

HEALTHCARE BUSINESS MONTHLY

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August 2015

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**CUT YOUR
PHYSICIANS
SOME SLACK**

Account for Dermatology Details: 18

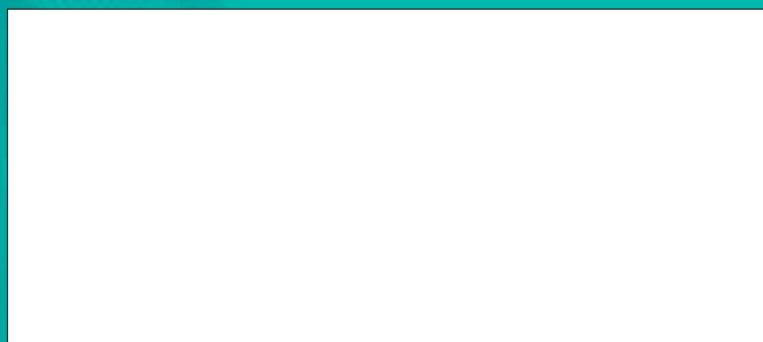
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A harmless photo may reveal an unintentional breach



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COMING UP:

- Multi-procedure Pay Reductions
- Renal System
- Women's Health
- Revenue Leaks
- Board Oversight

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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*.

Dive into ICD-10 and Make Waves

I'm deeply grateful to be a part of AAPC. In particular, I'm thankful for how far this organization has progressed, for the members who are its foundation, and for the voice we are developing in the industry. It's a pleasure serving you and I look forward to seeing as many of you as possible at the upcoming regional conferences in Dallas, Texas (August 16-18) and Chicago, Illinois (September 3-5). I'm also excited about what is happening in healthcare and the positive changes affecting our members.

Milestones Make Lasting Ripple Effects

July 30 marked the 50th anniversary of enacting amendments to the Social Security Act that established Medicare and Medicaid. These programs have transformed the delivery of our nation's healthcare system since their inception in 1965. The ripple effect began in the Department of Health, Education, and Welfare (now the U.S. Department of Health & Human Services) and continued when the Health Care Financing Administration (now the Centers for Medicare & Medicaid Services or CMS) was created to administer the programs in 1977. Today, CMS has many responsibilities, such as setting coding and billing standards, determining how much hospitals and providers are paid for services and supplies furnished to program beneficiaries, and implementing HIPAA provisions — an area in which AAPC is actively training its members.

CMS' most recent endeavor is to make the transition to ICD-10 go as smoothly as possible. CMS announced, July 6, a joint effort with the American Medical Association (AMA) to help ensure providers are ready for the October 1 implementation date.

The focus is on helping to keep revenue streams flowing and to minimize penalties while providers transition to ICD-10. For a period of one year, Medicare will not deny providers payment for unintentionally billing the wrong specificity of a valid diagno-

sis code, as long as the code is in the correct ICD-10 family. It also appears that providers won't be penalized for using unspecified codes in quality initiatives, such as the Physician Quality Reporting System, the Value Modifier, or the Medicare and Medicaid Electronic Health Record Incentive Programs. CMS will also offer leniency in the event it has difficulty calculating quality scores for these programs due to ICD-10 implementation.

AAPC wants to help ease the transition for you, as well. We remain dedicated to supplying members with expert ICD-10 instructors and educational materials to make sure you are fully prepared.

Jump in Head First

It's exciting to see increased momentum as the ICD-10 implementation date draws closer. Moreover, it's invigorating to know change, driven by both public policy and private enterprise, will continue to come in waves: from coverage and access changes associated with the Affordable Care Act, to technology penetration driven by meaningful use, to reimbursement shifts associated with value-based purchasing initiatives.

I cannot overstate how important it is to ensure you are ready for change — both the highly visible change just over the bow, as well as the less clear, but still certain, changes on the horizon. AAPC is here to help you chart a course that will successfully navigate the sea of changes and reach your full potential.

Sincerely,



Jason J. VandenAkker
CEO



CMS will also offer leniency in the event it has difficulty calculating quality scores for these programs due to ICD-10 implementation.

Resource:

CMS and AMA Announce Efforts to Help Providers Get Ready For ICD-10 Frequently Asked Questions: www.cms.gov/Medicare/Coding/ICD10/Downloads/ICD-10-guidance.pdf



Keep Moving Forward

I want to let you know how much I enjoyed reading the article “Grow as a Pro” by **Angela Clements, CPC, CEMC, COSC, CCS** (June, pages 54-55). It really made me think about my career as a coder; where I’m at and where I want to go. It gave me the nudge I needed to get busy going forward instead of just thinking about it. Thanks to you, my attitude is, “I am going to,” instead of, “Maybe I can.” Thank you.

Cindy Haugen, CPC, CCC



MAC by Separate Provider May Be Separately Reimbursed



In “Top Tips for Tiptop Anesthesia Billing” (May, pages 28-31), the author states, “You must alert the insurance company when monitored anesthesia care (MAC), rather than general anesthesia, is performed. MAC is included in the payment for the procedure.”

To clarify: Payers consider moderate sedation performed in a non-facility place of service to be included in the fee for the global procedure.

MAC administered by the provider who also performs the primary procedure is included in the payment for any procedure listed in Appendix G of the CPT® codebook. These American Medical Association coding rules are matched by code-pair edits in the National Correct Coding Initiative that bundle 99143 *Moderate sedation services (other than those services described by codes 00100-01999) provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient’s level of consciousness and physiological status; younger than 5 years of age, first 30 minutes intra-service time* and 99144 *Moderate sedation services (other than those services described by codes 00100-01999) provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient’s level of consciousness and physiological status; age 5 years or older, first 30 minutes intra-service time* to all codes listed in CPT® Appendix G “Summary of CPT Codes that Include Moderate (Conscious) Sedation.”

Also consistent with CPT® rules, the Centers for Medicare & Medicaid Services (CMS) Transmittal 1324 specifies, “In the unusual event when a second physician other than the health care professional performing the diagnostic or therapeutic services provides moderation sedation in the facility setting for the procedures listed in Appendix G,

the second physician can bill 99148 [*Moderate sedation services (other than those services described by codes 00100-01999), provided by a physician or other qualified health care professional other than the health care professional performing the diagnostic or therapeutic service that the sedation supports; younger than 5 years of age, first 30 minutes intra-service time*] to 99150 [*Moderate sedation services (other than those services described by codes 00100-01999), provided by a physician or other qualified health care professional other than the health care professional performing the diagnostic or therapeutic service that the sedation supports; each additional 15 minutes intra-service time (List separately in addition to code for primary service)*]. However, when these services

are performed by the second physician in the nonfacility setting, codes 99148 to 99150 are not to be reported.”

Note that payers require you to show medical necessity to allow payment for 99148-99150. Check with your individual payer for conditional or diagnosis requirements, as well as proper modifier use. Medicare assigns a “C” payment status to MAC codes — meaning, they are priced by individual contractors.

For additional information on MAC, as well as specific tips for coding and billing the services, check out the American College of Emergency Physicians website ([www.acep.org/Physician-Resources/Practice-Resources/Administration/Financial-Issues/-/Reimbursement/Moderate-\(Conscious\)-Sedation-FAQ/](http://www.acep.org/Physician-Resources/Practice-Resources/Administration/Financial-Issues/-/Reimbursement/Moderate-(Conscious)-Sedation-FAQ/)) and the *Healthcare Business Monthly* archives (<http://news.aapc.com/reduce-risk-of-poor-moderate-sedation-choices/>).

Turn to 72270 for Myelography at Multiple Spinal Levels

“Get a Clear Picture of Myelography Reporting” (June 2015, pages 30-31) included an incorrect code in the final example:

Provider A introduces contrast via lumbar puncture. Provider B performs RS&I [radiological supervision and interpretation] for cervical and lumbar myelogram, followed by CT of the same regions.

In this case, Provider A appropriately reports 62284 *Injection procedure for myelography and/or computed tomography, lumbar (other than C1- C2 and posterior fossa)*.

Because Provider B targeted two or more areas (cervical and lumbar), the correct myelography code is 72270 *Myelography, 2 or more regions (eg, lumbar/thoracic, cervical/thoracic, lumbar/cervical, lumbar/thoracic/cervical), radiological supervision and interpretation* — rather than 72240 *Myelography, cervical, radiological supervision and interpretation*.

As indicated in the article, Provider B may also report computed tomography following X-ray myelography, 72126 *Computed tomography, cervical spine; with contrast material* and 72129 *Computed tomography, thoracic spine; with contrast material*, each with modifier 59 *Distinct procedural service* appended.



By Sarah Wechselberger, CPC, CPB, CPMA

Chapter Mentoring Program Needs YOU!

Give your gift away and discover your purpose.



You've worked in the business side of medicine for several years, struggled to learn the correct way to do everything, spent countless hours researching guidelines, and felt helpless when the answers to your questions were nowhere to be found. Now, you finally feel like you've got this coding thing figured out. You're in the right field and you've found your "gift." It's time to give back.

One of my favorite quotes comes from David Viscott: "The purpose of life is to discover your gift. The work of life is to develop it. The meaning of life is to give your gift away."

What better way to "give your gift away" than through your local chapter's mentoring program? Not only will you help someone just starting out (either in the field or in a new specialty), but you'll quickly realize that being a mentor is a gift itself.

Attention Mentors

As a mentor, you can take great pride in knowing you are growing another member's skillset. There is truly no better feeling than to watch another person achieve his or her goals thanks to your help and encouragement.

Attention Mentees

Your mentor can assist you in getting to know other members within your chapter and familiarize you with the AAPC website and forums. The time spent learning and growing at the side of a skilled expert is irreplaceable. I encourage any member feeling overwhelmed by the challenges of starting out (or advancing) in this field to seek a mentor. Mentoring is not just for new members either; if you're an established member taking on a new certification, you may benefit from a mentor in your new field of interest. In attending local chapter meetings, you are in the perfect place to seek out a mentor.

Get with the Program

AAPC has created a chapter mentoring program to guide mentors and mentees along the way. If you are interested in mentoring, or if you are seeking a mentor, contact the member development officer of your local chapter. If your chapter doesn't have a member development officer, any officer should be able to assist you in getting the process started. Here's how it works:

- The local chapter will request that any interested parties, whether mentors or mentees, complete an interest form survey and return it to the member development officer.
- The member development officer will review the forms, match up mentors to mentees, and notify the involved parties.
- The mentor and mentee are then responsible for developing a relationship that will fulfill each other's goals and expectations.



Attention member development officers: The Chapter Mentoring Program paperwork can be found on the AAPC website under Best Practices, which is listed on the Chapter Officer Resources page.

Resources:

David Viscott "Finding Your Strength in Difficult Times: A Book of Meditations," 1993:
<http://quoteinvestigator.com/2014/06/16/purpose-gift/>

Local Chapter Handbook: www.aapc.com/documents/2015lc_handbook.pdf



Sarah Wechselberger, CPC, CPB, CPMA, is clinical coding and reimbursement coordinator at Baxter Regional Medical Center. She started her medical coding career in 2002 with a multi-physician obstetrics/gynecology practice. Wechselberger worked for a multi-specialty billing group before working at a healthcare system. She has served office for the Mountain Home, Ark., local chapter and is Region 5 representative of the 2015-2018 AAPC Chapter Association board of directors.



Focusing on Our Chapters

May MAYnia exploded with creativity and camaraderie throughout our local chapters.

More than 500 local chapters make up the backbone of AAPC. Every year these chapters celebrate May MAYnia as a fun way to provide quality education, draw in new members, and network with colleagues. Here are three chapters who made May MAYnia a memorable event and one chapter who had a spectacular half-day workshop featuring speed coding.

Phoenix, Arizona

Come one, come all! Step right up for a spectacular May MAYnia event! Carnival was the May MAYnia theme for the Phoenix, Arizona, local chapter, which offered members over-the-top education, prizes, games, and more. One of the funny, circus-themed prizes included clown noses in a jar, with a sign that said, “Pick Your Nose Here.” There was also a corn hole bean bag toss, big top character masks for fun selfies, and carnival-themed food: popcorn, hot dogs, and cotton candy.



Phoenix, Az., local chapter members pick their nose at MayMAYnia.

Clown, lion, or ring master? Choose the selfie mask that looks best at Phoenix’s MayMAYnia.



Besides all of the circus fun and games, Phoenix’s May MAYnia featured a cardiovascular presentation with Dr. Singh. A special thanks goes to vendors at 2015 HEALTHCON, for providing Phoenix with good “swag” to offer members as raffle prizes.

Watch out! The bean bags are flying in Phoenix, Az.



Warrenton, Virginia

The Warrenton, Virginia, local chapter also had a carnival theme. **Mary Gore, CPC, CEMC, COBGC**, said, “We had such a great time! Our members enjoyed winning the prizes given from AAPC and from our local chapter, as well.” The photos Warrenton captured for the event speak volumes about the camaraderie shared and the creative ways the chapter celebrated their May MAYnia carnival.

The trapeze artist and strong man stole the show at the Warrenton, Va., MayMAYnia carnival.



Warrenton, Va., donned in carnival attire.



Does anyone have scissors?

Step up to the curtain, dress silly, and take a photo.

Huntsville, Alabama

On May 12, the Rocket City Coders of Huntsville, Alabama, celebrated their May MAYnia event. The guest speaker, **Mary Bouldin, RN**, gave an enjoyable interactive presentation on “Living a Healthy Lifestyle.” Rocket City Coders President **Paula E. Elliard, CPC**, and Secretary/Treasurer **LeTisha Y. Kelly, CPC**, told *Healthcare Business Monthly* that members of Huntsville’s “Local Boys & Girls Club of America came out to observe what the chapter does — and we gave away tons of door prizes!”



◀ Rocket City Coders packed a full house for May MAYnia.



“Living a Healthy Lifestyle” for the Rocket City Coders starts with refreshing May MAYnia water.



Huntsville’s Boys & Girls Club of America gets a glimpse into a coder’s life.

Healthcare Business Monthly is spotlighting local chapters with photos and stories. If your chapter would like to be featured, please contact your AAPC Chapter Association regional representative or send your information to kudos@aapc.com. In sharing what your chapter is doing, others will benefit.

We ask for your stories to be short and your photos to be high resolution and clear. Send us highlights of what happened in your chapter recently. Spotlight your special events, coding training, special speakers, fundraising results, or honors bestowed on chapter members.

York, Pennsylvania

York, Pennsylvania, hosted a half-day workshop on April 18, with **Lashelle Bolton, COC, CPC, CPMA, CPC-I**, as the guest speaker on radiation oncology. Chapter President **Roxanne Thames, CPC, CEMC**, said, “We were not sure how well this would go over with our group as we’ve never had a speaker on radiation oncology, but it was a huge success!”

Thames said Bolton impressed members with her speaking skills, and members flocked from Philadelphia, Virginia, and Maryland to be a part of the event. During the workshop, Bolton introduced members to speed coding and awarded them with certificates and Starbucks’ gift cards.



◀ 2015 officers take a selfie with featured speaker. Front: Janaye Stewart. Left to right: Lashelle Bolton, Mary White, Roxanne Thames, Amy Walker, and Gwen Jones.

York, Pa., half-day workshop attendees are awarded certificates for speed coding.



What's New with X{EPSU}?

Append these modifiers to your memory.

Have you been using the “X{EPSU}” modifiers? The Centers for Medicare & Medicaid Services (CMS) unveiled the modifiers last summer to serve as “more selective versions of” modifier 59 *Distinct procedural service*. In case you've forgotten, here they are to refresh your memory:

- Modifier XE *Separate encounter*

Used to describe services that are separate because they take place during separate encounters;

- Modifier XS *Separate structure*

Used to describe services that are separate because they are performed on different anatomic organs, structures, or sites;

- Modifier XP *Separate practitioner*

Used to describe services that are distinct because they are performed by different practitioners; and

- Modifier XU *Unusual non-overlapping service*

Used to describe services that are distinct because they do not overlap the usual components of the main service.

In *MLN Matters* article MM8863, CMS lamented that modifier 59, “the most widely used HCPCS modifier... is associated with considerable abuse and high levels of manual audit activity; leading to reviews, appeals and even civil fraud and abuse cases.” The X{EPSU} modifiers were introduced because “CMS believes that more precise coding options coupled with increased education and selective editing is needed to reduce the errors associated with this overpayment,” and “The combination of alternative specific modifiers [i.e., the X{EPSU} modifiers] with a general, less specific modifier [e.g., modifier 59] creates additional discrimination in both reporting and editing.”

Although the X{EPSU} modifiers have been effective since January 1, 2015, CMS has continued to accept modifier 59 “in any instance in which it was correctly used prior to January 1, 2015.” In other words, Medicare hasn't yet required use of the X{EPSU} modifiers in lieu of modifier 59.

Look for Gradual Change in Use

But, that doesn't mean you should dismiss the X{EPSU} modifiers as moribund. Although CMS has said, “the rapid migration of providers to the more selective modifiers is encouraged,” its plan has always been to implement the modifiers gradually. MM8863 explains, “Additional guidance and education as to the appropriate use of the new -X {EPSU} modifiers will be forthcoming as CMS continues to introduce the modifiers in a gradual and controlled fashion.”

Just because rollout of the new modifiers has been slow, doesn't mean it isn't going to happen. CMS has already stated that “it may selectively require a more specific - X{EPSU} modifier for billing certain codes at high risk for incorrect billing.” To those familiar with CMS pronouncements, this means the agency almost certainly will require the more specific - X{EPSU} modifiers at some time in the future.

Takeaway Message

Be alert for a change, and perhaps begin working with your providers now to educate them about documenting key elements (separate anatomic structure, separate encounter, etc.). If CMS and other payers do begin to require X{EPSU} modifiers, the additional documentation detail may be necessary to get the claim paid. For example, CMS could require that a particular National Correct Coding Initiative code pair is payable only with modifier XE, the separate encounter modifier, but not with modifier 59 or other -X{EPSU} modifiers. You might even begin “practicing” with the X{EPSU} modifiers now, so you're ready for future mandates.

Resources

MLN Matters®, MM8863 (www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8863.pdf)

G.J. Verhovshek, MA, CPC, is managing editor at AAPC and a member of the Asheville-Hendersonville, North Carolina, local chapter.

Just because rollout of the new modifiers has been slow, doesn't mean it isn't going to happen.



CMS Provides Welcomed E/M Flexibility

Effective since September 10, 2013, The Centers for Medicare & Medicaid Services (CMS) allows an extended history of present illness (HPI), as defined by the 1997 Documentation Guidelines for Evaluation and Management Services, with the other elements of the 1995 guidelines. As a result, “the status of three or more chronic conditions” qualifies as an extended HPI for either the 1997 or 1995 guidelines.

