related to that work. Modifier 26 is used with the billing code to indicate that the PC is being billed.

• The TC is for all non-physician work, and includes administrative, personnel and capital (equipment and facility) costs, and related malpractice expenses. Modifier TC is used with the billing code to indicate that the TC is being billed.

CMS’ definition does not clarify whether transcription services constitute “indirect practice and malpractice expenses” (PC) or “administrative, personnel and capital (equipment and facility) costs” (TC). The American College of Radiology (ACR), however, explicitly says that transcription is a technical cost:

Transcription costs for radiology and radiation oncology services are reimbursed under the technical component and are never included in the professional component. The professional component for radiology services paid under the Medicare Physicians Fee Schedule (MPFS) is not intended to cover transcription costs.

In addition, transcription costs are not included in the physician work valuation process. The professional component represents the physician’s professional services associated with their interpretation (via hand written or dictation etc.) and not transcription itself. Transcribing a report or transcription from a Dictaphone is typically performed by administrative staff and not part of the physician interpretation/work.

Sources:

ACR, Medicare Regulation FAQ-Transcription: www.acr.org/FAQs/Medicare-Regulation-FAQs-Transcription

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Workshop | March 16-31, 2016
Reimbursement Impacts in Shifting Times

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- Physician Quality Reporting Standards

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CODING/BILLING

Is Transcription a Technical or Professional Component?

DEAR JOHN

In a Coding Quandary? Ask John
If you have a coding-related question for AAPC’s Healthcare Business Monthly, please contact Managing Editor John Verhovshek, CPC, at g.john.verhovshek@aapc.com.
The Office of Inspector General’s (OIG’s) annual work plan for 2016 indicates significant new areas, as well as ongoing target areas, on which the federal agency will focus its reviews and audits of U.S. Department of Health and Human Services (HHS) programs and operations this year. Let’s take a look at what’s under the OIG’s microscope for facilities submitting claims to Medicare Part A.

**What’s New for 2016**

Review of the OIG work plan is a critical element to any compliance program. For 2016 and beyond, OIG continues to focus on emerging payment, eligibility, management, and information technology systems security vulnerabilities in Affordable Care Act programs.

**Hospital-related Policies and Practices**

For hospital-related policies and practices, the OIG is focusing on:

- Reconciliation of outlier payments
- Outpatient/Inpatient stay reporting under the two-midnight rule
- Medicare costs associated with defective medical devices

Put these OIG compliance efforts on a high priority focus list at your hospital.
• Analysis of salaries included in hospital cost reports
• Comparison of costs for services provided in provider-based and freestanding clinics

**REVISED! Medicare oversight of provider-based status**
– OIG will determine the number of provider-based facilities that hospitals own and the extent of methods the Centers for Medicare & Medicaid Services (CMS) has to oversee provider-based billing. Provider-based status allows facilities owned and operated by hospitals to bill as hospital outpatient departments. Provider-based status can result in higher Medicare payments for services furnished at provider-based facilities and may increase beneficiaries’ coinsurance liabilities. The Medicare Payment Advisory Commission (MedPAC) has expressed concerns about the financial incentives presented by provider-based status and stated that Medicare should seek to pay similar amounts for similar services.

**NEW!** Medical device credits for replaced medical devices
– Federal regulations (see 42 CFR §§412.89, 419.45) require reductions in Medicare payments for the replacement of implanted devices. OIG has determined that Medicare administrative contractors have made improper payments to hospitals for inpatient and outpatient claims for replaced medical devices. If your facility or organization has been paid improperly, you should voluntarily disclose and refund any overpayments.

**NEW!** Medicare payment during the Medicare severity diagnosis-related group (MS-DRG) payment window
– OIG will initiate a review of Medicare payments to acute care hospitals to determine whether certain outpatient claims billed to Medicare Part B for services provided during inpatient stays were allowable under the Inpatient Prospective Payment System. Certain items, supplies, and services furnished to inpatients are covered under Part A and should not be billed separately to Part B. Facilities should review any payments from Part B to determine if such payments were appropriate. Overpayments should be disclosed and refunded.

