

What's New in 2010?

Coding Updates for the Physician Office



Health Directions

Business solutions for healthcare organizations

Presented to

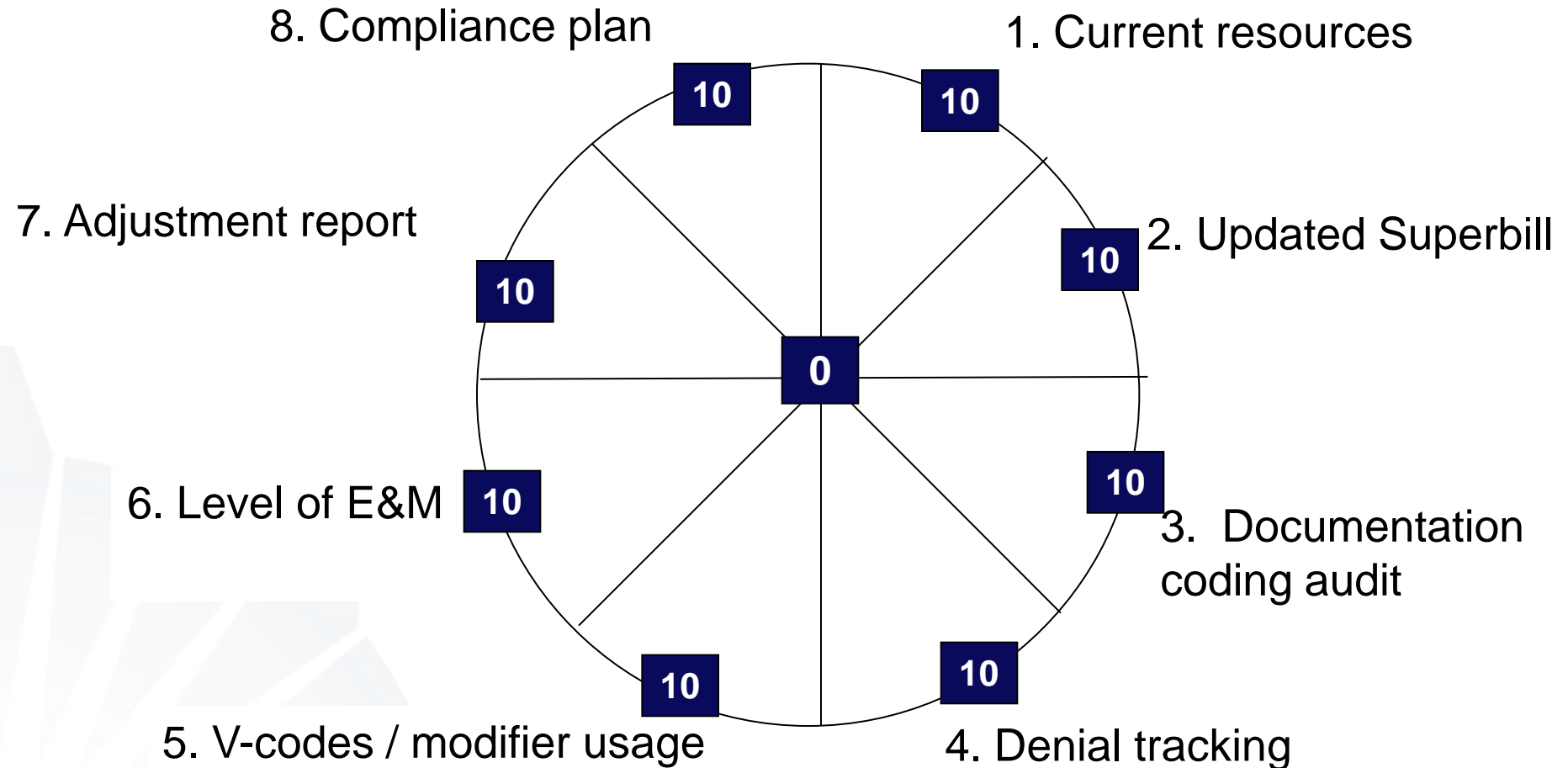
 **Advocate**
• **Christ Medical Center**

February 24, 2010

Agenda

- Assess your practice
- Introduce coding resources
- Review basic coding and documentation principles
- Present 2010 updates
 - CPT codes
 - ICD-9 codes
 - Medicare
 - HIPAA
- Discuss practice improvement tools
- Plan for ICD-10 implementation
- Create your Action Plan

Assess Your Practice: Coding Wheel



What is Coding?