CMS announced the change as a “Question and Answer” on its website:

Q Can a provider use both the 1995 and 1997 Documentation Guidelines for Evaluation and Management Services to document their choice of evaluation and management HCPCS code?

A For billing Medicare, a provider may choose either version of the documentation guidelines, not a combination of the two, to document a patient encounter. However, beginning for services performed on or after September 10, 2013 physicians may use the 1997 documentation guidelines for an extended history of present illness along with other elements from the 1995 guidelines to document an evaluation and management service.

CMS has also updated its Evaluation and Management Services Guide to reflect the new policy.

Coders should be aware of this change, and should measure evaluation and management (E/M) services against the revised guidelines. Those physicians who manage patients with multiple chronic conditions, especially, may find that the new rules allow their coding and billing to better reflect the documented level of service provided, thereby legitimately boosting E/M levels and reimbursement levels. If providers are already documenting their services well, they won't have to change their process to realize an advantage from these revised E/M guidelines.

Resources

MLN Matters®, MM8863: www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8863.pdf

FAQ on 1995 & 1997 Documentation Guidelines for Evaluation & Management Services: www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/EM-FAQ-1995-1997.pdf

Evaluation and Management Services Guide: www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/eval_mgmt_serv_guide-ICN006764.pdf

Pass the “Midpoint” Before Billing a Time-based Service

If a code describes the “first hour” of service, you must provide and document at least 31 minutes of service. Likewise, if the unit of service is 30 minutes, you must perform and document at least 16 minutes of service (and so on). If the service does not meet the minimum time required, either you may not separately report the service, or you should report another appropriate code. For instance, if you provide fewer than 30 minutes of critical care (99291 *Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes*), CPT® instructs you to report “appropriate evaluation and management codes.”

Some codes describe “24-hour services.” In most cases, you must document at least 12 hours of service to report such codes. For services lasting fewer than 12 hours, you may need to append modifier 52 *Reduced services*. Be sure to review CPT® guidelines before assigning codes or modifiers.

Remember: As a best practice, physicians providing time-based services should report the total time of service, and start and stop times.

Legislative Payment Regulations Established in MPFS Proposed Rule

The Centers for Medicare & Medicaid Services (CMS) issued a proposed rule on July 8 to establish relative value units (RVU) for 2016 for the Medicare Physician Fee Schedule (MPFS). The proposed rule also updates various payment policy and quality provisions for services furnished under the MPFS on or after January 1, 2016.

Payment and Policy Changes

CMS has been very busy. The agency identifies a long list of potentially misvalued MPFS codes and establishes proposed values for an even longer list of new, revised, and misvalued codes.

There are also critical policy changes for telehealth services, incident-to services, advance care planning services, the Physician Quality Reporting System and other incentive programs, and much more.

Stay tuned to AAPC News and *Healthcare Business Monthly* for complete assessments on individual policy changes subsequent to this report.





Billing Prolonged Services with Direct Patient Contact

image by Shutterstock.com/martapaso

Four steps lead you to proper coding and revenue capture.

Many of us struggle to bill prolonged services. Here's what you should know to be sure you aren't leaving money on the table.

CPT® defines prolonged services as, “when a physician or other qualified healthcare professional provides prolonged care involving direct patient contact that is provided beyond the usual service in either the inpatient or outpatient setting.” Direct patient contact is face to face, and includes additional, non-face-to-face services during the same session; however, Medicare will only accept prolonged services for the face-to-face time involved.

First, let's review some basic facts:

- Prolonged services with direct patient contact are reported using CPT® codes 99354-99357.
- Prolonged services are add-on codes; you must report them with their companion evaluation and management (E/M) code.
- Prolonged services are time-based codes; therefore, time must be documented. This time does not need to be continuous.
- The documentation should indicate why the visit went beyond the usual services.
- Prolonged services are only billed when the time involved exceeds the typical time of the E/M service by at least 30 minutes; therefore, services less than 30 minutes in total duration are not reported separately.

Billing for prolonged services can be a complex process, but I've narrowed it down to four steps.

STEP 1

Determine if Services Were Beyond Usual E/M

An E/M visit may go beyond the usual service because:

- The patient is noncompliant with the chosen treatment options.
- The patient has difficulty understanding the provider because of mental handicaps, physical handicaps, or language barriers.
- The provider has to explain complex treatment options, such as major surgery.
- The provider has to explain essential lifestyle changes to the patient.

STEP 2

Determine the Patient's Location

There are four codes to choose from when billing for prolonged services with direct patient contact. They are based on whether the patient is in the office/outpatient setting, or if the patient is in an inpatient/observation setting.

Report prolonged services in the office or outpatient setting with:

+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)

Report 99354 in addition to E/M codes 99201-99215, 99241-99245, 99324-99337, 99341-99350.

Time is a crucial piece to billing prolonged care. If time isn't documented, you can't bill these services.

+99355 each additional 30 minutes (List separately in addition to code for prolonged service)

Report 99355 in addition to 99354.

Report prolonged services in the inpatient or observation setting with:

+99356 Prolonged service in the inpatient or observation setting requiring unit/floor time beyond the usual service; first hour (List separately in addition to code for inpatient Evaluation and Management service)

Report 99356 in addition to E/M codes 99218-99220, 99221-99223, 99224-99226, 99231-99233, 99234-99236, 99251-99255, 99304-99310.

+99357 each additional 30 minutes (List separately in addition to code for prolonged service)

Report 99357 in addition to 99356.

STEP 3

Factor in Time

Calculating the time spent is key to billing prolonged care. Refer to **Table A** and **Table B** to determine if the typical time of the visit, as well as the actual time spent, supports billing of prolonged care.

Example 1: A new patient with cerebral palsy comes into the office to see a neurologist. The neurologist performs a comprehensive history, comprehensive exam, and moderate medical decision-making. Based on these three key components, the E/M level is 99204 *Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity*; however, due to the patient's inability to communicate with the neurologist, the visit takes 80 minutes instead of the typical 45.

Table A: Office/Outpatient Setting

Code	Typical E/M Time	Threshold Time to Bill 99354	Threshold Time to Bill 99354 & 99355	Code	Typical E/M Time	Threshold Time to Bill 99354	Threshold Time to Bill 99354 & 99355
99201	10	40	85	99326	45	75	120
99202	20	50	95	99327	60	90	135
99203	30	60	105	99328	75	105	150
99204	45	75	120	99334	15	45	90
99205	60	90	135	99335	25	55	100
99212	10	40	85	99336	40	70	115
99213	15	45	90	99337	60	90	135
99214	25	55	100	99341	20	50	95
99215	40	70	115	99342	30	60	105
99241	15	45	90	99343	45	75	120
99242	30	60	105	99344	60	90	135
99243	40	70	115	99345	75	105	150
99244	60	90	135	99347	15	45	90
99245	80	110	155	99348	25	55	100
99324	20	50	95	99349	40	70	115
99325	30	60	105	99350	60	90	135

Table B: Inpatient/Observation Setting

Code	Typical E/M Time	Threshold Time to Bill 99356	Threshold Time to Bill 99356 & 99357
99221	30	60	105
99222	50	80	125
99223	70	100	145
99231	15	45	90
99232	25	55	100
99233	35	65	110
99304	25	55	100
99305	35	65	110
99306	45	75	120
99307	10	40	85
99308	15	45	90
99309	25	55	100
99310	35	65	110
99318	30	60	105



Find 99204 in **Table A** and look to the column Threshold Time to Bill 99354. To bill prolonged care, a total of 75 minutes must have been spent. In this example, the visit was 80 minutes; therefore, the time spent supports billing a prolonged service.

If you bill the E/M service based on time, you must bill the highest-level E/M before you can factor in the prolonged service.

Example 2: A gastroenterologist informs an established patient that a lesion, biopsied a few days prior, is malignant. The provider spends 90 minutes reviewing surgical and non-surgical options with the patient. The entire visit consists of counseling and coordination of care. To bill this service based on time, the gastroenterologist would

report 99215 *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 comprehensive history; A comprehensive examination; Medical decision making of high complexity.*

Find 99215 in **Table A** and scroll to the Typical E/M Time column. The time given is 40 minutes. Because the total visit was 90 minutes, the remaining 50 minutes may be billed as prolonged care.

STEP 4 Calculate Total Duration of Prolonged Services

As the fourth and final step, you need to know which prolonged code to bill and the number of units. **Table C** illustrates the correct reporting of prolonged physician services with direct patient contact in the office/outpatient setting.

Table C: Office/Outpatient Setting

Total Duration of Prolonged Services	Code(s)
Less than 30 minutes	Not separately reported
30-74 minutes (30 minutes-1 hour 14 minutes)	99354 x 1
75-104 minutes (1 hour 15 minutes-1 hour 44 minutes)	99354 x 1 and 99355 x 1
105 minutes or more (1 hour 45 minutes or more)	99354 x 1 and 99355 x 2 (or more for each additional 30 minutes)

In **Step 3**, we determined that you could bill for prolonged services for neurology and gastroenterology patients by using a threshold chart.

If you look at **Example 1** and subtract the typical time spent (99204 = 45 minutes) from the actual time spent (Total time = 80 minutes) you get 35 minutes of prolonged service time; therefore, according to the **Table C**, you may bill 99204 and 99354 x 1.

In **Example 2**, the total time of the visit spent with the patient was 90 minutes. Per **Table C**, you would bill this visit 99215 and 99354 x 1.

Remember: Time is a crucial piece to billing prolonged care. If time isn't documented, you can't bill these services. **HBM**



Christy Jackson, CPC, CPC-I, CCVTC, is a coding educator at University Hospitals (UH) in Cleveland, Ohio. She has worked as a coder for 13 years, primarily educating new providers on the basics of E/M services and creating educational materials, such as webinars and articles, for providers and coders within the UH system. Jackson is a member of the Cleveland, Ohio, local chapter.

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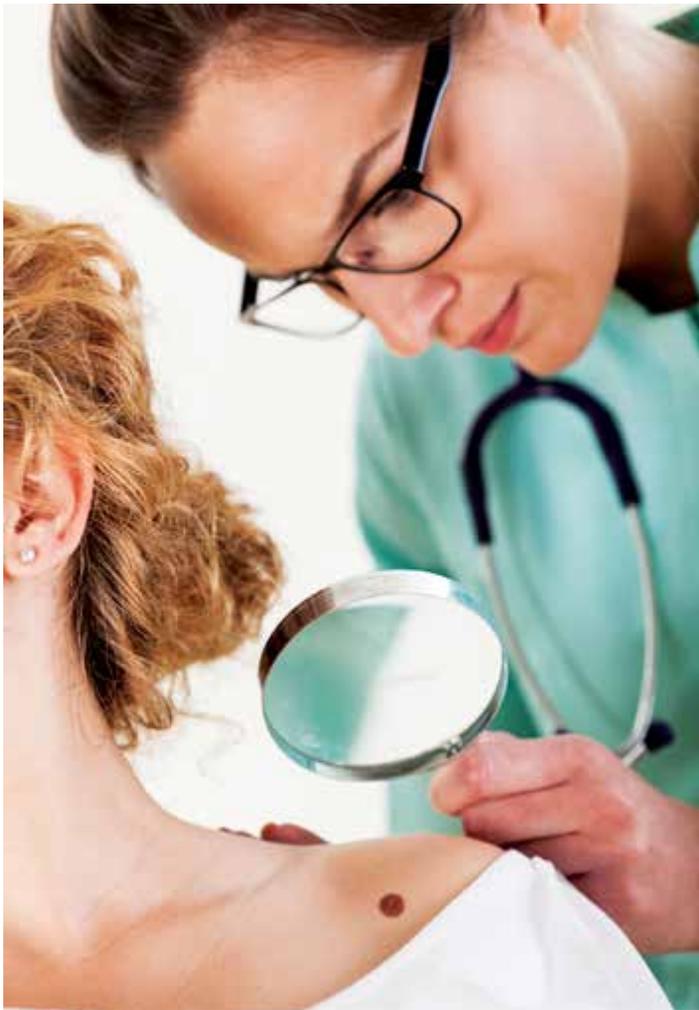
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Account for all Details in DERMATOLOGY Coding

Medical necessity hinges on several factors that must be documented.



- What is the method (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, excision)?
- What is the size and location?
- Is medical necessity established?

Let's explore these questions as they relate specifically to dermatology coding challenges.

Non-existent Shave Biopsy

Intent is crucial when records indicate “shave biopsy.” There are no codes for shave biopsies; the service is either a shave *or* a biopsy. A biopsy is included in a shave, but you can't simply code a shave. You must determine which technique was used.

Just like shaving your face, legs, etc., does not require sutures, neither does a shave in dermatology. Shaving includes a transverse or horizontal slice across the surface of the skin. A shave removes the top layer, but does not remove the root or cells below the skin's surface.

Shave documentation to look for:

- Location on the body
- Transverse/Horizontal excision
- Lesion diameter (no margins)

Biopsy documentation to look for:

- Notation of specimen sent to pathology
- Punch
- Excision without margins and without technique

Applying these principles, a 0.8 cm lesion to the right shoulder, removed via a transverse excision or shave is coded 11301 *Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 0.6 to 1.0 cm*. A 0.8 cm lesion to the right shoulder with irregular borders and color, removed for pathology, is coded 11100 *Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; single lesion*.

Excisions: The Start of Medical Accounting

Excisions require greater skill and documentation than a shave. Excisions are full thickness removal of a lesion through the dermis, to include simple closure and margins. Margins should be the narrowest size necessary to excise the lesion and to provide a safe border around the lesion; however, excisions are based on diagnosis, which

Looking back on my career of coding audits, investigations, and training bill reviewers, dermatology has always been a hot topic for payers, coders, and providers. To satisfy the documentation and coding challenges this specialty endures, dermatology providers and coders should ask themselves:

- What is the intent of the service?
- What is the diagnosis?
- What is the technique (e.g., biopsy, destruction, excision, shave, repair, etc.)?

Take caution when choosing excision codes before a pathology report confirms the diagnosis.

explains the bundling of the biopsy service and the need for margins. The location on the body remains a necessary component for accurate coding.

Take caution when choosing excision codes before a pathology report confirms the diagnosis. A diagnosis of a malignant lesion can have devastating consequences for patients. With a diagnosis of cancer, patients may be denied life insurance, have difficulty maintaining or obtaining employment, and experience depression or anger. If the diagnosis truly is cancer with a confirmation from a pathologist, did the dermatologist remove all of the cancer? Is there an appointment scheduled with an oncologist?

The procedure code and the diagnosis code should be consistent — meaning, if the diagnosis is benign, the excision CPT® code should be for a benign lesion. Do not assign a malignant lesion excision CPT® code with a benign diagnosis code (a red flag for audit).

When determining the size of the lesion diameter, no multiplication, subtraction, or division is used. Only the diameter of the lesion and the margins around the lesion determine the size for the selected code.

Example: A full-thickness, excised lesion measuring 2.6 cm x 1.5 cm, with 0.5 cm margins on both sides, located on the back, with a diagnosis of verruca vulgaris, is coded 11404 *Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 3.1 to 4.0 cm* because this is a benign lesion measuring 3.6 cm on the trunk. The size is determined by adding the widest lesion diameter (2.6 cm), plus the margins on both sides (0.5 cm + 0.5 cm).

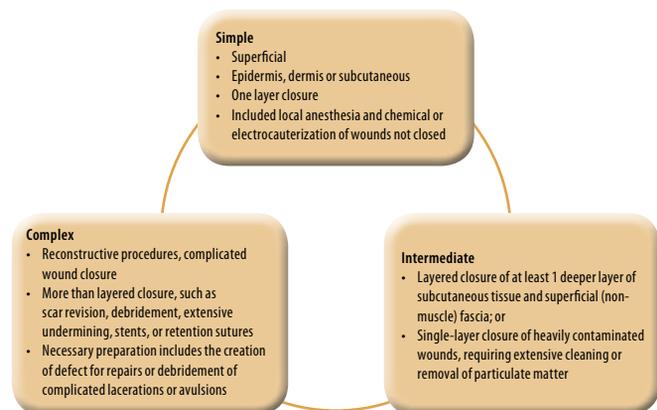
If the same lesion comes back with a diagnosis of basal cell carcinoma, the correct CPT® code is 11604 *Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter 3.1 to 4.0 cm*.

For excisions, remember:

- Location on body
- Malignant or benign diagnosis
- Malignant or benign excision code
- Lesion diameter plus margin
- Simple closure is included
- Intermediate and complex closures may be reported separately

Repairs: The Good, the Bad, and the Ugly

Repairs are classified as simple, intermediate, or complex. The depth of the repair is important when selecting the type of repair, as shown in the following chart:



When determining the type of repair, you cannot simply follow definitions. You must also apply specific rules for the repair services, including:

- Code selection is based on the size of the defect or wound. The size of the lesion is not applicable.
- Code selection requires you to know measurement in centimeters (cm).
- Shape does not matter.
- Add lengths of the wounds in the same classification and anatomical sites grouped together.
- Debridement is generally included, with exceptions:
 - Wound is not immediately closed.
 - Gross contamination requires prolonged cleansing.
 - Significant amounts of devitalized (dead) or contaminated tissue is removed.
- You may report repair of nerves, blood vessels, and tendons separately.
- Include simple ligation of vessels.
- Include simple exploration of nerves, blood vessels, or tendons unless significant dissection occurs.

Advise patients about potential costs of services they are about to receive if the services are not medically necessary.

After determining the number of wounds, identify the type of repair each wound required, based on the definitions of the repair types. All requirements must be met. For example, to support a complex repair, the wound documentation should indicate a defect or debridement of complicated lacerations, reconstructive service, and more than layered closure.

After determining the repair type, determine the location and length of each wound. To identify the appropriate repair code, combine all wound repairs of the same type and location by adding the lengths of those wounds.

Example: A patient in the emergency room with a 3 cm laceration to the forearm fell off his bike and cut himself on ground debris. The laceration is down to the bone. It is not a clean cut, and exhibits jagged edges.

The wound is thoroughly cleansed with a saline solution for better visualization of the underlying structures. Running along the neurovascular structures, which remain intact, the provider cauterizes all bleeders. Debridement of frayed tissue is done to prepare the wound for closure. The skin is revised with clean edges for repair, resulting in a 1 cm defect. The total wound size is now 4 cm.