**Hospitals – Billing and Payments**
For facility billing and payments, the OIG is focusing on:
• Inpatient claims for mechanical ventilation
• Compliance with selected inpatient and outpatient billing requirements
• Duplicate graduate medical education payments
• Indirect medical education payments
• Outpatient dental claims
• Nationwide review of cardiac catheterizations and endomyocardial biopsies
• Payments for patients diagnosed with kwashiorkor
• Bone marrow or stem cell transplants
• Review of hospital wage data used to calculate Medicare payments
• Intensity modulated radiation therapy

**NEW!** Medical device credits for replaced medical devices
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**Hospitals – Quality of Care and Safety**
Regarding quality of care and safety measures in facilities, the OIG is focusing on:
• Inpatient rehabilitation facilities — adverse events in post-acute care for Medicare patients
• Long-term care hospitals — adverse events in post-acute care for Medicare patients
• Hospital preparedness and response to high-risk infectious diseases
• Hospitals’ electronic health record system contingency plans

**NEW!** CMS validation of hospital-submitted quality reporting data
– OIG will determine the extent to which CMS validated hospital inpatient quality reporting data. CMS uses reported quality data for the Hospital Value-based Purchasing Program and the Hospital Acquired Condition Reduction Program, which account for future payment rates; therefore, so their accuracy and completeness are important.
There is no slowdown in OIG’s willingness to use exclusions and civil or criminal prosecution to achieve its goals. … compliance efforts must be a high priority for entities that submit claims to federally funded healthcare programs.

Nursing Homes
OIG will report on the implementation status and early results for the CMS National Background Check Program for long-term care employees from the first four years of the program.

NEW! Skilled Nursing Facility (SNF) Prospective Payment System requirements – Prior OIG reviews have found that Medicare payments for therapy greatly exceeded SNFs’ cost for therapy. In addition, OIG has determined that SNFs have increasingly billed for the highest level of therapy even though key beneficiary characteristics remained largely the same. OIG, relying on conformance with documentation requirements, will determine whether SNF care was reasonable and necessary. Such SNF documentation includes:

1. A physician order at the time of admission for the resident’s immediate care;
2. A comprehensive assessment; and
3. A comprehensive plan of care prepared by an interdisciplinary team that includes the attending physician, a registered nurse, and other appropriate staff.

SNFs should review past therapy payments and initiate a voluntary disclosure and refund of any improper payments. Going forward, they should review published Medicare guidance to ensure compliance.

Home Health
For home health, the OIG is honing in on:

• Home Health Prospective Payment System requirements

Get to Know the OIG Work Plan
This is a mere summary of the Part A portion of the 80-page work plan. For details pertaining to ongoing reviews, which are listed above only by name, or for details regarding risk areas associated with Part B, Part C, Part D, and Medicaid programs, please refer to the 2016 OIG Work Plan.

Note: We’ll address the new and revised focus areas applicable to Medicare Part B providers in an upcoming issue.

For each focus area affecting your facility, be certain to review appropriate CMS interpretive guidance and local coverage determinations, as well as other Medicare regulations, publications, and guidance referenced. This will help you to completely understand and comply with CMS expectations — particularly with respect to documentation content.

History in the Making
The Office of Inspector General (OIG) pursues perceived areas of fraud, waste, and abuse based on its obligation to protect the integrity of U.S. Department of Health & Human Services (HHS) programs through audits and suggested improvements to HHS programs. As evidence of its continued emphasis on recoveries, OIG reported expected recoveries in 2015 of more than $3 billion, comprised of $1.13 billion in audit receivables and approximately $2.22 billion in investigative receivables. OIG also estimates approximately $20.6 billion in savings for 2015 based on prior legislative, regulatory, or administrative actions supported by OIG recommendations.