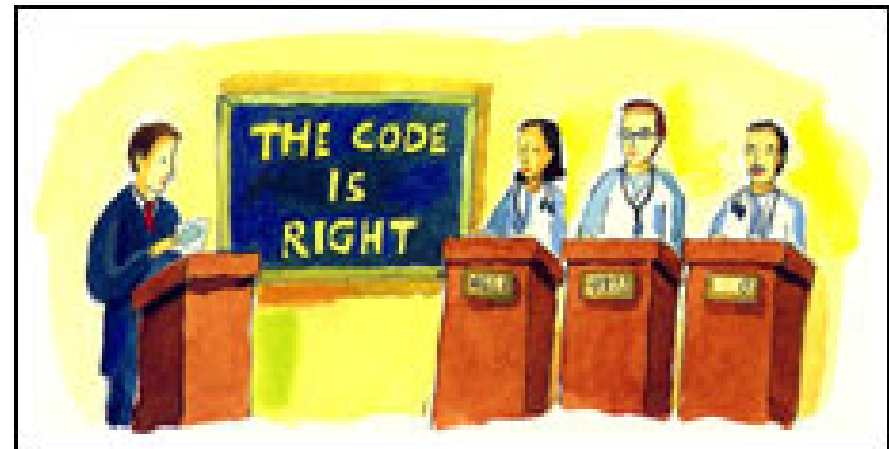
Coding is assigning codes to diagnoses and procedures, which

- helps in financial reimbursement from insurance companies, government agencies and patients
- supports quality and improved patient outcomes



Why is correct coding important?

- Improves reimbursement and cash flow
- Decreases denials
- Results in timely payments from payors
- Fosters positive patient relations
- May aid in contract negotiations
- Avoids audits and penalties
- Avoids Qui Tam



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Correct Coding

- If you...
 - Suspected it
 - Considered it
 - Reviewed it
 - Ruled it out
 - Discussed it
 - Monitored it
 - Were concerned about it
 - Thought about it
 - Disregarded it

Document it
or it did not
happen!

3 “Iron Rules” of Coding

1. To be paid appropriately, you must code accurately.
2. You must code what you document. You must document what you code.
3. You (physician) are responsible for all coding.

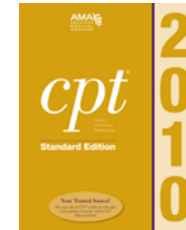
“Top 10” Coding Errors

1. Incomplete documentation
2. Not meeting CPT criteria
3. Inappropriate coding of physicals and preventative care
4. Non-covered services billed
5. CPT and ICD-9 codes are not linked
6. Undercoded levels of service
7. Modifiers not used
8. CPT codes unbundled
9. Medical necessity not documented
10. Assumptive coding

Coding Resources

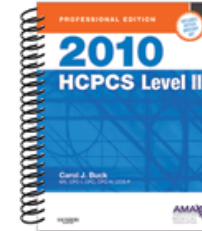
- **CPT 2010:** Current Procedural Terminology

- Updated January 1, 2010



- **HCPCS Level II 2010:** Healthcare Common Procedure Coding System

- Updated January 1, 2010

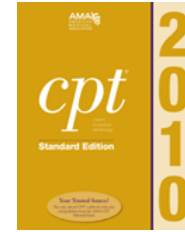


- **ICD-9 2010:** International Classification of Diseases

- Updated October 1, 2009



CPT 2010



What is it?

- A systematic listing of descriptive terms and identifying codes for reporting services and procedures performed by physicians

Purpose

- To provide a uniform language that will accurately describe medical, surgical and diagnostic services for communication/billing purposes

CPT 2010

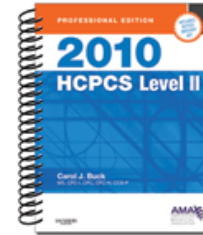
Divided into six sections

1. Evaluation & Management (E & M)
 2. Anesthesiology
 3. Surgery
 4. Radiology
 5. Pathology & Laboratory
 6. Medicine
-plus Appendices

“Five Steps” for CPT Coding

1. Search the index
2. Locate the code
3. Review the guidelines
4. Select the code that accurately identifies the service/procedure
5. If service/procedure was altered, use a modifier (for example:
 - -25 Significant, separately identifiable E&M services by the same physician on the same day of the procedure
 - -59 Distinct procedural services
 - -52 Reduced services

HCPCS 2010



What is it?

- A uniform method for providers and suppliers to report professional services, procedures, and supplies. HCPCS is the second level of codes not found in the CPT book.