Grafting is not necessary, but undermining of the tissue is needed to provide a healthy base for wound closure. Three-layered closure is performed. The correct code is 13121 *Repair, complex, scalp, arms, and/or legs; 2.6 cm to 7.5 cm.*

Upon examination, the patient has a smaller laceration on his flank, measuring approximately 1 cm. This is a clean laceration, penetrating through the superficial fascia. A two-layered closure is performed with vicryl and monocryl sutures. The correct code is 12031 *Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 2.5 cm or less.*

Medical Necessity

Fraud and compliance investigations in dermatology often focus on the destruction of lesions (CPT® 17000-17111); unbundling biopsies and other services with modifier 59 *Distinct procedural service*, and unbundling evaluation and management (E/M) services with modifier 25 *Significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service.* These focus areas are well known, and as documentation improves to meet coding requirements, medical necessity concerns have grown.

Unlike surgical procedures under the skin, procedures on the skin create questions about cosmetic services. Historically, skin tags have

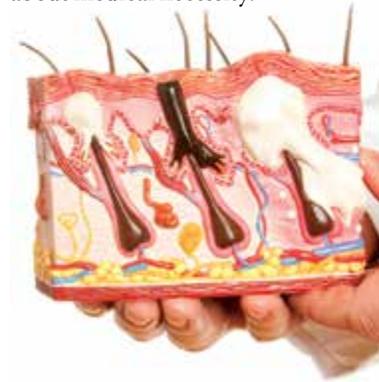
been denied for lack of medical necessity. Now, investigators, auditors, and others have started to question the necessity of procedures on benign lesions.

When evaluating for medical necessity, providers, coders, auditors, and investigators should ask:

- Where on the body is the treatment performed (e.g., visible or non-visible skin)?
- Are the lesions symptomatic and causing discomfort, pain, or reaction to the patient?
- Why do the patient and provider want to remove the lesions?
- What type of lesion is being removed (e.g., skin tag, benign, etc.)?
- Why are benign and asymptomatic lesions being treated?
- If there is no anticipated cause for concern with these lesions in the future, has medical necessity been established to remove them?

If medical necessity does not exist, the services are generally not payable by insurance. For patients who have signed an Advance Beneficiary Notice of Noncoverage (ABN), the services may be billable to the insurance, but should be reported with the appropriate modifiers (e.g., modifier GA *Waiver of liability statement issued as required by payer policy, individual case*, GY *Item or service statutorily excluded, does not meet the definition of any Medicare benefit or for non-Medicare insurers, is not a contract benefit*, or GZ *Item or service expected to be denied as not reasonable and necessary*) to indicate that services are not medically necessary.

Lesions on the face, upper chest, or other visible areas of skin may further cause concerns about medical necessity.



If the service is deemed cosmetic, the financial responsibility may be the patient's, and not the insurance carrier's. Advise patients about potential costs of services they are about to receive if the services are not medically necessary. This protects the patient's interests, and protects providers, billers, and coders from allegations of fraud and abuse.

Future of Dermatology Coding and Investigations

Scrutiny for medical necessity is increasing for all E/M services reported with excision codes, repair codes, and destruction codes.

Example: Medical necessity questions occur based on the patient's chief complaint. For instance, if the patient has a cut, is it necessary to ask, "Is there a family history of cuts?" It may be appropriate to ask, instead, if a patient has diabetes or other medical conditions that may place the patient at greater risk of infection or delay healing.

Concerning the exam, is it necessary to go beyond the vitals, skin, neurological structures, cardiovascular structures, and musculoskeletal system for lacerations or wounds that do not involve traumatic injury or chemical impairment? Other examination elements

may be necessary based on the history, but there is a difference between documenting to the code, and documenting the minimum necessary to establish a diagnosis and treatment plan.

Investigations also focus on procedures involving benign lesions. If the lesions were asymptomatic or benign, were the procedures necessary or were they performed due to the patient's desire for perfect skin? Was the procedure cosmetic or to reduce risk of skin cancer or other medical conditions based on the patient's personal, family, or social histories?

Templates also remain a focus of investigations for providers who document to fulfill a code or routinely pre-populate areas of the template. This could lead to allegations of falsifying medical necessity.



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Revisit Critical Care Reporting for Multiple Providers

Know when you may report critical care on the same date of service.

In the article “Critical Thinking for Critical Care Services” (June 2015, pages 26-28), the author advises, “Only one physician may bill for a given time of critical care, even if multiple providers simultaneously care for a critically ill or injured patient.”

This statement does not mean that only one physician may report critical care for a given date of service. Under the Centers for Medicare & Medicaid Services’ (CMS) rules, more than one physician or other qualified healthcare professional may report critical care services on the same date of service, as long as the time intervals claimed do not overlap.

Example: Two physicians provide critical care for the same patient on the same day of service. The first physician provides critical care to the patient between 12 p.m. and 1:30 p.m. The second physician provides critical care to the same patient on the same day between 6 p.m. and 7:30 p.m.

Pub. 100-04, Medicare Claims Processing Manual, chapter 12, section 30.6.12(I) confirms, “Concurrent critical care services provided by each physician must be medically necessary *and not provided during the same instance of time.*” [emphasis added]

Reporting Depends on Same or Different Provider Group

If the two physicians are unrelated (i.e., are part of different groups) and provide medically necessary critical care at different times on

the same date of service, each physician may report his or her individual service, applying time-based critical care codes 99291 *Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes* and +99292 *Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service)*, in the usual manner.

Reporting requirements change if the two providers are members of the same group practice and specialty. CMS Transmittal 2636 explains, “For the same date of service only one physician of the same specialty in the group practice may report CPT code 99291 with or without CPT code 99292, and the other physician(s) must report their critical care services with CPT code 99292.”

Per the Medicare Claims Processing Manual, “The initial critical care time, billed as CPT code 99291, must be met by a single physician or qualified NPP.” Additional critical care time, as reported using 99292, “may represent aggregate time met by a single physician or physicians in the same group practice with the same medical specialty.”

To illustrate, the Medicare Claims Processing Manual provides this example:

Drs. Smith and Jones, pulmonary specialists, share a group practice. On Tuesday Dr. Smith provides critical care services to Mrs. Benson who is comatose and has been in the intensive care unit for

4 days following a motor vehicle accident. She has multiple organ dysfunction including cerebral hematoma, flail chest and pulmonary contusion. Later on the same calendar date Dr. Jones covers for Dr. Smith and provides critical care services. Medically necessary critical care services provided at the different time periods may be reported by both Drs. Smith and Jones. Dr. Smith would report CPT code 99291 for the initial visit and Dr. Jones, as part of the same group practice would report CPT code 99292 on the same calendar date if the appropriate time requirements are met.

All services are billed as if provided by a single provider because Medicare payment policy requires physicians in the same group practice who are in the same specialty to bill and to be paid as though each were the single physician.

When Providers Might Bill Separately

If two physicians or other qualified healthcare professionals within the same group, but of different specialties, provide critical care to the patient on the same date of service, each provider *might* be able to bill separately. The Medicare Claims Processing Manual explains:

When the group physicians are providing care that is unique to his/her individual medical specialty and managing at least one of the patient's critical illness(es) or critical injury(ies) then the ini-

tial critical care service may be payable to each. ...For example, if a cardiologist and an endocrinologist are group partners and the critical care services of each are medically necessary and not duplicative, the critical care services may be reported by each regardless of their group practice relationship.

If the care provided is not unique to each specialist, however, you must combine the cumulative critical care time and report a single service. As required by the Medicare Claims Processing Manual, "... if a physician or qualified NPP within a group provides 'staff coverage' or 'follow-up' for each other after the first hour of critical care services was provided on the same calendar date by the previous group clinician (physician or qualified NPP), the subsequent visits by the 'covering' physician or qualified NPP in the group shall be billed using CPT critical care add-on code 99292."

Resources:

Pub. 100-04, Medicare Claims Processing Manual, chapter 12, section 30.6.12(l), www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS018912.html

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

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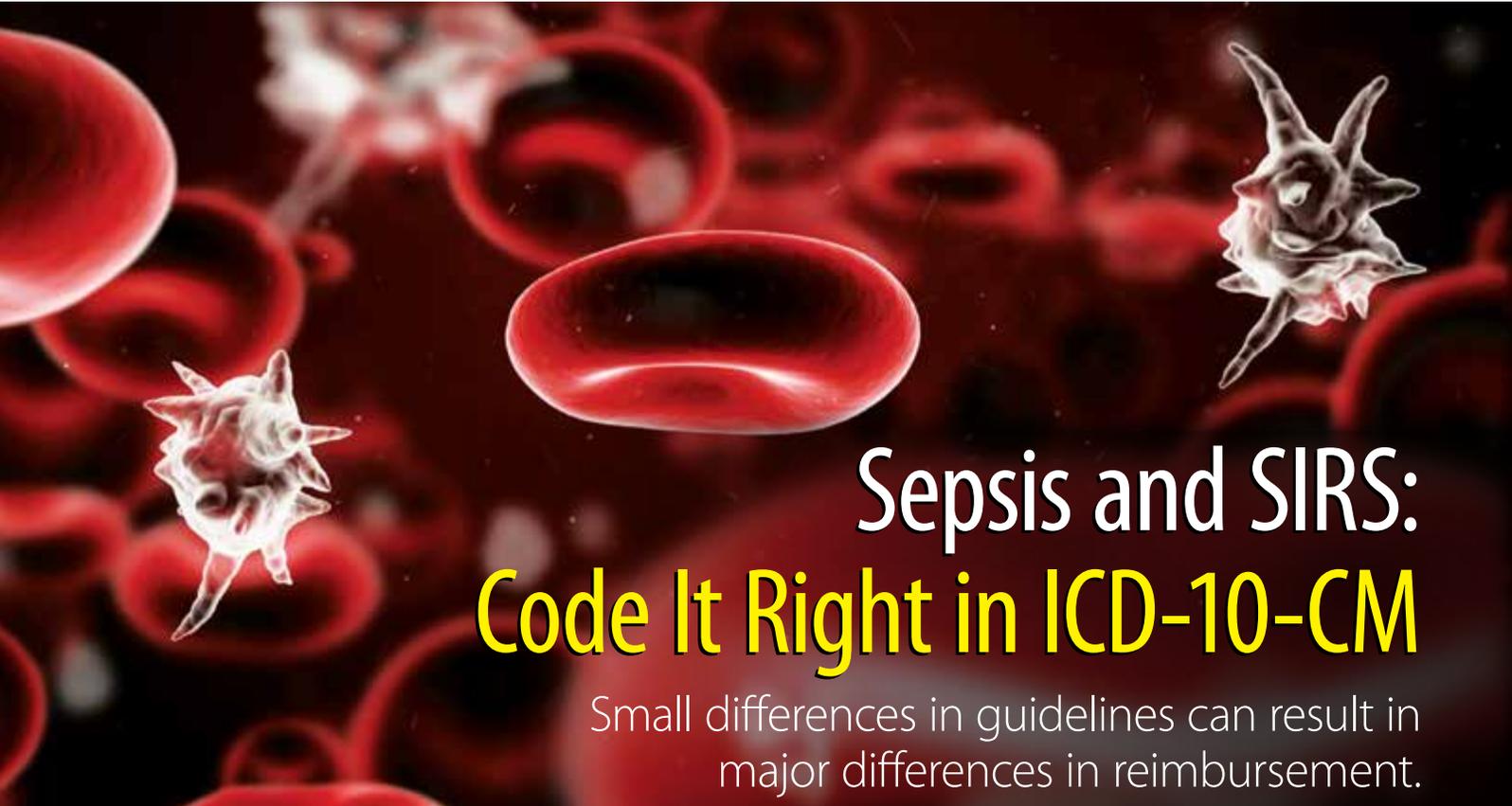
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Sepsis and SIRS: Code It Right in ICD-10-CM

Small differences in guidelines can result in major differences in reimbursement.

Sepsis, systemic inflammatory response syndrome (SIRS), and septicemia have historically been difficult to code. Much of the confusion has been due to changing terminology, evolving definitions, and guideline updates over the past 20 years. ICD-10-CM will introduce more changes to sepsis and SIRS coding.

It's critical to code sepsis properly due to the impact the diagnosis has on reimbursement. For example, consider the following case study:

A 39-year-old patient was admitted with the diagnosis of community-acquired pneumonia in the setting of presumptive influenza and concurrent sepsis. In the history and physical exam, it was documented that the patient had sepsis and SIRS, meeting the criteria of leukocytosis, fever, and tachypnea, with pneumonia as the source. The sputum culture was positive for pseudomonas pneumonia. The patient had a six-day stay. The discharge diagnoses were influenza with pneumonia bacterial superinfection, positive for pseudomonas, as well as acidosis, asthma exacerbation, hypoxemia, and chronic bronchitis.

Sepsis and SIRS were not mentioned on the discharge summary, and are mentioned only sporadically throughout the progress notes. As the documentation stands, the coding is:

Diagnostic Related Group (DRG): 194, \$5,694.01

- J11.08** Influenza due to unidentified influenza virus with specified pneumonia
- J45.901 CC** Unspecified asthma with (acute) exacerbation [complication and comorbidity]

- E87.2 CC** Acidosis
- J15.1** Pneumonia due to *Pseudomonas*
- R09.02** Hypoxemia
- J42** Unspecified chronic bronchitis

If you queried the physician regarding whether he or she agreed with the diagnosis of sepsis, and it resulted in a positive response, the chart would be coded:

DRG: 871, \$10,621.61

- A41.9** Sepsis, unspecified organism
- J11.08**
- J45.901 CC**
- E87.2 CC**
- J15.1**
- R09.02**
- J42**

The difference in reimbursement between the two scenarios is \$4,927.60 — a significant amount. The documentation of sepsis and SIRS must be solid to code a chart accurately and receive proper payment.

... if bacteremia is associated with a local infection, then the local infection is coded first, followed by the bacteremia, and then the infectious organism.

Sepsis progresses in clinical stages. The ICD-9-CM codebook defines these stages in the guidelines; the ICD-10-CM draft does not. To help you understand what is necessary for proper coding, let's review the stages of sepsis, common documentation issues, coding tips, and coding examples.

Localized Infection

Sepsis almost always begins with localized infection. The source of the systemic infection is typically pneumonia, urinary tract infection (UTI), cellulitis, or a complication of a surgery or device. When these infections are contained, they are self-limiting, but sepsis can occur when the infectious organisms enter the blood stream. For this reason, it's important that localized infections are identified and treated promptly.

Documentation issues: Often, a patient with a localized infection may exhibit tachycardia, leukocytosis, tachypnea, and fever, but not truly have SIRS or sepsis. These are typical symptoms of any infection. It's up to the physician's clinical judgment to decide whether the patient has sepsis or SIRS. You cannot assume the patient has sepsis or SIRS based on the criteria being met — you must rely on the physician's documentation.

Coding tips: Per the guidelines, if the patient is admitted with a localized infection and sepsis or severe sepsis, the code for the systemic infection should be assigned first, followed by a code for the localized infection. If the patient is admitted with a localized infection and the patient does not develop sepsis or severe sepsis until after the admission, the localized infection is coded first, followed by the appropriate codes for sepsis or severe sepsis.

Example: A patient is admitted with pneumonia and acute hypoxic respiratory failure. On day four, the patient worsens and becomes hypotensive and is diagnosed with sepsis, septic shock, and acute renal failure. On the discharge summary, pneumonia is documented as the principal diagnosis.

- J18.9** Pneumonia, unspecified organism
- J96.01** Acute respiratory failure with hypoxia
- A41.9** Sepsis, unspecified organism
- N17.9** Acute kidney failure, unspecified
- R65.21** Severe sepsis with septic shock

Bacteremia

Bacteremia is a lab finding of infectious organisms in the blood. The patient has no clinical signs of sepsis or SIRS. Bacteremia may be transient, or may lead to sepsis. When a patient's blood cultures are positive and not believed to be a contaminant, the patient is usually treated with antibiotics.

Documentation issues: The coding of bacteremia is not based on blood culture results (whether negative or positive), but on the physician's documentation of the condition. If the patient has bacteremia with sepsis, the alphabetic index directs you to "see sepsis." When both bacteremia and sepsis are documented, code only sepsis. If different physicians document bacteremia and sepsis, and the documentation conflicts, query the attending physician.

Coding tips: According to *AHA Coding Clinic*[™], second quarter 2011, if bacteremia is associated with a local infection, the local infection is coded first, followed by the bacteremia, and then the infectious organism.

Example: A 79-year-old patient is admitted with dizziness and fever. A urine sample is collected on admission and is positive for Klebsiella. The blood sample taken on admission is also positive for Klebsiella. The doctor lists: UTI due to Klebsiella, bacteremia due to Klebsiella.

- N39.0** Urinary tract infection, site not specified
- R78.81** Bacteremia
- B96.1** *Klebsiella pneumoniae* [*K. pneumoniae*], as the cause of diseases classified elsewhere

Septicemia

Septicemia is a systemic disease associated with the presence and persistence of pathogenic micro-organisms or their toxins in the blood. Whereas the patient with bacteremia was not symptomatic, the infectious organisms of septicemia cause symptoms. This is not a transient lab finding: The condition warrants inpatient admission with antibiotics and supportive treatment.

Documentation issues: Septicemia is rarely a term physicians document, and to reflect this shift in terminology, the term "septicemia" in ICD-10-CM's alphabetic index refers you to "sepsis." Various causative organisms and septic conditions are listed under the entry.

Example: A 39-year-old woman is admitted with high fever, malaise, and myalgias. Blood cultures and urine cultures taken on ad-

If the physician specifies a causal organism, such as “sepsis due to E. Coli,” “sepsis with blood cultures positive for E. Coli,” or “E. Coli sepsis,” use the code for sepsis naming the specific organism.

mission are positive for E. coli. The patient is diagnosed with septicemia and UTI due to E. coli.

A41.51 Sepsis due to *Escherichia coli* [E. coli]

N39.0

SIRS

SIRS is the body’s clinical cascading response to infection or trauma that triggers an acute inflammatory reaction and progresses to coagulation of the blood, impaired fibrinolysis, and organ failure. SIRS is manifested by two or more of the following symptoms: fever, tachycardia, tachypnea, leukocytosis, or leukopenia.

Documentation issues: When SIRS is documented on the chart, determine if it’s due to an infectious or non-infectious cause. SIRS due to a localized infection can no longer be coded as sepsis in ICD-10-CM. If “SIRS due to pneumonia” is documented, the term “sepsis” must also be documented to code a systemic infection. This is a major change from ICD-9-CM. If the term “sepsis” is not documented with “SIRS” when it’s due to a localized infection, you must ask for clarification from the physician.

Coding tips: In the alphabetic index under “Syndrome, systemic inflammatory response,” you are led only to the non-infectious SIRS (R65.10 *Systemic inflammatory response syndrome (SIRS) of non-infectious origin without acute organ dysfunction and R65.11 Systemic inflammatory response syndrome (SIRS) of non-infectious origin with acute organ dysfunction*). The guidelines in chapter 1 no longer make reference to SIRS with sepsis and severe sepsis. Guidelines pertaining to SIRS are now found in chapter 18.