Besides the recovery figures, OIG reported exclusions of 4,112 individuals and entities (up from 4,017 in 2014), 925 criminal actions (down from 971 in 2014), and 682 civil actions (533 were filed in 2014). The civil actions included false claims or unjust enrichment lawsuits, civil monetary penalty settlements, and administrative recoveries relative to provider self-disclosure matters.

There is no slowdown in OIG’s willingness to use exclusions and civil or criminal prosecution to achieve its goals. For this reason, compliance efforts must be a high priority for entities submitting claims to federally funded healthcare programs.

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Resource
I find the CMS 1500 claim edit checker to be the most helpful tool ever created by coding-mankind. I also love the fact that everything is in one place: LCD, NCCI edits, Fee Schedule, etc.

Vanessa M.
Be sure the practitioner is authorized to practice in your state and requirements are met. When working in an organization that bills for services performed by a nurse practitioner (NP) or physician assistant (PA), discussion may arise regarding limitations on the scope of practice for these non-physician practitioners (NPPs).

Medicare provides coverage for services performed by NPs and PAs when certain requirements are met. One of those requirements is that the practitioner is legally authorized to perform the services in the state in which they are provided. Medicare regulations comply with the applicable state law.

**Define Scope of Practice**

Scope of practice laws and regulations define the activities, including procedures, that a practitioner is authorized to carry out under his or her licensure. For NPs and PAs, these definitions vary in some notable ways among states.

Beyond the specific laws and guidance implemented by a state, an NP’s or PA’s practice may be further limited by the supervising physician’s specific terms and delegation. For example, the determination of certain procedures or services that can be performed by the
PA or NP may be specified in the statute or regulation, but in many states it’s determined and incorporated into a written agreement or policy by the physician who is supervising the NP or PA. This means, even within a state, there may be scope of practice variations among organizations.

When identifying scope of practice, there are certain areas where state-specific variations are found. These may include:

- **Whether the NP may practice independently of physician involvement.** In a slim majority of states, NPs may diagnose and treat patients without direct physician involvement. These laws vary in the scope of autonomy they grant to NPs. In New York, for example, not only are NPs held independently responsible for the diagnosis and treatment of patients without direct physician supervision, but NPs with 3,600 hours of practice can opt to practice under “collaborative relationships” with physicians. The collaborative relationship is defined as communication (including electronic) with a physician to exchange information or make referrals. These collaborative relationships do not require the NP to have a written agreement with a physician, to have a physician co-sign or review records or orders, or to be supervised in person.

  Other states do not have this level of autonomy. In Missouri, for example, the NP is authorized to treat only in collaboration with a physician under a written agreement, must remain within a certain distance of the supervising physician, is subject to review and consultation with the physician every two weeks, and can provide only a limited scope of treatment in the absence of a follow-up visit with a physician.

- **The scope of authority to prescribe medications.** A very narrow majority of states do not allow an NP to prescribe medications without physician involvement. Typically, in these states, which include California and Texas, an NP must have a collaborative agreement in place with a physician to prescribe medications. Other states, such as Arizona and Washington, allow NPs to prescribe medications without physician involvement. Prescriptive authority may also vary from state to state as to whether the supervising physician retains responsibility for prescriptions issued by an NP.

  Prescription authority may be even more restrictive for PAs. In most states, a PA is authorized to prescribe medications under physician supervision, but the supervising physician may limit this prescriptive authority. Some states limit the extent to which a physician may delegate prescribing to a PA. For instance, in Georgia, PAs may not prescribe schedule II drugs (controlled substances). Other states are even more restrictive: in Kentucky and Florida, PAs generally may not administer or schedule drugs.