Purpose

- To provide a uniform language that will accurately describe medical, surgical and diagnostic services for communication/billing purposes

HCPCS 2010: Categories

1. **Medical & Surgical Supplies**
2. Enteral and Parenteral Therapy
3. Temporary Codes
4. Dental Procedures
5. Durable Medical Equipment
6. **Procedures/Professional Services**
7. **Drugs Administered**
8. Orthotic/Prosthetic Procedures
9. Medical Services
10. Hearing Services

CPT Coding: E&M Services

Select Categories

- Office/Outpatient Services
- Hospital Observation Services
- Hospital Inpatient Services
- Consultations
- Emergency Department Services
- Critical Care Services
- Nursing Facility Services
- Preventive Medicine Services

E&M Services: New vs.. Established Patient

A new patient is one who has not received any services from the physician or another physician of the **same specialty** who belongs to the **same group** practice (FEIN) **within three years.**



E&M Documentation Guidelines

- Providers can use 1995 or 1997 guidelines
<http://cms.hhs.gov/medlearn/emdoc.asp>
- 1997 guidelines expand to single organ exams
- Payors will apply whichever is most advantageous to the provider

Key Components

1. History of Presenting Condition
2. Examination
3. Complexity of medical decision
4. Time

1. History

- Chief complaint (CC)
- History of present illness (HPI)
- Review of systems (ROS)
- Past family and social history (PFSH)

2. Exam

Types of examinations

- General Multi-system
- Cardiovascular
- Ear, Nose, Throat
- Eye
- Genitourinary
- Hematologic/Lymphatic/Immunologic
- Musculoskeletal
- Neurological
- Psychiatric
- Respiratory
- Skin

3. Complexity of Medical Decision Making

- Number of diagnoses or treatment options
- Amount and/or complexity of data to be reviewed
- Risk of complications and/or morbidity or mortality

Table of Risk

Level of Risk	Presenting Problem(s)	Diagnostic Procedure(s) Ordered	Management Options Selected
Minimal	One self-limited or minor problem, eg, cold, insect bite, tinea corporis	Laboratory tests requiring venipuncture Chest x-rays EKG/EEG Urinalysis Ultrasound, eg, echocardiography KOH prep	Rest Gargles Elastic bandages Superficial dressings
Low	Two or more self-limited or minor problems One stable chronic illness, eg, well controlled hypertension, non-insulin dependent diabetes, cataract, BPH Acute uncomplicated illness or injury, eg, cystitis, allergic rhinitis, simple sprain	Physiologic tests not under stress, eg, pulmonary function tests Non-cardiovascular imaging studies with contrast, eg, barium enema Superficial needle biopsies Clinical laboratory tests requiring arterial puncture Skin biopsies	Over-the-counter drugs Minor surgery with no identified risk factors Physical therapy Occupational therapy IV fluids without additives
Moderate	One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment Two or more stable chronic illnesses Undiagnosed new problem with uncertain prognosis, eg, lump in breast Acute illness with systemic symptoms, eg, pyelonephritis, pneumonitis, colitis Acute complicated injury, eg, head injury with brief loss of consciousness	Physiologic tests under stress, eg, cardiac stress test, fetal contraction stress test Diagnostic endoscopies with no identified risk factors Deep needle or incisional biopsy Cardiovascular imaging studies with contrast and no identified risk factors, eg, arteriogram, cardiac catheterization Obtain fluid from body cavity, eg lumbar puncture, thoracentesis, culdocentesis	Minor surgery with identified risk factors Elective major surgery (open, percutaneous or endoscopic) with no identified risk factors Prescription drug management Therapeutic nuclear medicine IV fluids with additives Closed treatment of fracture or dislocation without manipulation
High	One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment Acute or chronic illnesses or injuries that pose a threat to life or bodily function, eg, multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure An abrupt change in neurologic status, eg, seizure, TIA, weakness, sensory loss	Cardiovascular imaging studies with contrast with identified risk factors Cardiac electrophysiological tests Diagnostic Endoscopies with identified risk factors Discography	Elective major surgery (open, percutaneous or endoscopic) with identified risk factors Emergency major surgery (open, percutaneous or endoscopic) Parenteral controlled substances Drug therapy requiring intensive monitoring for toxicity Decision not to resuscitate or to de-escalate care because of poor prognosis

4. Time

When counseling or coordination of care takes more than half (>50%) of the “face-to-face” time, the length of the time determines the level of service.