Non-infectious causes are the result of trauma, burns, pancreatitis, drug reaction, etc. When SIRS is due to a non-infectious cause, the non-infectious process is coded first, followed by R65.10 — or, if organ dysfunction is present, R65.11.

SIRS Criteria Table

Temperature > 38° C or < 36° C (> 100.4° or < 96.8° F)

Heart rate > 90 beats/min

Respiratory rate > 20 breaths/min

WBC > 12,000 cell/mm³ or < 4,000 cells/mm³

Example: A 27-year-old patient is admitted with fever, tachypnea, and a high lipase level. The patient is diagnosed with SIRS due to pancreatitis.

K85.9 Acute pancreatitis, unspecified

R65.10

Sepsis

Sepsis is a systemic inflammatory response due to an infection. It’s not necessary for blood cultures to be positive to code sepsis.

Documentation issues: You can code for sepsis when the physician documents the term “sepsis.” Documentation should be consistent throughout the chart. Occasionally, during an extended length of stay, sepsis may resolve quickly and the discharging doctor may not include the diagnosis of sepsis on the discharge summary. In these cases, it may be appropriate to ask the physician whether he or she agrees if the patient had sepsis.

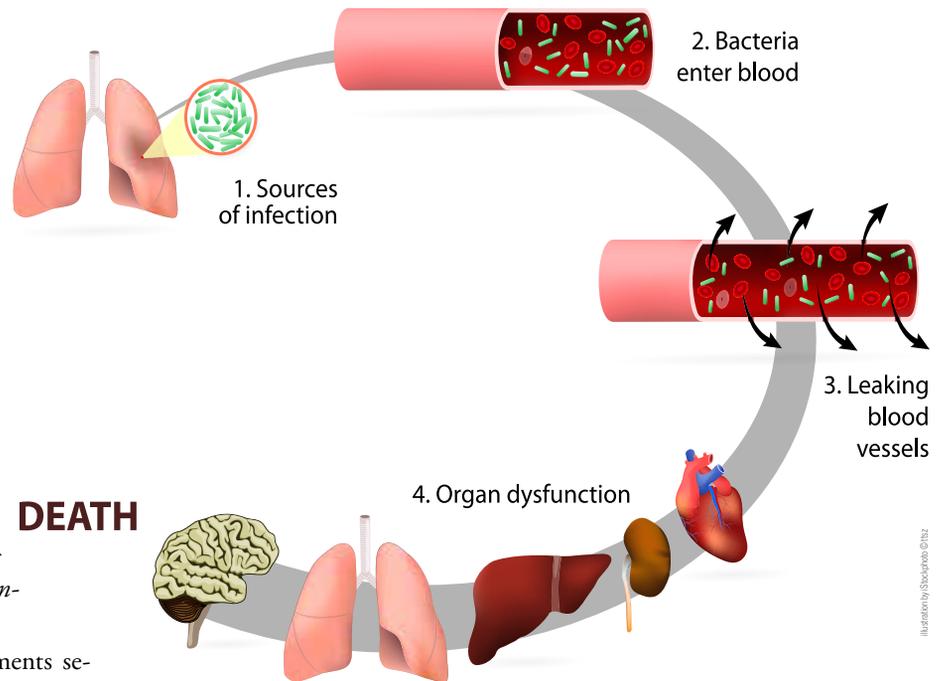
When the patient has clinical evidence of sepsis, a negative or inconclusive blood culture does not preclude or rule out sepsis. When the patient has clinical indicators for sepsis, question the provider, even when blood cultures are negative.

Coding tips: In ICD-10-CM, only one code is needed to report sepsis without organ dysfunction. Most sepsis codes can be found in A40.- through A41.9. If the physician specifies a causal organism, such as “sepsis due to E. Coli,” “sepsis with blood cultures positive for E. Coli,” or “E. Coli sepsis,” use the code for sepsis naming the specific organism.

The category A40.- through A41.9 is for sepsis due to bacteria or unspecified bacteria. Fungi, candida, or viruses also may cause sepsis. It’s important to use the alphabetic index to select the appropriate code for the systemic infection. For example, if a patient is diagnosed with candidal sepsis due to a candida UTI, report B37.7 *Candidal sepsis* as the principal diagnosis and B37.49 *Other urogenital candidiasis* as the secondary diagnosis. A code from A40.- through A41.9 is not selected because candida is not a bacterial infection.

Example: A 45-year-old woman presents with severe stomachache, fever, vomiting, and bloating. On a computed tomography (CT) scan, a perforated bowel with abscess is discovered. The patient has sepsis with peritoneal abscess as the source. The peritoneal fluid and blood cultures are positive for enterococcus (group D strep).

Sepsis



A41.81 Sepsis due to enterococcus

K65.1 Peritoneal abscess

K63.1 Perforation of intestine (nontraumatic)

Severe Sepsis

Severe sepsis is sepsis with acute organ dysfunction or multi-organ dysfunction. The organ dysfunctions commonly associated with severe sepsis are listed under R65.- *Symptoms and signs specifically associated with systemic inflammation and infection* in ICD-10-CM.

Documentation issues: If the doctor documents severe sepsis, sepsis with evidence of organ dysfunction, or severe sepsis with elevated lactate but does not specifically name the organ dysfunction, do not code severe sepsis. It's appropriate to query the physician regarding which organ dysfunction occurred during the admission. You should be able to identify the clinical signs and symptoms of organ dysfunction, and ask the physician about organ dysfunction if it's not documented.

Occasionally organ dysfunctions such as acute renal failure or acute respiratory failure are documented, but may not be documented as "due to" the sepsis; in which case, severe sepsis cannot be coded. For instance, if severe sepsis, pneumonia, and acute renal failure due to dehydration are documented, the code for severe sepsis may not be assigned because the acute renal failure is not stated as due to or associated with sepsis. If the documentation is unclear, query the physician. "Multi-organ dysfunction" is not coded. The patient may have many concurrent organ dysfunctions, but they must be specifically named to code them.

Coding tips: When severe sepsis is documented, there will be a minimum of two codes when using ICD-10-CM: a code for the underlying systemic infection, followed by a code for *Severe sepsis*, R65.2-. If organ dysfunction other than septic shock is present, the codes for the specific organ dysfunction are added.

Note that under R65.2, "Systemic inflammatory response syndrome due to infectious process with acute organ dysfunction" is also listed as an inclusion term. This, however, cannot be indexed under "syndrome, systemic inflammatory response," and clarification regarding this entry will be necessary.

Example: A 90-year-old patient is admitted with sepsis meeting criteria with tachypnea and tachycardia. The source is determined to be aspiration pneumonia. The patient develops acute hypoxic respiratory failure and acute renal failure related to the sepsis.

A41.9 Sepsis, unspecified organism

R65.20 Severe sepsis without septic shock

J69.0 Pneumonitis due to inhalation of food and vomit

J96.01 Acute respiratory failure with hypoxia

N17.9

Septic Shock

Septic shock generally refers to circulatory failure associated with severe sepsis, usually manifested by hypotension. Septic shock is a form of organ failure.

Documentation issues: The term "septic shock" is occasionally documented without the term "sepsis." According to the guidelines, for all cases of septic shock the code for the underlying systemic infection is sequenced first, followed by R65.21 *Severe sepsis with septic shock* or T81.12- *Postprocedural septic shock*. Additional codes for other acute organ dysfunctions should be coded, as well. The code for septic shock can never be assigned as principal diagnosis.

Coding tips: Septic shock does not have a separate code in ICD-10-CM, as it does in ICD-9-CM. Septic shock is combined into code R65.21.

Septic shock does not have a separate code in ICD-10-CM as it does in ICD-9-CM. Septic shock is combined into code R65.21.

Example: A patient is admitted with cellulitis and abscess of the left leg, severe sepsis, septic shock, and acute renal failure and encephalopathy due to the sepsis.

A41.9

R65.21

L03.116 Cellulitis of left lower limb

L02.416 Cutaneous abscess of left lower limb

N17.9

G93.41 Metabolic encephalopathy

Post-procedural Sepsis and Sepsis Due to a Device, Implant, or Graft

A systemic infection can occur as a complication of a procedure or due to a device, implant, or graft. This includes systemic infections due to wound infection, infusions, transfusions, therapeutic injections, implanted devices, and transplants.

Documentation issues: The physician must document the relationship between the infection and the procedure. If the documentation isn't clear, query the physician. An example of when clarification is necessary is if "sepsis due to complicated UTI" is documented on it. In this statement, it's unclear as to what is complicating the

UTI: could be the patient's medical condition or it could be an indwelling Foley catheter. The cause of sepsis must be accurately captured because when a complication code is sequenced first, the case will no longer fall into a sepsis Medicare Severity-Diagnostic Related Group and reimbursement will be affected.

Coding tips: When sepsis is due to a complication of a procedure, the complication code will be sequenced first, followed by the code for the specific infection. If the patient has severe sepsis, add R65.2- with the codes for specific organ dysfunctions. If the specific causative organism is known, the code for the infectious agent can be added.

Obstetrical Sepsis

When sepsis and septic shock are complicating abortion, pregnancy, childbirth, and the puerperium, the obstetrical code is sequenced first, followed by a code for the specific type of infection. If the patient has severe sepsis, add R65.2- with the codes for specific organ dysfunctions. If the specific causative organism is known, add the code for the infectious agent. According to the guidelines for puerperal sepsis, a code from category A41 *Other sepsis* should not be added.

Newborn Sepsis

When a newborn is diagnosed with sepsis, assign a code from category P36 *Bacterial sepsis of newborn*. If the sepsis isn't documented as congenital or community acquired, the default is congenital; assign a code from P36. Codes from category P36 include the organism; an additional code for the infectious organism is not assigned. If the P36 code does not describe the specific organism, an additional code for the organism can be assigned.

Urosepsis

The term "urosepsis" is not coded in ICD-10-CM. When urosepsis is documented, you must query the physician.

Sepsis Syndrome

Sepsis syndrome also cannot be coded in ICD-10-CM. You must query the physician when the term "sepsis syndrome" is documented as a final diagnosis.



Know when to Query

Sepsis is a complicated condition to code, and it is often necessary to query the physician to code the case correctly. The guidelines for sepsis refer to querying five times, demonstrating the complexity of these cases and the need to ask for clarification. Query the physician:

- When the documentation is conflicting, imprecise, incomplete, illegible, ambiguous, or inconsistent.
- When clinical indicators are present without a definitive diagnosis.
- When diagnostic evaluation or treatment was performed without a related diagnosis.
- When a diagnosis is given without clinical validation.
- When the term “urosepsis” is used.
- When the term “sepsis syndrome” is used.
- When severe sepsis is documented without specific organ dysfunctions named.
- When organ dysfunctions are not documented as due to sepsis.

- When it is unclear whether sepsis was present on admission.
- When it is unclear if sepsis is related to a device or to the local infection.

Remember: The current version of ICD-10-CM is a draft. Revisions may still be made when it's implemented on October 1. Small differences in the guidelines have the potential to result in major changes in principal diagnosis selection and reimbursement. A careful comparison of ICD-9-CM and ICD-10-CM is necessary to correctly code in the new system.

Resources

AHA Coding Clinic™, second quarter 2011, pages 7-8
2016 release of ICD-10-CM, www.cdc.gov/nchs/icd/icd10cm.htm#icd2016

Jill Kulanko, RHIA, CPC, CIC, COC, CPC-I, CCS, is an educator for her company My Coding Mentor, where she teaches AAPC PMCC curriculum and a variety of other coding-related courses. She is also the owner of Advanced Coding Solutions, Inc., where she has worked as an independent contract coder in the Denver Metro area for more than 20 years in both inpatient and outpatient facility coding. Kulanko is a member of the Denver, Colo., local chapter.



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Let Me Be Direct About Physician Supervision Requirements

Besides having patients' lives in their hands, clinicians must observe loads of rules and requirements.



When it comes to directing the care of services performed by clinical staff (e.g., qualified healthcare professionals, ancillary staff, technicians, residents, fellows), it's important to understand the levels of physician or non-physician practitioner (NPP) supervision required to satisfy billing and regulatory requirements.

You have to feel somewhat sorry for physicians, particularly those who work in large healthcare delivery systems where innumerable professionals participate in patient care. Some locations in which physicians practice are provider-based settings (i.e., facility), while others are physician-based, and the patient's payer class isn't necessarily broadcast with a flashing light. If you do not understand why it's so difficult for physicians to grasp the supervision rules governing billing services, try walking a mile in their paper-booty covered shoes.

To understand the required level of physician supervision for billing, physicians must know whose definition applies, who is being supervised, what is being supervised, and where the service is being supervised. There are varying degrees of physician supervision dictated by Medicare Parts A, B, and C, as well as state Medicaid fiscal intermediaries (whose definition may be regulated by state law), state regulations governing licensing of certain professions (e.g., Board of Medicine or Board of Nursing), and even the Accreditation Council for Graduate Medical Education (ACGME). Throw in some private payers who may have their own requirements for physician supervision, and perhaps you'll start to understand why physicians don't always get this stuff right.

Medicare

Professional Billing of Diagnostic Services

With limited exceptions, diagnostic X-rays and other diagnostic tests covered under the Medicare Physician Fee Schedule (MPFS) must be provided under some level of physician supervision, or the services will not be considered reasonable and necessary. The level of physician supervision for diagnostic tests varies based on the complexity of the service. For most of these services, three levels of physician supervision are applicable: general, direct, and personal (42 CFR 410.32).

General supervision means the service is furnished under the physician's overall direction and control, but the physician's presence is not required during the performance of the procedure. Under general supervision, the training of the non-physician personnel who actually perform the diagnostic procedure and maintain the necessary equipment and supplies, is the physician's continuing responsibility.

Direct supervision in the *office* setting means the physician must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the service; however, the physician does not need to be in the room when the service is performed.

Direct supervision is defined from the perspective of the *office* setting; therefore, you must determine whether the service in question is provided in an office setting (non-facility) or a facility setting. Direct supervision in an outpatient hospital setting is defined differently.

Personal supervision means a physician must be in attendance in the room during the performance of the procedure.

Medicare regulations also state that diagnostic X-rays and other diagnostic tests must be furnished under the appropriate level of supervision by a *physician*, and may not be supervised by NPPs; however, certain exceptions are afforded for some diagnostic tests furnished by some NPPs. In a nutshell, this means physician assistants (PAs), nurse practitioners (NPs), clinical nurse specialists, and certified

nurse midwives may not supervise other staff in the performance of a diagnostic test; but when these same NPPs perform the tests themselves, the only level of physician supervision needed is that which is required for all services performed by that specific NPP. For example, NPs must work in collaboration with a physician, and PAs must practice under the general supervision of a physician.

Medicare Part B Incident-to Billing

Coverage of services and supplies incident-to the professional services of a physician are limited to situations in which there is direct physician supervision of auxiliary personnel. Again, direct supervision in the office setting does not mean the physician must be in the same room with his or her aide; however, the physician must be in the office suite and immediately available to provide assistance and direction throughout the time the aide performs services. This concept also applies to NPPs who are supervising auxiliary personnel. The definition of "direct supervision" for incident-to billing mirrors that of professional billing for diagnostic services.

Outpatient Facility Billing

Under the Outpatient Prospective Payment System (OPPS), the level of supervision, who may supervise, and the proximity of the supervising party to the location where the service is performed varies, based on whether the service is diagnostic, therapeutic, or falls under the category of nonsurgical extended duration therapeutic services (NSEDTS).

Diagnostic Services

For diagnostic services furnished in an on-campus or off-campus outpatient department of the hospital, "direct supervision" means the *supervisory practitioner* must be immediately available to furnish assistance and direction throughout the performance of the procedure. The *supervisory practitioner* is not required to be present in the room where the procedure is being performed, or within any other physical boundary, as long as he or she is immediately available. The *supervisory practitioner* may be present in locations, such as physician

To understand the required level of physician supervision for billing, they must know whose definition applies, who is being supervised, what is being supervised, and where the service is being supervised.

offices that are close to the hospital, or the provider-based department of a hospital where the services are furnished but are not located in actual hospital space, as long as the supervisory physician remains immediately available.

Immediate availability requires immediate physical presence of the supervisory physician. The Centers for Medicare & Medicaid Services (CMS) has not specifically defined the word “immediate” in terms of time or distance; however, an example of lacking immediate availability would be situations where the supervisory physician is performing another procedure or service that he or she could not interrupt. Also, for services furnished on-campus, the supervisory physician may not be so physically distant from the location where hospital outpatient services are furnished that he or she could not intervene right away. The hospital or supervisory physician must judge the supervisory physician’s relative location to ensure he or she is immediately available.

Therapeutic Services

Physicians, clinical psychologists, licensed clinical social workers, PAs, NPs, clinical nurse specialists, and certified nurse midwives may furnish the required supervision of hospital outpatient therapeutic services in accordance with state law and all additional rules governing the provision of their services. Medicare requires direct supervision of all hospital outpatient therapeutic services unless CMS makes an assignment of either general or personal supervision for an individual service. For these services, direct supervision means the immedi-

ate availability to furnish assistance and direction throughout the performance of the procedure. General and personal supervision were already defined under “Professional Billing of Diagnostic Services.” For pulmonary rehabilitation, cardiac rehabilitation, and intensive cardiac rehabilitation services, direct supervision must be furnished by a doctor of medicine or a doctor of osteopathy.

NSEDTS

There is a hybrid level of supervision for certain services described as NSEDTS, which are hospital or critical access hospital outpatient therapeutic services that:

- Can last a significant time;
- Have a substantial monitoring component typically performed by auxiliary personnel;
- Have a low risk of requiring the supervisory practitioner’s immediate availability to furnish assistance and direction after the initiation of the service; and
- Are not primarily surgical in nature.

In the provision of these services, CMS requires a minimum of direct supervision during the initiation of the service, which may be followed by general supervision for the remainder of the service at the discretion of the supervisory practitioner. *Initiation* is the beginning portion of the NSEDTS that ends when the patient is stable and the supervising physician or appropriate NPP determines the remainder of the service can be delivered safely under general supervision.

For these services, direct supervision is the immediate availability to furnish assistance and direction throughout the performance of the procedure. General supervision means the service is performed under the supervisory practitioner’s overall direction and control, but his or her presence is not required during the performance of the procedure.

The list of services that may be furnished under general supervision or that are defined as non-surgical extended duration therapeutic services is available on the CMS website.