- **How the scope of services is defined.** In most states, the physician and NP or PA establish the procedure and services within the scope of practice in a written agreement. Historically, this was not the case, and scope of practice laws defined the precise procedures an NP or a PA was authorized to perform. Some states still establish the scope of practice in this fashion. In these states, there may also be variation, depending on the type of facility in which services are performed. In Ohio, for example, a PA’s scope of practice is determined based on the facility type and state law specifies certain permitted or prohibited processes while retaining broader considerations of facility policy.

- **Limits on the number of NPs or PAs a physician may supervise.** Most states have some limit on the number of NPs or PAs a physician may supervise. Illinois and Washington, for example, allow a physician to supervise up to five PAs. In Mississippi, a physician can only
supervise up to two PAs, but cannot supervise any PAs while supervising two NPs. In states such as Massachusetts and North Carolina, there is no numerical limit.

Requirements of a collaborative practice or supervision agreement. Perhaps the greatest variation among states arises in the specifics on what must (or may) be provided for in a written agreement between an NPP and the supervising physician. Generally, state law may require these agreements include provisions such as:

• **Scope of practice.** Although this may be statutorily defined, in most cases, the scope of practice should be established in the agreement.

• **Prescriptions.** Often a drug protocol is necessary to identify medication types and indications the practitioner may prescribe.

• **Availability and consultation.** Because scope of practice laws generally provide some level of supervision by a physician over the practitioner, the scope of these responsibilities should include when the physician must be consulted and the extent to which the physician must be available when the NP or PA is providing services, consistent with state law.

• **Documentation review.** Some states require the written agreement to include a periodic review of NP or PA documentation by the supervising physician.

Know the Impact of Scope of Practice
Determining scope of practice is no mere formality. Treating patients using procedures not provided for or allowed in the state’s scope of practice law constitutes as practicing medicine without a license, or unprofessional conduct, and may subject the practitioner to disciplinary actions or judicial proceedings. Because scope of practice is incorporated in Medicare regulations, billing for a service provided outside an NPP’s scope of practice may create an overpayment or false claim liability.

When determining the scope of practice for an NP or PA, you should take the following steps:

1. Identify and review the state law for each state where the services will be provided. Because of variances between states, problems may arise when an organization expands into a new state.

2. Consider practitioner-specific requirements. The laws regulating an NP are separate from the laws regulating a PA.

In most states, the physician and NP or PA establish the procedure and services within the scope of practice in a written agreement.
Treating patients using procedures not provided for or allowed in the state’s scope of practice law constitutes as practicing medicine without a license, or unprofessional conduct, and may subject the practitioner to disciplinary action or judicial proceedings.

Your organization should ensure it considers the laws applicable to the license held by the NPP. If an organization replaces an NP with a PA, this may significantly affect the scope of practice.

3. Review the collaborative practice or supervision agreement. Because many states allow discretion to the supervising physician in determining the scope of services to be delegated, it’s important for the organization to understand how this delegation may have been limited by the physician.

4. Establish processes for patient care that ensure the NP or PA will provide services within the authorized scope of practice.

5. Create a process to identify and resolve exceptions. This is especially important if you are in a state that requires a high level of involvement by the supervising physician.

By establishing processes consistent with the authorized scope of practice for an NP or PA, your organization can protect the licensure of staff and improve compliance with billing obligations and coverage of services.

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Resources

42 C.F.R. §§410.74 & 410.75.
Missouri - RSMo. §334.735 et seq.
Georgia - Physician Assistant Act, O.C.G.A. §43-34-100 et seq.
Kentucky - KRS §311.840 et seq.
Florida - Florida Statute §458.347 et seq.
Ohio - RC §4730.01 et seq.; Ohio Administrative Code 4730-1 et seq. (http://codes.ohio.gov/oac/4730-1)
Illinois - Physician Assistant Practice Act of 1987, 225 ILCS 95/1 et seq.
Washington - RCW 18.71A.010 et seq. and 18.79.050 et seq.
North Carolina - NCGS §90-9.3; 21 NCAC 325.0201 et seq.
Massachusetts - 263 CMR 5.00 et seq.; Scope of Practice and Employment of Physician Assistants.
Mississippi - Mississippi Code of 1972 Annotated §73-26-1 et seq. (2013); Mississippi Administrative Code 30-17-2615 et seq.
Arizona – ARS §32-1601 et seq.; A.A.C. R4-19-501 et seq.
Texas – Texas Administrative Code 22 §221.1 et seq.
California – California Business & Professional Code §2834 et seq.
Pennsylvania – 63 Pennsylvania C.S. §218.1 et seq.
Be Aware of Your Payers’ Teaching Physician Guidelines