ACGME

The ACGME Program Requirements for Graduate Medical Education in General Surgery states that the



... the definition of direct supervision as it applies to the supervision of diagnostic tests billed under the MPFS differs greatly from ACGME's definition.

residency program must use the following classifications of supervision to ensure oversight of resident supervision and graded authority and responsibility:

- Direct Supervision - the supervising physician is physically present with the resident and patient.
- Indirect Supervision:
 - with direct supervision immediately available – the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide direct supervision.
 - with direct supervision available – the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide direct supervision.
- Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

As you can see, the definition of direct supervision as it applies to the supervision of diagnostic tests billed under the MPFS differs greatly from ACGME's definition, which is more in line with Medicare's definition of personal supervision. ACGME also includes terms that Medicare does not recognize. In part, the ACGME definition for indirect supervision (i.e., with direct supervision immediately available) looks very similar to Medicare's definition for direct supervision — at least as far as the physician office is considered.

Residents and fellows are afforded progressive responsibility commensurate to their level of training. The level of teaching physician supervision is based on the resident or fellow's competence and experience, as well as ACGME residency program guidelines.

The level of teaching physician supervision and participation (and documentation) needed to support compliant billing may be more stringent than the levels described in ACGME residency program protocols, regardless of the resident or fellow's experience or demonstrated competence.

State Medicaid Programs

Each state's Medicaid program may establish the level of physician supervision required for certain services. For example, in the Flori-

da Medicaid Practitioner Services Coverage and Limitations Handbook, personal supervision is required to bill services performed by a PA or advanced registered nurse practitioner under the physician's provider number. The Florida Administrative Code, 59G-1.010 (276) defines direct supervision as "face-to-face supervision during the time the services are being furnished," while personal supervision is defined as services furnished "while the supervising practitioner is in the building ..." As such, Florida's definition of personal supervision is more in line with Medicare's definition of direct supervision.

Staying on top of these various levels of supervision may not be rocket science, but cut your physicians some slack. In addition to keeping up with all of these billing and regulatory requirements, they have another very important job to perform: Taking care of patients. **HBM**

Resources

42 CFR 410.32: www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/downloads/410_32.pdf

CMS OPPS web page: <http://cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html>

ACGME Program Requirements for Graduate Medical Education in General Surgery (VI.D.3.a, VI.D.3.b (1-2), VI.D.3.c): www.acgme.org/acgmeweb/portals/0/pfassets/programrequirements/440_general_surgery_07012014.pdf

Florida Medicaid Practitioner Services Coverage and Limitations Handbook: http://portal.fimmis.com/FLPublic/Portals/0/StaticContent/Public/HANDBOOKS/Practitioner%20Services%20Handbook_Adoption.pdf

The Florida Administrative Code & Florida Administrative Register, FAC 59G-1.010 (276): www.flrules.org/gateway/ruleno.asp?id=59G-1.010



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Have a Coding Quandary? Ask John

Psychiatric Medication Management

Q Which evaluation and management (E/M) codes should be billed for patients seen in either a free-standing post-acute brain injury rehabilitation facility or a free-standing residential brain injury rehabilitation facility? The physician would be visiting the patient for psychiatric medication management.

—California Physician

A In years past, CPT® included a code for medication management (90862), but that code is no longer active. CPT® instead includes an add-on code for “pharmacologic management” when performed with psychotherapy services (+90863 *Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services (List separately in addition to the code for primary procedure)*); however, that code doesn’t fit in this case because psychotherapy is not performed.

For the medication management described, the best choice is the standard E/M codes for a new or established patient. In the outpatient setting, the codes are 99201-99215.

The American Psychiatric Association (APA) advises, in its “Frequently Asked Questions: 2013 CPT Coding Changes:”

Question: *In my outpatient practice I often see patients for medication management and previously used CPT® code 90862, which was deleted for 2013. What code will I use in place of 90862?*

Answer: The typical outpatient 90862 is most similar to E/M code 99213. If the patient you are seeing is stable, and really just needs a prescription refill, code 99212 might be a more appropriate crosswalk. If you have a patient with a very complex situation, you might need to use 99214, a higher level E/M code. The E/M codes have documentation guidelines published by the Centers for Medicare and Medicaid Services



es (CMS) that explain how to determine which level code to choose. There is a link to this information at <http://psychiatry.org/cptcodingchanges>.

The APA further advises in “Changes to Psychiatry CPT Codes” that to determine the E/M service level, “The 1997 [E/M documentation] guidelines are the most appropriate ones for psychiatrists to use since they include a single-system psychiatric exam.” **HBM**

Resources

American Psychiatric Association, “Frequently Asked Questions: 2013 CPT Coding Changes,” www.psychiatry.org; and “Changes to Psychiatry CPT Codes,” www.psychiatry.org/practice/managing-a-practice/coding--reimbursement/changes-to-psychiatry-cpt-codes



In a Coding Quandary? Ask John

If you have a coding-related question for AAPC’s *Healthcare Business Monthly*, please contact John Verhovshek, managing editor, at g.john.verhovshek@aapc.com.

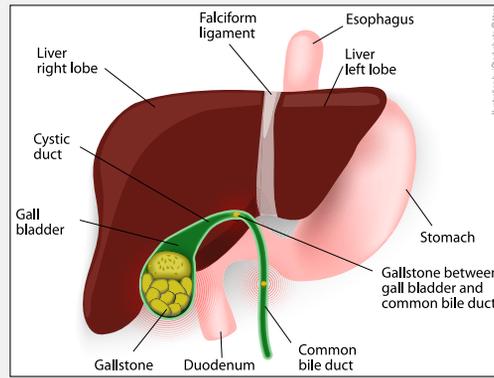


By Rhonda Buckholtz, CPC, CPMA, CPC-I, CENTC, CGSC, COBGC, CPEDC

Gallstone Ileus

Gallstone ileus accounts for only 1-4 percent of all mechanical small bowel obstructions, but increases to 25 percent for patients over 65 years. The common locations for stones are in the distal ileum, followed by the jejunum and gastric outlet.

The clinical course is often subacute and indistinct, with progressive worsening. The initial treatment of gallstone ileus begins with stabilization, correction of electrolyte abnormalities, and surgical exploration. The primary goal is to relieve the obstruction. A decision to perform a cholecystectomy concurrently and a fistula closure is controversial because it leads to increase in operative time and the risk of morbidity and mortality. More often, because gallstone



ileus occurs most commonly in older, debilitated patients, the length and complexity of the procedure is minimized. In case of recurrence, the fistula closure may be considered along with a cholecystectomy.

Patients presenting with bowel obstruction have many differential diagnoses to consider. The initial workup is directed toward narrowing the lists of potential diagnoses. Lab work and X-rays can help narrow diagnostic options.



Rhonda Buckholtz, CPC, CPMA, CPC-I, CENTC, CGSC, COBGC, CPEDC, is vice president of ICD-10 Training and Education at AAPC.



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Understand Risk Adjustment Basics

Good documentation is the foundation of capturing the provider's work and the patient's condition.



Risk adjustment is a predictive model introduced by the Affordable Care Act. It gauges the risk a healthcare plan member will incur medical expenses above or below an average, over a defined time. Risk adjustment assists in financial forecasting of future medical need. The more severe or complex a diagnosis, the higher the risk value assigned. The concept was introduced to minimize the incentive to choose enrollees based on their health status; and to encourage competition among health plans based on quality, efficiency, and premium stabilization.

Model Relies on Thorough Documentation

A risk adjustment value is assigned to each diagnosis code that falls into the payment model. The ICD-9-CM codes are then grouped into a hierarchical condition category (HCC). HCC categories are related both clinically and financially. Unlike hospital diagnosis-related groups (DRGs), HCCs are cumulative: Each additional HCC in an unrelated disease category is factored into the risk profile.

Hospital and physician claims are the main source of data that drives the risk adjustment model. Accuracy and specificity in ICD-9-CM coding and medical documentation is critical for risk adjustment. ICD-9-CM diagnosis coding is used to represent the member's health status and establish an accurate risk score. As in all coding, ICD-9-CM diagnoses cannot be inferred from physician orders, nurse notes, or lab or diagnostic tests — they need to come from the medical record documentation.

If medical documentation lacks the accuracy and specificity needed to assign the most appropriate diagnosis code, providers face the possibility of reduced payment in a performance-based payment model. There is also missed opportunity for patients to be identified for care management programs or disease intervention programs.

Dodge ICD-9 Pitfalls

As you examine your ICD-9-CM coding documentation, here are some common pitfalls to avoid:

- **Coding from a superbill.** A superbill simply does not allow a provider to see all the diagnosis options available to him or her. It is usually a limited, generic list of unspecified codes.
- **Coding from a problem list.** Make sure all problems listed as active are appropriate and haven't been brought forward (copied and pasted) in error.
- **Coding only the primary diagnosis code.** Diagnosis codes are not limited to what brought the patient to the office today. Any condition the provider monitors, evaluates, assesses, or treats should be included in the documentation.
- **Coding generic or unspecified codes.** Code to the level of specificity known for that encounter. This will be even more important when ICD-10 is implemented.

Hospital and physician claims are the main source of data that drives the risk adjustment model.

- **Using rule out diagnosis codes.** The rule of thumb is to code what you know at the time of the encounter. If a definitive diagnosis has not been established, code the signs or symptoms that brought the patient to the office today.
- **Coding “history of” as current.** Anything that is listed as “repaired” or “resolved” should not be coded as current. Providers should be made aware of V codes that are appropriate for these scenarios.
- **Not linking manifestations and complications.** Do not assume there is a connection with conditions listed in the medical record — the provider needs to make the link. Some terms that can be used to link conditions are “because of,” “related to,” “due to,” or “associated with.”
- **Overlooking chronic conditions.** Chronic and/or permanent diagnoses should be documented as often as they are assessed or treated. For risk adjustment, the Centers for

Medicare & Medicaid Services requires these diagnoses to be submitted at least annually.

Paint the True Clinical Picture

The business of healthcare may be changing, but good documentation continues to be a cornerstone of accurately reflecting the provider’s work and the patient’s condition. Risk adjustment takes a close look at how ICD-9-CM documentation and coding contributes to the complexity level of the encounter, medical decision-making, and time spent with the patient. Good ICD-9-CM coding documentation will paint the true clinical picture of the patient and reflect the provider’s thought process. **HBM**



Colleen Gianatasio, CPC, CPC-P, CPMA, CPC-I, is a risk coding and education specialist for Capital District Physician’s Health Plan. She enjoys teaching PMCC, auditing, and ICD-10 classes. Gianatasio is on the AAPC National Advisory Board, serving from 2015-2018, and she serves as secretary for the Albany, N.Y., local chapter.

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Is Risk-adjusted and Value-based Reimbursement the End of CPT®?

The payment model reflects a possible transition to using diagnosis coding exclusively.

The healthcare community is in a period of transition. The concept of value-based reimbursement is centered on paying for quality, not for quantity, of healthcare. Moving away from the old way of doing things means that “the more you do, the more you get paid” no longer applies. It’s a drastic change from what we have been doing for the past 30-plus years. It’s here, and it requires attention. It’s our future.

On January 26, 2015, U.S. Department of Health & Human Services Secretary Sylvia Mathews Burwell made an historic announcement of a timetable for shifting from fee-for-service to value-based reimbursement. She discussed alternative payment models in which providers are accountable for the quality and cost of care for the people in populations they serve. The timetable calls for 50 percent of all Medicare provider payments to be in an alternative payment model by 2018. It is estimated that 20 percent of Medicare payments currently come from alternative or population-based payment models.



ed. Depending on the risk model, there is a method for evaluating financial risk for each disease and determining the available revenue to pay for the healthcare costs.

The best analogy is to consider an empty pool into which dollars are thrown, depending on risky conditions each member/patient has. Primary care physicians (PCPs) are paid out of that pool, as are consultants and hospitals. Diagnostic tests also are paid from the pool. There are variations on this model but, basically, the money used to pay for patients’ treatment is generated based on the diseases those patients have. There is no penalty for taking care of sick patients; indeed, there may be incentive. In a true risk model, PCPs get a share of what’s left over in the pool at the end of the year.

The bottom line: PCPs are incentivized to find all of patients’ diseases, document and code them correctly, and keep their patients out of the hospital. In other words, the incentive is to keep patients as healthy as possible.

What a concept: A reimbursement model that parallels the practice of medicine!

Medicare’s Alternative Payment Models

Medicare Advantage and Accountable Care Organizations (ACOs) are relatively newer payment models. In 2015, 17.3 million beneficiaries were enrolled in a Medicare Advantage plan, and approximately 8 million Medicare beneficiaries received healthcare from ACOs by January 2015.

Both models use a risk-adjusted reimbursement methodology called hierarchical condition categories (HCCs). HCCs are based on ICD-9-CM diagnoses, and have almost nothing to do with CPT®. Tests, consultations, and procedures are still reimbursed through CPT® codes, but in future models even that may go away because the revenue generated to pay for healthcare in these models is based on patient diagnoses.

Risk-adjusted Reimbursement and HCCs

Risk-adjusted reimbursement focuses on the treatment of disease states, rather than on office visits. This means the disease states that cause risk for the patient (as well as the financial risk for taking care of the patient) must be appropriately identified, documented, and cod-

Private Insurers Are Heading in the Same Direction

The same week that Burwell made her announcement, a private industry consortium of healthcare leaders (Health Care Transformation Task Force) announced they “aspire to put 75 percent of their business into value-based arrangements that focus on the Triple Aim of better health, better care and lower costs by 2020.” They specifically reference HCCs as the basis for tracking and accounting for the disease states that generate revenue.

In addition, there is Obamacare, which has enrolled 22 million individuals since inception, according to a 2015 RAND study. Each private health plan in a health insurance exchange receives a set amount of money for each patient/member. At the end of a year, the health plans with the healthier patients pay the health plans that have the sicker patients, based on documentation and ICD-9-CM coding assignment. Plans that don’t identify the risk conditions their patients have will end up paying money to plans that do.

Currently, 90-95 percent of all risk-adjusted ICD-9-CM codes are assigned by physicians. I am a physician, so I can say, "That doesn't make sense." Physicians are not coders, and probably never will be. Yet, today, the revenue available to take care of approximately 48 million patients is based on physicians trying to document for ICD-9-CM, and then trying to code in ICD-9-CM, although this has never been important to them in the past.

Would the End of CPT® Be a Bad Thing?

Physicians and coders both have adjustments to make to keep up with healthcare reform. I can't say for sure which payment model will prevail in 10 years, or whether ICD-10 and HCCs will replace CPT®, but I do know the changes we face will create opportunities for those who not only accept those changes, but prepare for them. **HBM**



Todd M. Husty, DO, FACEP, is the president of Medical Audit Resource Services, Inc. (MARS), a coding and documentation consulting company in business for 26 years. He admits to not being an expert in coding — his job is training physicians on documentation improvement. MARS's expert coders provide ongoing training through queries.

Resources

HHS press release, "Better, Smarter, Healthier: In historic announcement, HHS sets clear goals and timeline for shifting Medicare reimbursements from volume to value," January 26, 2015, www.hhs.gov/news/press/2015pres/01/20150126a.html

CMS press release, "Better Care. Smarter Spending. Healthier People: Paying Providers for Value, Not Volume," January 26, 2015, www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-01-26-3.html

CMS press release, "CMS Ensures Higher Value and Quality for Medicare Health and Drug Plans," July 4, 2014, www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2014-Press-releases-items/2014-04-07.html

Oliver Wyman, "ACO Update: Accountable Care at a Tipping Point", April 2014, [www.oliverwyman.com/content/dam/oliver-wyman/global/en/files/insights/health-life-sciences/2014/April/NYC-MKT08001-034%20\(4\).pdf](http://www.oliverwyman.com/content/dam/oliver-wyman/global/en/files/insights/health-life-sciences/2014/April/NYC-MKT08001-034%20(4).pdf)

RAND, "Trends in Health Insurance Enrollment, 2013-15," www.rand.org/pubs/external_publications/EP50692.html

Health Care Transformation Task Force, "Task Force Letter to CMS Regarding Next Generation ACO Model," www.hcttf.org/resources-tools/2015/5/28/cms-next-generation-aco-model

ICD-10 Quiz



By Rhonda Buckholtz, CPC, CPMA, CPC-I, CENTC, CGSC, COBGC, CPEDC

Think You Know ICD-10? Let's See ...

Read the example below:

This 75-year-old female presents with possible small bowel obstruction. She is demented and resides at an extended care nursing facility. Over the past 6 days, she has had intermittent abdominal pain, confusion, and emesis. She was treated empirically for a UTI. She continued to have episodic bouts of emesis, abdominal pain, and confusion over the ensuing days and was sent to the ER for evaluation.

By her chart history, she has COPD, pulmonary disease, diabetes mellitus, hyperlipidemia, Alzheimer's dementia, hypothyroidism, and cholelithiasis. She has had no prior abdominal surgeries.

On initial evaluation she is found to be confused and somnolent. She is afebrile, mildly tachycardiac at 102 beats per minute; bp is 116/78. On abdominal exam, she has no prior surgical scars; her abdomen is moderately distended and tympanitic. She has diffuse, non-localized tenderness over her abdomen without involuntary guarding or signs of peritonitis. There are no palpable masses. She has no costovertebral angle tenderness. Her rectal exam reveals no masses or fissure, normal tone, and

no fecal impaction. On abdominal X-ray, she has diffusely dilated small bowel loops throughout her abdomen, with a paucity of gas in the colon. Careful inspection reveals a radiopaque density in the lower abdomen, consistent with an ectopic gallstone. CT showed evidence of cholecystoduodenal fistula and based on the CT, the diagnosis of a bowel obstruction secondary to gallstone ileus is made. The patient has been adequately resuscitated, but continues to vomit, remain uncomfortable and distended, despite nasogastric decompression.

The patient is taken to the OR where a midline laparotomy incision is used to explore the abdomen. The stone is located in the distal ileum. It's extracted atraumatically through an enterotomy and closed in a transverse orientation.

How would you code this in ICD-10-CM? Code only the final diagnosis and not the underlying conditions.

Check your answer on page 65.

Rhonda Buckholtz, CPC, CPMA, CPC-I, CENTC, CGSC, COBGC, CPEDC, is vice president of ICD-10 Training and Education at AAPC.



When staff is relaxed, you can breathe easy knowing they can concentrate on tasks at hand.

Most of us working in the healthcare industry know the importance of employee wellness, but we do not always take the time to take care of ourselves, or encourage our staff to take care of themselves. Research shows that when employees use wellness programs, they are happier at work, use fewer sick days, and are more productive in their jobs (“The Impact of Wellness Programs on America’s Workforce,” The Institute for Healthcare Consumerism). Not all employers have wellness programs available to their employees, however.

Regardless of whether your office has an official wellness program, there are things you can do to improve wellness for yourself and your staff. Some can even be done right at an employee’s desk.

For example, yoga has been proven to be an effective way to reduce stress and improve fitness (“Yoga: Fight Stress and Find Serenity,” Mayo Clinic). A five- to 15-minute office yoga session might be all that’s needed to get you and your employees motivated to finish the task at hand. Here are five simple yoga exercises that can be done daily without having to leave the office.



Photos by Stephanie Knutson Photography.

Neck

Posture: Sit comfortably with a straight spine, either at the front of the chair or all the way to the back. Keep your feet flat on the floor, about hip distance apart.

Technique: Place your hands on your thighs and lower the right ear toward the right shoulder. Rotate your head back, making sure to lift your neck up and over your spine so you don't compress it. Repeat on the left side. As you do these moves, make sure to take long, deep breaths. Continue this for one minute in each direction.

Benefits:

- Improves blood flow to the brain.
- Helps to reduce tension and calm the mind.

Shoulders

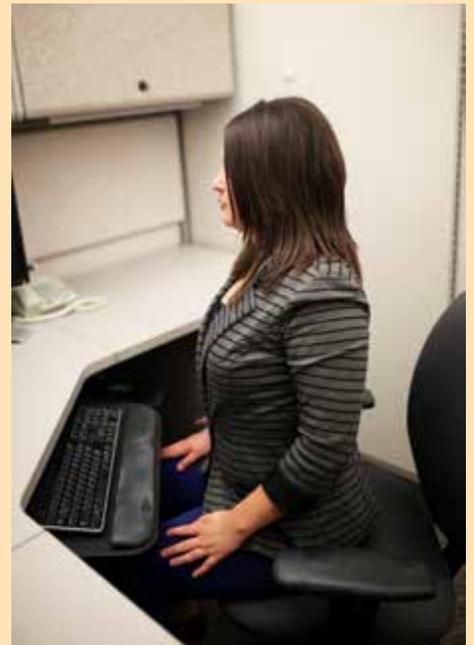
Posture: Sit comfortably with a straight spine, either at the front of the chair or all the way to the back. Keep your feet flat on the floor, about hip distance apart.

Technique: Rest your arms straight down to your side and begin rotating the shoulders forward. After a minute, reverse direction. Remember to breathe.

Benefits:

- Keeps the muscles around the shoulders flexible and reduces tension.
- Improves posture. Helps to counteract hunching.

Working at a desk
all day can leave you
feeling hunched over.
Shoulder rolls will help
to counteract that.



Legs

Posture: Sit comfortably into the back of the chair with a straight spine.

Technique: Hold the arms of the chair or the edge of the seat and raise both legs. You can start with just one leg at a time if that is better for you. Flex your toes towards your body and hold for 10 seconds. Then point your toes away from your body and hold for 10 seconds. Repeat this movement five to seven times.

Benefits:

- Stretches your feet and your hamstrings.
- Improves blood circulation. Sitting at a desk for long periods can inhibit blood flow, which can create all sorts of problems.



Back

Posture: Sit comfortably with a straight spine, either at the front of the chair or all the way to the back. Keep your feet flat on the floor, about hip distance apart.

Technique: Interlock the palms of your hands behind your back. Pull your arms down while inhaling; open the chest and bring the head and neck back to gaze up. Hold this posture for 10 seconds, or however long it feels good. Remember to breathe. Then, slowly release the arms and bring the head and neck back to a neutral position. Repeat as many times as needed.

Benefits:

- Helps to keep the back and shoulders flexible and eases tension caused by hunching in front of a computer all day.
- Reduces stress. Methodical breathing increases benefits.



Breathing

Posture: Sit comfortably with a straight spine, either at the front of the chair or all the way to the back. Keep your feet flat on the floor, about hip distance apart.

Technique: Alternate nostril breathing.

Use the right thumb to close off the right nostril. Inhale deeply through the left nostril. When your breath is full, close off the left nostril with the pinkie finger and exhale through the right nostril. Repeat.

Use the left thumb to close off the left nostril. Inhale deeply through the right nostril. When your breath is full, close off the right nostril with the pinkie finger and exhale through the left nostril. Repeat.



Benefits:

- Focused breathing can help with headaches, migraines, and other stress-related symptoms.
- Inhale left, exhale right: Relieves stress.
- Inhale right, exhale left: Improves focus.

Resources

Kundalini Research Institute, Perspective & Emotional Balance: Alternate Nostril Breathing: www.yogibhajan.org/ybkriyas/index.php?id=117

Mayo Clinic, Yoga: Fight Stress and Find Serenity: www.mayoclinic.org/healthy-living/stress-management/in-depth/yoga/art-20044733

Thakur, Bharat. Desktop Yoga. New Delhi: Wisdom Tree, 2007. Print

The Institute for Healthcare Consumerism; The Impact of Wellness Programs on America's Workforce: www.theihcc.com/en/media_center/editors_picks/the-impact-of-wellness-programs-on-america%E2%80%99s-workf_h2jeegra.html

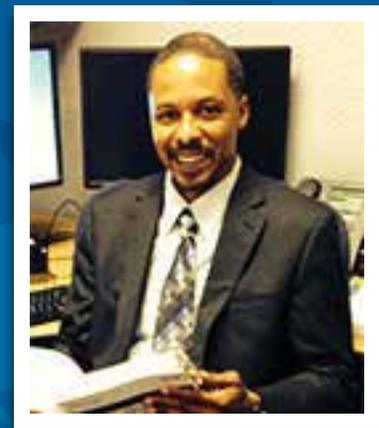


Bridget Toomey, CPC, CPB, RYT-200, teaches Kundalini Yoga at Heartland Yoga in Iowa City, Iowa. She is certified by the Kundalini Research Institute as a Kundalini Yoga teacher and is a member of the International Kundalini Yoga Teachers Association. Toomey works for the University of Iowa Hospitals and Clinics in Patient Financial Services as an education coordinator, where she trains new hires and current staff in many areas of the revenue cycle including denial management and claims. She is a member of the Iowa City, Iowa, local chapter.

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CUBAN HEALTHCARE SYSTEM: A Primary Care Model

The United States could learn from the Cuban healthcare system's success.

Last December, President Barack Obama announced that it was time — after 50 years of complex policy and politics — to restore diplomatic and economic ties with Cuba. Whatever the pros and cons of this decision, I believe the two countries have a lot to learn from one another.

In December 2011, I had the pleasure to be part of a team of healthcare administrators who toured Cuba to learn how the Cuban government has established an effective public healthcare system. Based on my observations, the Cuban healthcare system works well.

“Access to healthcare for all, is a basic human right.”

— Cuban Constitution

Eighty percent of Cuba's physicians are primary care doctors, with only 20 percent trained as specialists. In the United States, these proportions are reversed.

While the United States struggles to provide universal, affordable healthcare for its citizens, our Cuban neighbors have made healthcare a constitutional right. The Cuban healthcare system is not only free for all Cuban citizens, the quality of primary care is equal to or better than the United States and other industrial nations, at a fraction of the cost. For example, Cuba has the same 78-year life expectancy as our country, while spending only 4 percent of the amount the United States spends on healthcare per person, annually.

Fundamentals of Cuban Healthcare

According to "Primary Health Care in Cuba, The Other Revolution," the development of the Cuban healthcare system is based on three central assumptions:

1. Health is the responsibility of the state;
2. Health is a social issue, as well as a biological one; and
3. Health is a national priority, requiring participation from all sectors of the government and civil society.

The basis for the entire Cuban healthcare system is preventive care and the primary healthcare (PHC) model. Although Cuba has achieved success with its current model, it was not the starting point. Shortly after the 1959 revolution, the government established municipal "polyclinics," which continue to function as multi-specialty clinics. In the early 1960s, the emphasis was on health screenings, vector control, and other measures to bring infectious disease under control. The PHC model of the community family doctor was introduced in 1984.

The healthcare system is now structured on two levels: level 1 is PHC, and level 2 is secondary healthcare (hospitals).

Primary Healthcare Level 1:

- Family doctor unit
- Polyclinics (includes dental care)
- Specialty institutions
- Mothers' homes
- Grandparent homes (not a nursing home setting, but senior day care)
- Community mental health clinics



Secondary Healthcare Level 2:

- Inpatient hospital
- Inpatient nursing home care (This is minimal, as the culture focuses on family members remaining in the home.)

With the limited time available to our tour group, we did not have the opportunity to visit any secondary healthcare facilities; however, we did visit all of the PHC Level 1 care units. We found the medical directors, physicians, nurses, and everyone we came in contact with to be welcoming and informative.

We learned that the "family doctor unit" is a single physician with a team of nurses, statisticians, and technical assistants who care for a set number of individuals within their community. Eighty percent of Cuba's physicians are primary care doctors, with only 20 percent trained as specialists. In the United States, these proportions are reversed.

Better Family Healthcare and Minimizing Hospital Visits

Most primary care offices are on the first floor of a building, and the physician resides on the upper level with his or her family. Physicians and their teams know their patients well, and often tend to three or four generations of the same family in a single home visit. The average number of patients is approximately 1,000 per physician, compared to approximately 2,500 patients per primary care physician in the United States. The physician in each unit has been trained to care for the entire group assigned to him. This includes home visits, specialty care after consulting with specialists in the polyclinic, office visits, acute illnesses, long term care in the home, and — ultimately — keeping his or her patient population out of the secondary level of care (hospitalization). In short, all care is coordinated through the family doctor unit.



Other Cuban Level 1 Healthcare System Components

Polyclinics are larger, more regional clinics that include multiple specialties, dental, rehab, diagnostic lab, radiology, urgent care, and 24 hour emergency services accessible by everyone in the community. Generally, this is done by consultation request of the family unit doctor. But per Cuban health officials, anyone may enter the polyclinic on his or her own. After consultation, the specialist recommends treatment options to the family unit physician. The family doctor then resumes care, consulting with the specialist to meet the continued needs of the patient.

Specialty institutions are available if further specialty care is needed. For example, if a cardiac patient needs further testing, such as a stress test, the patient is referred to the Cardiovascular Institute for further care. Some testing, due to limited resources within the PHC, must be done at the hospital. This varies from procedure to procedure, and resource availability at the time of need. As we would expect, there are fewer magnetic resonance imaging and computed tomography scanners in all of Cuba than exist in my rural Western Pennsylvania hometown marketplace.

Mothers' homes are maternity homes for at-risk, pregnant mothers or fetuses, based on limited criteria. Mothers can be admitted at any point during their gestation. This would include the need for bed rest due to possible early labor or hypertensive diabetic status or nutritional deficiencies. Ninety-nine percent of babies are born in the hospital; thus, if the expectant mother is in a rural location, she may reside at the mothers' home late in her trimester. Evidence of Cuba's success with this model shows up in its infant mortality rate — at 4.6 percent, one of the lowest in the world, and lower than the U.S. rate of 6.4 percent.

A Grandparent home is not equivalent to a U.S. nursing home. They are adult day care centers where working families can bring the elderly during the day. The senior adults are cared for and fed, and have

Because the Cuban system is nonprofit and is not reimbursement-based, there is no need to spend resources on coding and billing claims for services rendered.

a chance to mingle with other senior adults from the community. Elderly care is promoted at the home as part of the Cuban culture. Families are encouraged to care for the grandparents with supervision of the family unit physician team. This team also includes social workers.

Community mental health centers care for mentally ill patients and support their families in centers located in the community. The director stressed that, optimally, the whole family is involved in the patient's care and in supporting their own needs as caretakers. Group sessions with patients and families are held daily at the center. For example, mothers of children with attention deficit disorder (ADD) are able to network and lean on each other for support. Each center is staffed with psychologists, psychiatrists, nurses, technicians, and social workers.

Prevention, Not Profit, Is the Primary Focus

The Cuban healthcare system stresses preventive health. Despite limited resources, Cuba has a record unmatched by any economically disadvantaged nation of dealing with chronic and infectious diseases. These include polio (eradicated 1962), malaria (eradicated 1967), neonatal tetanus (eradicated 1972), diphtheria (eradicated 1979), congenital rubella syndrome (eradicated 1989), post-mumps meningitis (eradicated 1989), measles (eradicated 1993), rubella (eradicated 1995), and tuberculous meningitis (eradicated 1997).

You could argue that it's easy to accomplish such goals when various elements are implemented or mandated within the community. For example, in Cuba education is free from preschool through graduate level degrees, and they integrate the education and healthcare systems. Children are vaccinated and receive periodic checkups at schools. School lessons include proper hygiene, such as brushing teeth, all the way to learning about contraceptive use. Adults are "required" to check in for a yearly physical.

Cuban physicians have learned to work effectively without the heavy emphasis on technology and pharmaceuticals, commonly relied on in the United States. Although they are proud of their ability to diagnosis and treat underlying problems without automatically reaching for a prescription pad, most Cuban physicians acknowledge the benefit of access to cancer-treating technologies and drugs that are not available, today (even though U.S. law exempted medicine and healthcare supplies from the U.S. embargo of Cuba in 1992).



To discuss this article or topic, go to www.aapc.com

Because the Cuban system is nonprofit and not reimbursement-based, there is no need to spend resources on coding and billing claims for services rendered. The office “statistician” focus is on quality indicators. Despite the lack of ICD-9 and ICD-10, electronic health records, and other end-user systems, they manage to capture data throughout the entire healthcare system. Because Cubans seldom move more than a few houses or blocks from where they were born, the same physician may treat an individual from the cradle to the grave, and has knowledge and records of all family members. This allows office visits to be interactive discussions, rather than focused on meeting evaluation and management documentation guidelines.

Although the embargo has blocked U.S. products from entering Cuba, it has not stopped the Cuban government from giving humanitarian help to other countries. Cuban doctors were some of the first in the world to step up during the 2014 Ebola breakout in Africa. We learned that Cuba has sent more than 125,000 healthcare professionals to provide care in 154 countries. In fact, Cuba—which is approximately the size of Pennsylvania—has more physicians than all of Africa.

The members of my tour group and I received an open invitation to return to learn more about Cuba’s healthcare success and strug-

gles, along with its culture and people. It was a wonderful learning opportunity, and one that I am happy to share with others. If you have any questions, or would like to learn more, please contact me at jpgderricks@gmail.com. **HBM**

Resources:

Linda M. Whiteford and Laurence G. Branch, “Primary Healthcare in Cuba, The Other Revolution,” 2008, page 19.

J. Pérez, “Gender and HIV Prevention,” slide presentation at the Pedro Kouri Institute of Topical Medicine, Havana, Cuba, May 15, 2012.

Elio Delgado Legón, “Cuba Updates its Health Care System,” *Havana Times*, April 9, 2014 www.havanatimes.org/?p=102916



Joette Derricks, MPA, CMPE, CPC, CHC, CSSGB, has 35 years of healthcare finance, operations, and compliance experience. A national speaker and author, her unique style is to bridge the regulatory requirements with the practical realities of day-to-day operations. Derricks has provided numerous expert reports and testimony regarding Medicare, Medicaid, and third-party payer regulations with an emphasis on coding, billing, and reimbursement rules. She serves as the vice president, regulatory affairs at Anesthesia Business Consultants, and is a member of the Ann Arbor, Mich., local chapter.

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Let's Clarify How to Keep Incident-to from Becoming Incident-4

Part 2: Billing services incident-to the supervision of an NP or a PA.



Sort Through the Rules

In isolation, you may conclude (incorrectly) that non-physician practitioners (NPPs) such as nurse practitioners (NPs) and physician assistants (PAs) can initiate care and bill for services performed under their own supervision (alone) under the terms of the incident-to rule. Such a conclusion is contrary to the law (although the *MLN Matters*[®] article created unnecessary confusion). I hope the following — although esoteric — will help to sort the facts, and to demonstrate why interpretation of the law is best left to lawyers.

The incident-to concept has its genesis in the payment provisions of the Social Security Act (SSA) as follows:

Several readers have questioned the accuracy of the Ask the Legal Advisory Board article “Don’t Let Incident-to Turn into ‘Incident-4’ Billing” (May, page 42). Their concerns are based on the Centers for Medicare & Medicaid Services’ (CMS) *MLN Matters*[®] SE0441 containing the following note:

“Incident-to” services are also relevant to services supervised by certain non-physician practitioners such as physician assistants, nurse practitioners, clinical nurse specialists, nurse midwives, or clinical psychologists. These services are subject to the same requirements as physician-supervised services. Remember that “incident services” supervised by non-physician practitioners are reimbursed at 85 percent of the physician fee schedule. For clarity’s sake, this article will refer to “physician” services as inclusive of non-physician practitioners.

(s) Medical and other health services

The term “medical and other health services” means any of the following items or services:

(1) physicians’ services;

(2)(A) services and supplies (including drugs and biologicals which are not usually self-administered by the patient) furnished as an incident to a physician’s professional service, of kinds which are commonly furnished in physicians’ offices and are commonly either rendered without charge or included in the physicians’ bills (or would have been so included but for the application of section 1395w-3b of this title);

— 42 U.S. Code §1395x(s)

... an NPP must be authorized by the SSA to receive payment for services performed incidental, although integral, to his or her own professional service.

Note that there is no provision in the SSA that permits any person who might otherwise qualify as “auxiliary personnel,” for purposes of the rule, to be supervised by an NPP, such that those services would be reportable under the name and National Provider Identifier (NPI) of the NPP.

Limitations of the Term “Physician”

Services performed by licensed or unlicensed assistants in compliance with the incident-to rule can be billed under the name and NPI of the physician who provides direct, on-premise supervision. This, however, does not extend to NPPs because the statute only provides authority for payment when such services are performed incident-to physician services. The term physician is defined in the SSA:

(r) Physician

The term “physician,” when used in connection with the performance of **any function or action**, means (1) a doctor of medicine or osteopathy ..., (2) a doctor of dental surgery or of dental medicine..., (3) a doctor of podiatric medicine ..., (4) a doctor of optometry..., or (5) a chiropractor ...

— 42 U.S. Code §1395x(r) [emphasis added and statutory payment limitations pertaining to scope omitted]

Applying standard rules of statutory construction, you must conclude Congress — while providing a limited definition of physician, and not providing authority in the statute for payment of services performed incident-to the professional services of NPPs — did not intend for Medicare to pay for services that are integral, although incidental, to the services of an NPP. Although there are some exceptions (e.g., under the physical therapy payment rules), which are addressed in a separate rule, there is no general exception for “medical or other health services” performed by NPs or PAs.

Understanding the limitations of the term “physician,” now turn to the regulatory coverage requirements (42 CFR §410.10), as well as the regulatory expression of the incident-to rule (42 CFR §410.26). Medicare coverage, from an incident-to perspective is generally limited, as follows:

(b) Services and supplies furnished incident to a **physician’s professional services**, of kinds that are commonly furnished in physicians’ offices and are commonly either furnished without charge or included in the physicians’ bills.