Dig in to “Test Your Knowledge of Teaching Physician Guidelines” for clarification.

Because Medicare is a national program, one might expect the billing and documentation rules to be the same in all 50 states. As healthcare business professionals, however, we know this is not the case. In the article “Test Your Knowledge of Teaching Physician Guidelines” (September 2015), we tested your knowledge of teaching physician guidelines. Now, let’s expand your knowledge even further.

**Evaluation and Management (E/M) Services**

Relative to what the teaching physician must document to comply with the Centers for Medicare & Medicaid (CMS) rules for E/M services, a statement such as, “I saw and evaluated the patient. I agree with the resident’s documentation” may be acceptable in some states. But in other states, the Medicare administrative contractor (MAC) would consider this to be a generic attestation, and require the teaching physician to personalize the documentation to the specific patient and the teaching physician’s role in the plan.

CMS does not require the teaching physician to see every Medicare patient. Based on the experience level of the resident, it’s not always necessary for the teaching physician to render services when the resident has already seen the patient. Some MACs require more than a generic attestation (“macro” or “smart phrase”) to support the teaching physician’s services. The statement, “I saw and evaluated the patient with the resident” is an acceptable smart phrase for the teaching physician to use in the electronic health record, if the teaching physician adds patient-specific details of the plan.

The level of E/M billed should reflect what was medically necessary for the patient, and not necessarily the level required and documented for teaching purposes.

Given that, the 2nd, 4th, 5th, and 15th examples in “Test Your Knowledge of Teaching Physician Guidelines” may need to include a personalized teaching physician note, depending on your MAC.

Regarding medical students, a teaching physician may only use the medical student’s review of systems and past family social history. A teaching physician may not use a teaching physician attestation when working with a medical student.

**Time-based Billing**

There are specific requirements the teaching physician must meet when billing for critical care. Key elements that must be documented include:

- The time the teaching physician spent providing critical care;
- That the patient was critically ill during the time the teaching physician saw the patient;
- What made the patient critically ill; and
- The nature of the treatment and management provided by the...
Some payers require two specific times to be documented in the medical record: the time spent counseling and the total time of the visit.

Procedures

“Test Your Knowledge of Teaching Physician Guidelines” provided an example (No. 10) in which, “The general surgery resident documents the hernia repair and states the attending physician was present for the entire surgery. The attending co-signs the note,” and concludes that this is acceptable documentation because “The guidelines state that if the teaching physician is present the entire time, a resident or operating room nurse can document the entire encounter, including the teaching physician’s presence.” Note that the teaching surgeon must also sign either the operative note or her own progress note. Unless the surgeon’s signature is present, outside auditors may consider the service to be an overpayment.

For overlapping surgeries (e.g., “Test Your Knowledge of Teaching Physician Guidelines,” No. 12), the teaching surgeon must indicate the qualified surgeon who was available to immediately assist the resident. Medicare Carriers Manual section 100.1.2 (revision 1859) states, “When a teaching physician is not present during the non-critical or non-key portions of the procedure and is participating in another surgical procedure, he or she must arrange for another qualified surgeon to immediately assist the resident in the other case should the need arise.”

“Test Your Knowledge of Teaching Physician Guidelines” No. 13 provided a scenario in which a family medicine resident sees an established patient for follow-up of his hypertension and to receive a knee injection to relieve pain caused by osteoarthritis. The resident documents the encounter, including the injection administration. The attending documents, “I saw and examined the patient. I agree with the resident’s note.”