— 42 CFR §410.10(b) [emphasis added]

When you turn to the more detailed provisions found at §410.26(b) (2), you see the services reportable under the incident-to rule are generally limited to those which are integral, although incidental, to the service of a physician (or other practitioner). There are other requirements, as well.

Covered services and supplies are defined with reference to the statutory definition found at 42 U.S. Code §1395(x)(s)(2)(A), which is limited to those services furnished incident-to a physician’s service.

The incident-to rule also requires that services performed by “auxiliary personnel” must be those that auxiliary personnel are legally permitted to perform under the licensure rules of the supervising provider.

Finally, consider the definition of the term “practitioner,” found in §410.26(a)(6). Under that rule, “practitioner” means an NPP “who is **authorized by the Act to receive payment** for services incident to his or her own services.” [emphasis added]

Who Can Receive Payment

To determine who is authorized by the SSA to receive payment for services incident-to his or her own services, turn to the payment provisions of the SSA, and those found in the regulations. Note that the statutory expression of the incident-to rule does not address practitioners. The regulatory payment provisions pertaining to practitioners (PA, NP, certified registered nurse practitioner (CRNP), nurse midwife, etc.) merely define the payment amount, and only speaks in terms of the services performed by those individuals. The payment rules contain no language that expressly or impliedly authorizes payment for services performed incident-to their professional services (42 CFR §414.54-60).

You might point out that the regulatory provisions applicable to “coverage” of nurse practitioners services (as an example) would seem to permit incident-to billing as follows:

(d) Services and supplies incident to a nurse practitioners’ services. Medicare Part B covers services and supplies incident to the services of a nurse practitioner if the requirements of §410.26 are met.

— 42 CFR §410.75(d).

Unfortunately, note that such coverage is conditioned on compliance with 42 CFR §410.26. Remember that this rule has a number of important requirements, all of which must be met. For practitioners, the biggest concern is their authority to legally delegate the per-

This is an extremely complex issue that requires very fact-specific analysis, on a case-by-case basis.

formance of services to auxiliary personnel. Note also that §410.26 requires supervision by a physician or a practitioner who is authorized under the payment provisions of the Act to receive payment for services performed incident-to their professional services. As aforementioned, there is no such payment authority where the practitioner is a PA, NP, clinical nurse specialist, CRNP, nurse midwife, etc. When you turn to the Medicare Benefit Policy Manual, you can see the source of the confusion expressed by the *MLN Matters*® article on the subject. In the section of the manual, “Services and Supplies Furnished Incident To a Physician’s/NPP’s Professional Service,” CMS states:

For purposes of this section, physician means physician or other practitioner (physician, physician assistant, nurse practitioner, clinical nurse specialist, nurse midwife, and clinical psychologist) **authorized by the Act to receive payment for services** incident to his or her own services.

— Pub. 100-02, Medicare Benefit Policy Manual, chapter 15, §60 [emphasis added]

Note that CMS has replicated the regulatory language and, as is the case under the regulation, an NPP must be authorized by the SSA to receive payment for services performed incidental, although integral, to his or her own professional service. Unfortunately, the payment provisions applicable to PAs, NPs, etc., do not provide such authority.

Note: There are NPPs for whom such authority does exist. Licensed/certified physical therapist (PT) or occupational therapist (OT) assistants, for example, are auxiliary personnel who can perform services that are integral, although incidental, to a licensed PT’s/OT’s (as applicable) professional service. In such a case, a licensed PT develops a therapy care plan based on his or her physical therapy evaluation, which is then certified by a doctor of medicine/doctor of osteopathic medicine. The physical therapist assistant is then permitted under the payment regulations applicable to therapy services to provide the skilled therapy service under the direct on-premise supervision of the PT. In such a case, the service is billed under the name and NPI of the licensed PT. Unfortunately, similar authority does not clearly exist under the SSA for NPs/PAs.

Apply the Rules

The following scenarios explain the basis for the conclusions expressed in the prior article and illustrate how the rule works in practice.

Scenario 1: A physician performs the initial evaluation, determines a diagnosis, and develops the care plan. Either an NP/PA or auxiliary personnel perform subsequent follow-up services under the physician’s direct on-premise supervision.

In this case, assuming all other criteria under the incident-to rule are satisfied, the service can be reported under the name/NPI of the physician.

Scenario 2: A physician performs the initial evaluation, develops a diagnosis, and develops the care plan. Auxiliary personnel perform subsequent follow-up services. The physician, however, is not on the premises. Instead, an NP/PA supervises performance of the services by auxiliary personnel.

For this case — even if all other criteria under the incident-to rule were satisfied — the service cannot be legitimately reported under the name/NPI of the NP/PA. The most obvious reason is because the NP/PA did not initiate the care; therefore, the auxiliary person is not performing a service that is integral although incidental to the NP’s/PA’s professional service. As a result, the authority in the coverage rules for NPs/PAs, which are conditioned on compliance with §410.26, would not be satisfied.

Depending on your state, compliance with §410.26 requires that the auxiliary personnel are permitted under applicable licensure rules to perform the service under an NP’s/PA’s supervision. As delegation authority is not commonly found in most NP/PA licensure rules (and where it’s found, it’s extremely limited), it’s possible that such a delegation would not be permissible. As a result, the requirements of §410.26 would not be met.

Finally, consider that the express payment regulations, which are consistent with the statutory limitations of the incident-to rule, do not authorize payment to an NP/PA acting purely in a supervisory role.

Scenario 3: An NP/PA performs the initial evaluation, develops a diagnosis, and develops the care plan. Auxiliary personnel perform subsequent follow-up services under the NP’s/PA’s supervision.

In this case, determine whether the service actually performed by auxiliary personnel is a service that the NP/PA is permitted to delegate/supervise under his or her licensure rules. Assuming you surpass that hurdle, you still have the payment limitations of the SSA, which authorizes no payment for an NP/PA who is supervising a service performed by auxiliary personnel (understanding that the coverage rules suggest otherwise, at least superficially). As a result, do not bill such services under the name and NPI of the NP/PA.

Understand that Incident-to Is Confusing

If you are confused, don't worry. As my mentor used to tell me (before I became a lawyer): This is just one of those issues that three years of law school will help you understand.

This is an extremely complex issue that requires very fact-specific analysis, on a case-by-case basis. Even ignoring the understandable conflict between the payment and coverage provisions of the SSA, there are a number of other substantial hurdles that preclude the simple conclusion that NP/PAs can bill for services performed incident-to their supervision. Such a broad assumption would be legally indefensible, and would lead to substantial compliance risk. **HBM**



Michael D. Miscoe, JD, CPC, CASC, CUC, CCPC, CPCO, CPMA, is the president-elect of AAPC's National Advisory Board, serves on the AAPC Legal Advisory Board, and is the AAPC Ethics Committee chair. He has over 20 years' experience in healthcare coding and over 16 years' experience as a compliance expert, forensic coding expert, and consultant. Miscoe has provided expert analysis and testimony on coding and compliance issues in civil and criminal cases and his law practice concentrates on representing healthcare providers in post-payment audits and with responding to HIPAA OCR issues. He speaks on a national level, and is published in national publications on a variety of coding, compliance, and health law topics. Miscoe is a member and past president of the Johnstown, Pa., local chapter.

Resources

- MLN Matters*® SE0441, CMS, April 9, 2013: www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE0441.pdf
- SSA, 42 U.S. Code §1395x(s), 42 U.S. Code §1395x(r), 42 U.S. Code §1395(x)(s)(2)(A)
- Federal Register*, 42 CFR. §410.10: www.gpo.gov/fdsys/pkg/CFR-2014-title42-vol2/pdf/CFR-2014-title42-vol2-sec410-10.pdf
- Federal Register*, 42 CFR §410.75(d): [www.gpo.gov/fdsys/pkg/CFR-2014-title42-vol2-sec410-75.pdf](http://www.gpo.gov/fdsys/pkg/CFR-2014-title42-vol2/pdf/CFR-2014-title42-vol2-sec410-75.pdf)
- Federal Register*, 42 CFR §414.54-60: www.gpo.gov/fdsys/granule/CFR-2011-title42-vol3/CFR-2011-title42-vol3-sec414-54
- Federal Register*, CFR. §410.26 (b), CFR. §410.26 (b)(2), www.gpo.gov/fdsys/pkg/CFR-2011-title42-vol2/pdf/CFR-2011-title42-vol2-sec410-26.pdf
- Pub. 100-02, Medicare Benefit Policy Manual, chapter 15, §60, Services and Supplies Furnished Incident To a Physician's/NPP's Professional Service, www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf

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FROM THE CODING INSTITUTE

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Protect Your Assets with a Social Media Policy



Even if your organization avoids social media, your staff may be a HIPAA liability.

Image by Shutterstock.com/mick

Inappropriate use of social media can cause HIPAA violations, even if your company has avoided an official presence on popular social media venues (e.g., Twitter, Facebook, etc.). Despite company efforts to avoid social media, if your staff is on it actively, you have reason to be concerned. Staff members using social media in the office or discussing work online could subject your practice to a HIPAA security breach or, even worse, a fine or a lawsuit.

Social Media Basics

Social media tools allow people to share information, photographs, and videos on the Internet. Often, you'll hear of posts "going viral," meaning the post is being seen and spread by tens of thousands of individuals, if not millions. Even if a post doesn't go viral, when something has been posted in social media, it's nearly impossible to delete before other users download and share the post with their friends and followers.

"Selfies" — photos of yourself taken with a smartphone and posted to a social media site — are all the rage. People snap selfies while they're stuck in traffic, after a new haircut, all dressed up for a night

on the town, holding a baby, flexing in a mirror ... and even at the office. While the social significance of these posts can be debated, healthcare employers are rightly concerned with the office selfie.

Selfie Backgrounds May Violate HIPAA

Concerns with office selfies are due to high-resolution camera smartphones now feature, and what is captured in the entire image. If a photo is uploaded to social media and saved in its original, high-resolution format, the poster's friends and public have the ability to view the photo in its original format. These high-quality images make it simple for anyone to see clearly the selfie-taker, as well as all the information in the background of the photo.

For example, **Figure 1** shows Trish, a volleyball coach at Fordham University, who had her conference's standings written on the whiteboard in the background over her left shoulder. While the whiteboard is over 15 feet away from her desk, her iPhone picked up the writing quite easily, as shown in **Figure 2**. What if this was your office and the whiteboard contained patient information or other sensitive data?

These high-quality images make it simple for anyone to see clearly the selfie-taker, as well as all the information in the background of the photo.



Figure 1

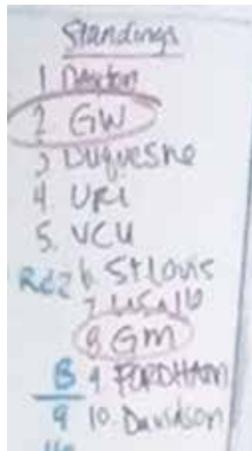


Figure 2

HIPAA Privacy Violation Examples

Here are a few real examples of selfies and social media postings that should not have been taken or posted:

- Joan Rivers' physician allegedly took a selfie in the procedure room while Rivers was under anesthesia, leading to questions about the physician's professionalism and competency.
- An off-duty employee of Spectrum Health Systems took a photo of an attractive woman in the emergency room and posted it on Facebook. He was fired, along with all of the employees who "liked" the post.
- An emergency room technician at Abington Health was posting patient information and X-rays to Twitter. She was fired.

Implement Social Media Policy

Medical practices would do well to adopt a Social Media Policy. Recommended core components are:

Think Before Posting: After something is posted on the Internet, it's no longer within your control. Even if you delete it later, it may still be available via an electronic medium and will have your name attached to it. Please consider the consequences of such communication and understand that you are responsible for what you post.

Patient's Cell Phone Records Doctor's Insults

The electronic revolution is changing the face of healthcare. From electronic health records, to patient portals, to cell phones and other handheld devices — opportunities abound for HIPAA Privacy and Security Rule violations.

Physicians who think avoiding all of this new age mumbo jumbo is the answer to eliminating risk may be in for a rude awakening. A recent lawsuit reminds us that patients can expose doctors to non-compliance, as well.

Outpatient Surgery Magazine reports on a case where a patient was awarded \$450,000 to make amends for things a doctor said about him while he was under anesthesia. The anesthesiologist was unaware that her comments were being recorded on the patient's cell phone during the procedure.

According to the June 24 report, the patient had been recording post-op instructions prior to the procedure and left his phone on. On his way home from the doctor's, while listening to the post-op instructions, he was shocked to hear the anesthesiologist's comments.

"After 5 minutes of talking to you in pre-op, I wanted to punch you in the face and man you up a little bit," the doctor said. And the insults continue.

The anesthesia practice where the doctor worked was also ordered to pay \$50,000 in punitive damages. Needless to say, the doctor is no longer employed with that practice.

This turned out to be just a case of a doctor behaving badly. It could've been worse. She could've, for example, subjected the facility to a HIPAA breach had she discussed other patients that day. It's something to think about.

Source: "Colonoscopy Patient's Cell Phone Records Doctor's Insults," www.outpatientsurgery.net

Renee Dustman is executive editor at AAPC.

Privacy Concerns: Governed by HIPAA, staff is obligated to guard against the exposure of protected health information (PHI). Posts to social media should never contain confidential company data, including PHI.

Monitor Activity: The practice has the right to monitor unauthorized disclosure of information, as well as postings that may affect the reputation of the company.

Respect Company Time and Property: Company computers and the time you spend on them are paid for by and are for the benefit of the company. Use of this equipment for social media activity is to be treated as any other use of equipment, such as telephones and/or email.

Reporting: All employees are to immediately report any violations, or possible or perceived violations, of this policy to their supervisor.

Discipline: The organization will investigate and respond to all reports of violations of the Social Media Policy and other related policies. Violation of this policy may result in disciplinary action up to and including termination.

For more information on the Security Rule and the HITECH Act, and for a complimentary Social Media Policy, visit: www.HIPAASecurityHelp.com.



Brian Shrift, CISSP, HCISPP, is president and founder of Precision Business Solutions, which brings information technology solutions to clients throughout west-central Pennsylvania. He obtained Certified Information Systems Security Professional (CISSP) and HealthCare Information Security Privacy Practitioner (HCISPP) certification to better meet the needs of clients in the healthcare industry. His guidance and initiative drives Precision Business Solutions to develop a more simplified and sure-fire process for helping healthcare clients become HIPAA Security Rule compliant.

Plan for Compliance

When the OIG enacts ACA provisions, will you be ready?



The Patient Protection and Affordable Care Act (ACA), section 6401, requires the U.S. Department of Health & Human Services (HHS) to establish core health-care compliance elements. When these core elements are implemented, medical providers will be required to establish a compliance program that contains the core elements as a condition of enrollment in Medicare, Medicaid, and Children Health Insurance Program (CHIP).

Although an implementation date has not yet been set for this particular provision, it's not too early for practices to prepare. Already, many providers who participate in Medicare Part C programs must annually attest to having compliance policies, procedures, and employee training in place to various Medicare Advantage plans.

On April 20, the Office of Inspector General (OIG) in collaboration with the American Health Lawyers Association, the Association of Healthcare Internal Auditors, and the Health Care Compliance Association announced an education outreach program, in regards to communication with healthcare boards. The program's aim is to assist healthcare organizations establish compliance plan oversight and communication.

Start with Core Elements of Compliance

The "OIG Compliance Program for Individual and Small Group Physician Practices," published in the October 5, 2000 *Federal Register*,

is an excellent guide for practices looking to develop a compliance plan. The seven, basic elements of healthcare compliance defined by OIG include:

1. Conducting internal monitoring and auditing
2. Implementing compliance and practice standards
3. Designating a compliance officer or contact
4. Conducting appropriate training and education
5. Responding appropriately to detected offenses and developing corrective action
6. Developing open lines of communication
7. Enforcing disciplinary standards through well-publicized guidelines

A code of conduct protects your healthcare organization and informs employees of expectations.

Include Specific ACA Requirements

The ACA discusses specific requirements for practices to consider when designing a compliance program. For example:

- The ACA will require policies and procedures for conducting assessments of compliance/fraud, waste, and abuse risk areas. The efforts must be ongoing to identify and minimize potential risks.

Compliance is regulatory guidance to which employees can turn if there are questions and concerns about coding, billing, reimbursement, HIPAA, ethical or code of conduct questions, etc.

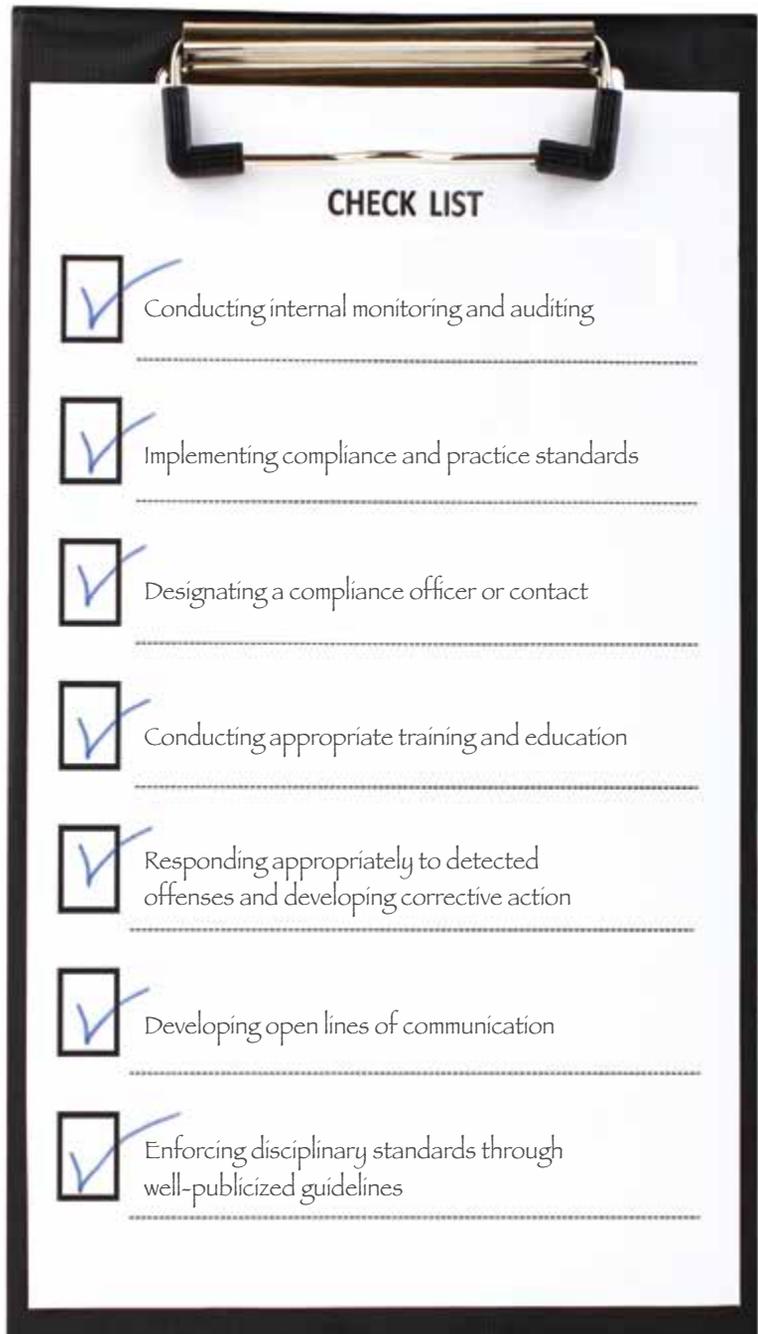
Training employees about compliance and providing them with compliance policies, procedures, and standards of conduct should be done within 90 days of hire, and at least annually, thereafter. Training and education doesn't have to be burdensome. Consider using games and other incentives to help employees learn more about compliance.

- The ACA will expect healthcare providers/ organizations to have a standard of conduct, so employees can report violations of laws to CMS/ Medicare Coverage Database/CHIP.

A code of conduct protects your healthcare organization and informs employees of expectations. To create an ethical culture, discuss with employees expectations of honesty and integrity in the workplace, and set an example by following the recommendations of compliance professionals.

- The ACA suggests involving leaders in the plan (senior management, board members, etc.). Compliance professionals need to be able to have access to senior leaders to present sensitive information that needs to be acted on in a timely manner.

Ensure your compliance professional is well supported. Many respondents to the Health Care Compliance Association's November 2014 Survey stated that they thought management saw compliance as a hindrance. In the January 2012 issue of *Compliance Week*, 60 percent of compliance professionals surveyed stated, "they have considered quitting their jobs in the past 12 months due to work-related stress." This is unfortunate and unnecessary.



Don't place a person in the compliance chair who does not know and understand the basic components of compliance.

Resources and References

Health Care Fraud Prevention and Enforcement Action Team, Healthcare Compliance Program Tips: <https://oig.hhs.gov/compliance/provider-compliance-training/files/Compliance101tips508.pdf>

OIG, A Roadmap for New Physicians, http://oig.hhs.gov/compliance/physician-education/roadmap_web_version.pdf

OIG, Practical Guidance for Healthcare Governing Boards on Compliance Oversight, April 20, 2015: <http://oig.hhs.gov/compliance/compliance-guidance/docs/Practical-Guidance-for-Health-Care-Boards-on-Compliance-Oversight.pdf>

Medicare Learning Network®, Fraud & Abuse Products: www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Fraud-Abuse-Products.pdf

Medicare Learning Network®, Affordable Care Act Provider Compliance Programs: Getting Started Webinar, June 2014: www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/MLN-Compliance-Webinar.pdf

59434 *Federal Register*, volume 65, No. 194, OIG Compliance Program for Individual and Small Group Physician Practices, October 5, 2000

Federal Register, volume 70, No. 19, OIG Supplemental Compliance Program Guidance for Hospitals; January 31, 2005

Federal Register, volume 65, No. 52, Publication of the OIG Compliance, Program Guidance for Nursing, Facilities, March 16, 2000

Reese Darragh, *Compliance Week*, "Study Finds Compliance Officers Are Highly Stressed," January 2012

Brenda J. Tranchida, Esq., HCCA, June 2012, www.aanac.org/docs/corporate-compliance-solution-page/compliancetoday_tranchida.pdf?sfvrsn=2

A.D. Romney, R.G. Homchick, "The Dark Side of Health Care Reform: The First '60-Day Rule' False Claims Act Case," July 2014: www.dwt.com/The-Dark-Side-of-Health-Care-Reform-The-First-60-Day-Rule-False-Claims-Act-Case-07-10-2014/

Kane v. Continuum Health Partners, New York qui tam suit: www.law360.com/articles/594189/fca-case-will-likely-set-standard-on-aca-overpayments

Today's compliance professional wears many hats. Make sure the person in your organization who wears the compliance hat is knowledgeable and approachable. Don't place a person in the compliance chair who does not understand the basic components of compliance. Compliance professionals should also be familiar with risk management, credentialing, and licensure issues.

- The ACA says that you must be able to demonstrate "through written materials," a strong ethical culture and commitment to compliance with all applicable laws, regulations, and requirements.

It's important to set the tone for your compliance program. Compliance means following rules, but it does not need to be unpleasant. Good soft skills and quality communication will yield better results than threats. Look at the culture of your organization, plan to add and organize what it's lacking, and decide how you can use your skills to make your organization compliant.

- The ACA will require Medicare/Medicaid overpayments to be repaid within 60 days, accompanied with an explanation of why/how the overpayment occurred (even if the overpayment was received by accident). Individual states might have stronger rules regarding Medicaid dollars. Pay close attention to new False Claim Act cases in progress to learn more about the 60-day rule (for example, New York qui tam suit, Kane v. Continuum Health Partners who allegedly failed to take necessary steps to identify over 900 overpayments).

Have a Plan for when Violations Occur

Your compliance plan should include steps to take when a violation occurs. Does your organization have legal counsel, and do your compliance personnel have access to these legal sources? Consider giving your compliance staff a budget for legal counsel advice.

Designing a compliance plan does not need to be costly. Know where to find free resources. Sit down today with these tools and design your compliance plan. Make sure it's readable and manageable. Never write something that you do not plan to follow. **HBM**



Jacqueline Nash Bloink, MBA, RHIA, CHC, CPC-I, CPC, CMRS, has worked in the healthcare industry for 20 years in professional roles such as director of compliance, corporate responsibility auditor, coding manager, practice administrator, and health information management educator.

Compliance: A Growing Career Opportunity

When HHS designates a date for practices to have mandatory compliance plans, all healthcare providers will need to have a Compliance Point of Contact. That could be you! If you like the regulatory side of healthcare, prepare now for an interesting and rewarding career.

Coders and billers are well suited for this role because they are already familiar with coding guidelines.

Begin by investigating what you need to do to prepare for this career. Two possible credentials for healthcare compliance professionals include AAPC's Certified Professional Compliance Officer (CPCO™) and the Health Care Compliance Association's Certified in Healthcare Compliance (CHC™). Both credentials require an examination to obtain the designation and yearly continuing education units to maintain certification.



CANDICE M. RUFFING, CPC, CPB, CPMA, CENTC



I began my journey in healthcare in 1996 at a local hospital as an outpatient registration clerk. I was immediately fascinated by the different testing and procedures of patients. A couple of years later I was recruited to the private practice of one of the hospital's physicians and hired to work in the front office and to file medical records, as needed.

Welcome to the Business Side

The billing manager at the practice sensed my desire to learn and asked me if I would be interested in seeing how the business side of healthcare worked. I jumped at the opportunity. That's where my future changed. My mentor, **Dawn Kleabir, CPC, CGSC**, began by showing me how charges are entered, claims are filed, payments are posted, and denials are worked. About a year later, she handed me operative reports and coding books.

I Was Hooked

I knew I wanted to be a coder. My manager introduced me to AAPC and the Stuart, Florida, local chapter. I admit, I was scared to death the first time I walked into a meeting, but the overwhelming welcome was a nice surprise. A year later, I sat for my Certified Professional Coder (CPC®) exam and passed.

Giving Back to AAPC

Today, I am a compliance consultant for an amazing consulting firm, hold four AAPC certifications, and have served as an officer for my local chapter three times. I am now serving my third year on the AAPC Chapter Association Board of Directors as vice chair.

The members, friends, and colleagues I have met over the years through AAPC are priceless. I encourage my clients to invest in their staff by joining AAPC and having their staff certified. **HBM**

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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).

Who Has the CPT® Code Final Say?



Find out if code selection ends with the coding professional or the provider.

Q Our facility is having a heated debate about who should have the final say on the CPT® code submitted for billing: the provider or the coder?

The providers' argument is that they should have the final say since it's their National Provider Identifier (NPI) number listed on the claim, and if the billing is wrong, they are personally liable.

The facility says coders should have the final say, since they are the coding experts, and although the providers' NPI is listed, the facility is ultimately responsible for billing compliantly. The facility reasons the coder is the individual who reviews the documentation and determines which code best applies to the documentation.

Please provide direction on who would be held accountable for billing issues at a provider-based billing facility.

A There isn't a black and white answer to your question.

On one hand, you could argue that the provider makes the final decision. After all, the provider is the one who enrolled in the program and whose NPI forms the basis for the claim. On the other hand, the coding professional is the one with the skill set to correctly apply codes based upon the documentation the provider presents.

In the course of providing care, much of the cognitive information obtained by the physician fails to get reduced to writing, and the phy-

sician's perception may be that the situation was more acute than reflected in the documentation. When encountering such a situation, the coder should seek additional documentation. If none is received, the coder should make the provider aware of the documentation guidelines that apply to the claim in question. The claim should go out the door as an accurate representation of the provided service.

Legally, the provider is responsible for any claims not supported by correct codes and documentation; however, part of a coder's job is to ensure coding accuracy.

Perhaps, through collaboration, the parties can work toward a process that will result in both the coder and the provider agreeing on the appropriate code. Communication and education can resolve most disputes. **HBM**



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By G.J. Verhovshek, MA, CPC

Instant Coding Guide to Brachytherapy Isodose Planning

Brachytherapy is a radiation therapy that places a short-range radiation source within the body. In a process known as afterloading, one or more catheters, or the channels of the intracavitary applicator, are placed under guidance at the cancer site(s). The source (radioisotope) is delivered via the catheter or channels. By targeting cancer cells precisely, damage to nearby, healthy tissue is minimized.

A specialist must calculate the proper dose and distribution of radiation, which depends on the type and the stage of the cancer being treated. Brachytherapy isodose planning is a billable service, for which CPT® 2015 introduced several new codes. CPT® differentiates the codes by service complexity, as measured by the number of radiation sources or channels that must be considered.

- 77316** Brachytherapy isodose plan; simple (calculation[s] made from 1 to 4 sources, or remote afterloading brachytherapy, 1 channel), includes basic dosimetry calculation(s)
- 77317** intermediate (calculation[s] made from 5 to 10 sources, or remote afterloading brachytherapy, 2-12 channels), includes basic dosimetry calculation(s)
- 77318** complex (calculation[s] made from over 10 sources, or remote afterloading brachytherapy, over 12 channels), includes basic dosimetry calculation(s)

All of the above codes (which replace deleted codes 77326-77328) include basic dosimetry calculation(s), which is a measurement of the radiation dose that the body receives and absorbs. Do not separate-

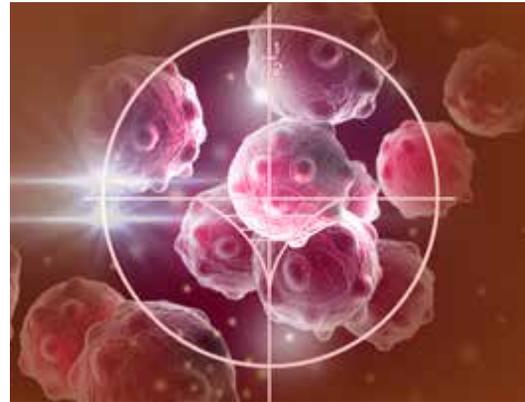


Image by Shutterstock.com

QUICK TIP

ly report 77300 *Basic radiation dosimetry calculation, central axis depth dose calculation, TDF, NSD, gap calculation, off axis factor, tissue inhomogeneity factors, calculation of non-ionizing radiation surface and depth dose, as required during course of treatment, only when prescribed by the treating physician with 77316-77318.* **HBM**

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ICD-10 Quiz Answer (from page 41)

The correct answer is:
 K56.3 Gallstone ileus. Look up: ileus, gallstone.

Learning About the Codes and the Bees

Nature can sometimes be the best coding training.



I recently took up beekeeping. It took years of planning and studying, followed by postponement after postponement born of doubt, fear, and ignorance. There were many issues to consider:

- What were the legal implications, and would the neighbors mind?
- Would a hive attract skunks?
- Would the bees sting us or our pets?
- How would they affect our other activities?

Delay after delay happened as we fretted, imagining the worst.

At the last practical deadline for establishing a new hive this spring, I drove home with a shoebox-sized container full of about as many bees as there are codes in ICD-9-CM, and I nervously dumped them into the hive box. My wife and I welcomed them by planting bee-friendly flowers, feeding them sugar water, and hovering over the hive as we did our first child. The bees survived in spite of us.

The hive's population has grown to around 70,000 worker bees, or about as many codes as you'd find in ICD-10. They're pretty self-sufficient, and our regular inspections are becoming fewer and more comfortable as we interact with them. While it's understandable that we had doubts and delays, our anxiety seems silly now. They are a part of our lives, and someday we may harvest honey. More importantly, the world needs more bees to keep plants pollinated and people fed.

What does this have to do with coding? We often seek metaphors to help us with challenges. For the last decade or so, ICD-10 has consumed a good part of our lives while we prepare to use it for all claims. On-again, off-again, ICD-10 has suffered so many delays some believe it won't happen. Rumors about it abound, and some challenge its necessity and efficacy.

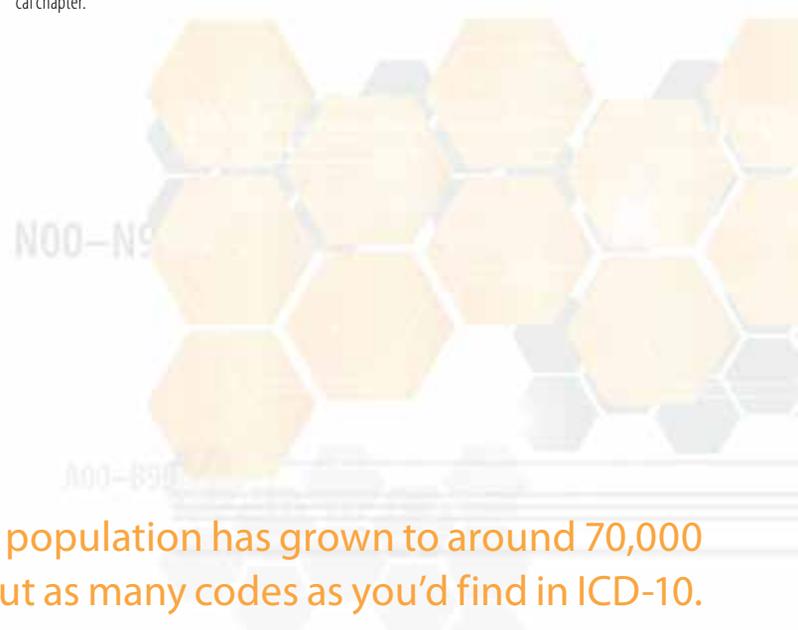
Like our codes, worker bees are individual in activity and purposeful in union. Each worker returns with a unique tale. She carries pollen specific to a plant, and communicates the site and distance of that plant to her colleagues with impressive accuracy. Her role can be appended by the information she brings back or by the state of the hive itself. The

ultimate goal is to preserve the hive through expansion and food production. Each hive hums with energy and shared knowledge.

When accepted as they are rather than feared for what they might be, ICD-10 codes are our worker bees, foraging information that makes up an accurate description of a patient's illness or injury. Neither ICD-10 codes nor bees bear malice, nor do they cause havoc unless mishandled. ICD-10 codes thrive when surrounded by the blossoms of knowledge and acceptance, like honey bees. We harvest honey from bees in the same way we hope to harvest revenue from the new code set.

ICD-10 will finally be implemented in a couple of months. Like my hive, its novelty soon will be forgotten. ICD-10 will help us care for patients and assure our employers' accurate and timely reimbursement. ICD-10 will be a part of our lives, and we may well reap the harvest. More importantly, the world needs the information ICD-10 allows us to share. **HBM**

Brad Ericson, MPC, CPC, COSC, is director of publishing at AAPC and a member of the Salt Lake City, Utah, local chapter.



The hive's population has grown to around 70,000 worker bees, or about as many codes as you'd find in ICD-10.

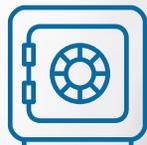


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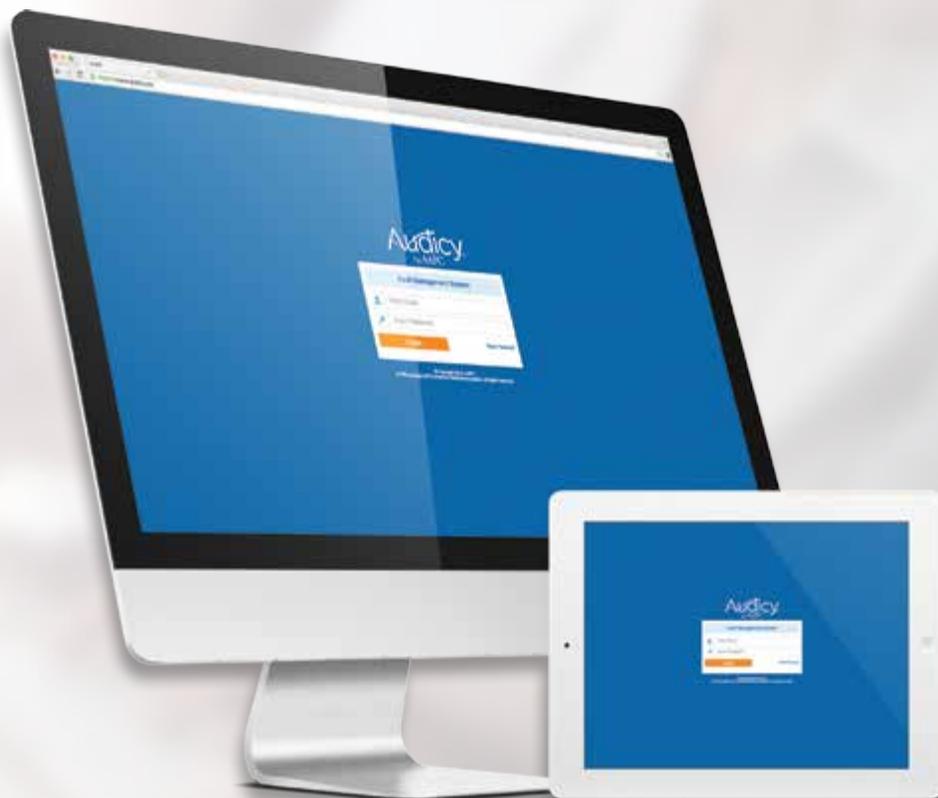
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