In this case, you may be able to bill the visit if your MAC doesn’t require a personalized teaching physician note; however, you cannot bill the injection because the teaching physician does not state that he or she was present for the injection.

Judy Harris-Guay, CPC, has been the director of medical billing and research compliance at Yale University School of Medicine for 18 years. She is the author of “Ready, Set, Comply” (first edition) and owner of the Compliance Audit Tracking System, LLC. Harris-Guay is a member of the New Haven, Conn., local chapter.

Resources


Crack specialty coding with the American Medical Association’s 2016 CPT® Coding Essentials series—the perfect companion to your CPT® Professional codebook

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Don’t Let Medical Billing Accounts Grow Old

Time is ticking: Target and manage unpaid claims now to increase revenue.

Manage Office Claims

The basic steps of managing a medical billing claim are:

• Verify the patient’s registration information, including identification and health insurance benefits.
• Collect the copayment and, if you know there will be co-insurance, try to collect it up front.
• Generate a patient encounter form.

I cannot stress enough: Do your best to collect co-insurance and copayments up front. This reduces the issue of trying to collect later as a claim gets older (and older, and older).

Claims Life Cycle

After the patient encounter, coders should assign the proper codes to tell the story of what happened during the encounter. All CPT®, HCPCS Level II, and ICD-10-CM codes should be assigned immediately and properly.

To show medical necessity, ensure all diagnosis and procedure codes are supported by clinical documentation in the patient’s medical record. This avoids claim denials and resubmissions, and helps to eliminate the issue of aging unpaid claims.

Total charges for procedures and services on the patient encounter form. Post all charges to the patient’s ledger or account record and on the daily accounts receivable record. This can be done manually or using in-office practice management software (which nearly all practices are using now).

If there’s uncertainty about the coding (it happens), call the payer and ask for guidance. This reduces the time, energy, and expense of going through resubmissions and appeals.

Next, it’s time to bill the patient’s insurance carrier. Attach to the claim any supporting documentation, such as copies of medical reports, authorizations, pathology reports, etc. Always ask the payer how it wants attachments to be submitted.

If the patient has a co-insurance amount not collected up front, bill the patient now.

If you are manually processing, obtain the provider’s signature. If fill-
ing electronically, the physician’s EDI number and password serve as signature. File a copy of the claim in the provider’s insurance files, or in the computer if using electronic claims. Log the completed claim in the insurance registry. Software will generate a claims log for you.

At this point, the life cycle of the claim starts, which is claims submission, claims processing, claims adjudication, and payment.

**Claims Adjudication**

For proper claims adjudication, the claim must contain the required information (patient information, proper coding for medical necessity, proper documentation in the patient record, etc.). The claim cannot be a duplicate or it will be rejected. Verify that payer rules and regulations have been followed and that the claim covers the services provided and documented.

**Claims Files**

Let’s backtrack to discuss claim files. Claim files should contain open claims, closed claims, and remittance advice files. Open claims are filed by month and insurance carrier. Closed claims are filed by the year and insurance carrier, after all processing and appeals have been completed. The remittance advice files are filed according to the date of service; this is due to the batch remittance advice, which may contain the results for many patients/claims at once.

**Tracking Claims**

Tracking claims diligently is key to avoiding aged claims. A medical billing professional will maintain a copy (electronic or paper) of each submitted claim, and they will review the remittance advice to make sure that the claim was paid accurately. If there is a non-payment issue, draft an appeal and resubmit the claim.

**Appealing Denials**

To reduce the amount of aged claims, it’s important to submit appeals right away. Do not hold onto them for 30, 60, or 90 days’ time. Common reasons for denials include:

- Services were deemed not medically necessary: Ensure medical necessity is documented. If not, request the physician to append the medical record with the necessary information to support the coding.
- Pre-existing condition: Under the Affordable Care Act, health insurance companies can’t refuse coverage just because of a pre-existing condition.
- Non-covered benefit: Check the patient’s benefits before treatment.
- Termination of coverage: Verify coverage prior to the encounter.
- Failure to obtain pre-authorization (when required).
- Out-of-network provider was used: Call the payer first.
- Incorrect codes: Even the best medical coders sometimes make a mistake. Learn from your mistakes to reduce the
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Medical Billing

amount of aged claims your practices has. Fix the mistake and resubmit the claim immediately.

- Claim contained incomplete information: Make sure all required information is supplied (patient information, physician information, etc.).

Collections: Steps for Success

Although it’s best to collect all coinsurance, copayments, etc., from the patient on the date of service, sometimes the patient requests to be billed.

To reduce aged claims, focus on the newest claims first. Do not ignore aged claims, but initially pursue those claims most likely to pay out for the practice. When looking over aged claims, always:

- Verify health carrier and identification cards.
- Determine the coverage for each patient to avoid denials based on “it’s not covered.”
- Check claims for errors before submitting.
- Make sure the carrier received the claim.

Submit supporting documentation requested by the payer to support the claim. To collect on a claim, call the patient within one week after the encounter, mail a copy of the invoice 10 days after the due date, mail a reminder two weeks after the invoice, and make at least one collection call to determine the reason for delinquency. If necessary, mail a collection letter. Usually two or three collection letters are mailed before taking further action. If necessary, make a few more telephone calls in an attempt to collect, or submit the claims to the office’s collection service. Taking these steps as quickly as you can reduces the need to call in an outside collection agency.

Let It Go

Bad (i.e., uncollectable) debts can usually be written off. Don’t keep trying to collect on a bad debt, which can cause you to “throw good money after bad.” In the end, it’s cheaper to let it go.

Work smart and organize your time. Aged claims and bad debt, along with fraud and abuse, are downfalls of many medical practices. Doing things right the first time will reduce the amount of aged claims in your system. If there’s too much work for one person, speak to the office manager about hiring someone to assist the medical biller or perhaps hiring a second medical biller. There is no shame in needing assistance. Providers will see the advantage of hiring additional help if it means increasing revenue.

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WANT TO WRITE?

Share Your Expertise & Write for HBM

Writing for *Healthcare Business Monthly* can be a rewarding experience.

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To make the editing process run smoothly, we ask all of our contributors* to follow a few guidelines:

- **Format** – Articles should be submitted electronically as a Word Document. We cannot publish PowerPoint presentations, but we can help you turn them into articles.
- **Length** – Articles should be between 500 to 2,000 words. If your article runs longer than 2,000 words, you may want to break it into two articles.
- **Citations or sources** – Make sure you quote anything that is not in your own words. List the source separately after the article or attribute sources in the text. You may include website URLs in your article.
- **Codes** – On the first use in your article, CPT®, ICD-10-CM, or HCPCS Level II codes must be accompanied with full code descriptions. Avoid confusing your readers by paraphrasing descriptions or using unofficial short descriptions.
- **Acronyms** – Spell out acronyms and abbreviations on first use. Not everyone is familiar with the acronyms and abbreviations unique to your specialty.
- **About you** – Include a 50-word or less biography at the end of the article and a digital photo for each author. Be warned that photos taken off the Web are usually low resolution and don’t print well, so send the original photo before it was adjusted for the Internet. Send the photo as a separate attachment from the Word Document.

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**Don’t Sweat the Small Stuff**

Don’t let your inexperience in writing stop you from sharing your experience in the business of healthcare. Our editors will help you make your article look its best. If you’re unsure about where a comma should go, or if you should use “then” or “than,” don’t worry about it — we’ve got you covered.

Send your healthcare business-related articles to John Verhovshek, CPC, at g.john.verhovshek@aapc.com or your member-related articles to Michelle Dick at michelle.dick@aapc.com.
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