Documentation must include:

- ✓ the total face-to-face time
- ✓ time spent counseling/coordination of care
- ✓ the nature of counseling/coordination of care

Coding Office Visits : Time as Factor

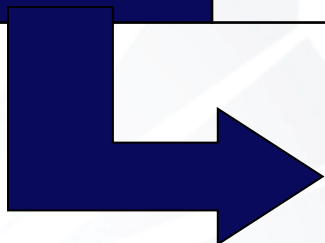
New Patient	Time	Established Patient	Time
99201	10	99211	5
99202	20	99212	10
99203	30	99213	15
99204	45	99214	25
99205	60	99215	40
*99354	Add'l 1 hour	*99354	Add'l 1 hour
*99355	Add'l 30 minutes	*99355	Add'l 30 minutes

E&M Documentation: Key Points

- Documentation or checklists completed by staff and/or patient
- Review of previous records
- Discussions with patients
- History not obtained from patient
- Normal vs. Abnormal findings
- Your “secret code”

Coding E&M: New Patient Office Visit

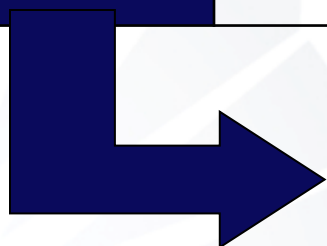
	99201	99202	99203	99204	99205
Decision Making	Straight-forward	Straight-forward	Low	Moderate	High
History	Problem focused	Expanded problem focused	Detailed	Comprehensive	Comprehensive
Exam*	Problem focused (< 6 elements)	Expanded problem focused (≥ 6 elements)	Detailed (≥ 2 elements from 6 systems OR ≥ 12 elements)	Comprehensive (All elements from ≥ 9 systems)	Comprehensive (All elements from ≥ 9 systems)



Meet 3 out of 3 requirements

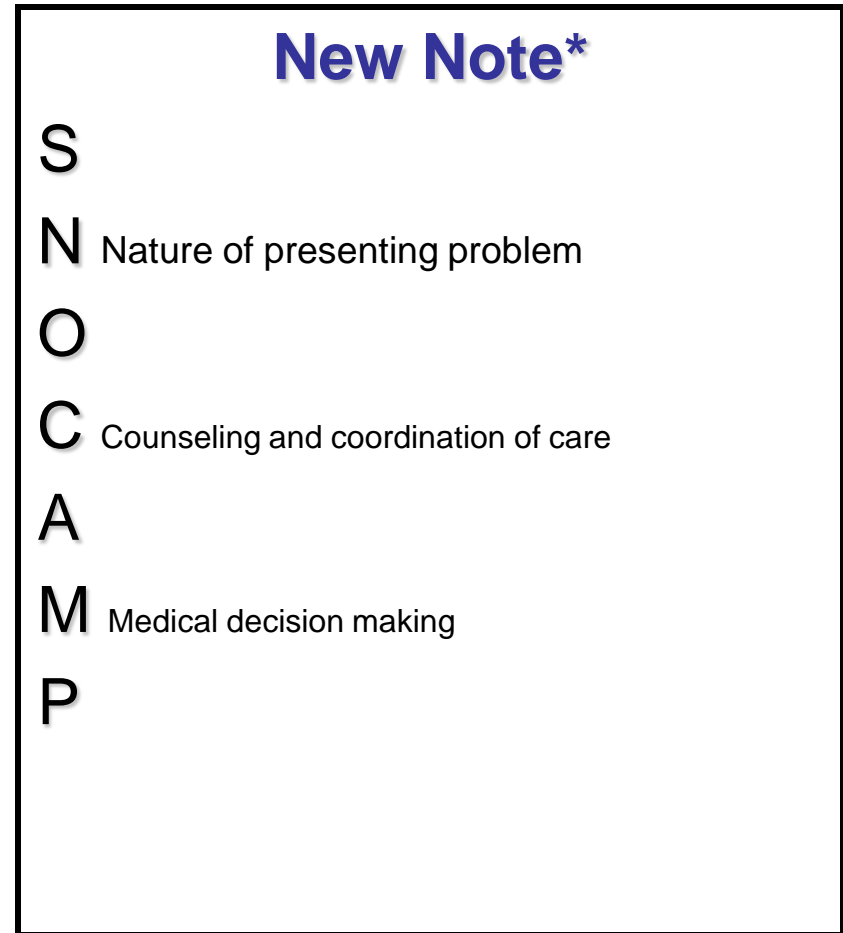
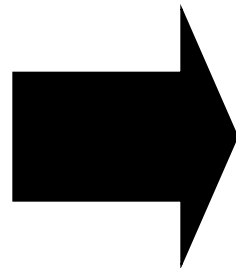
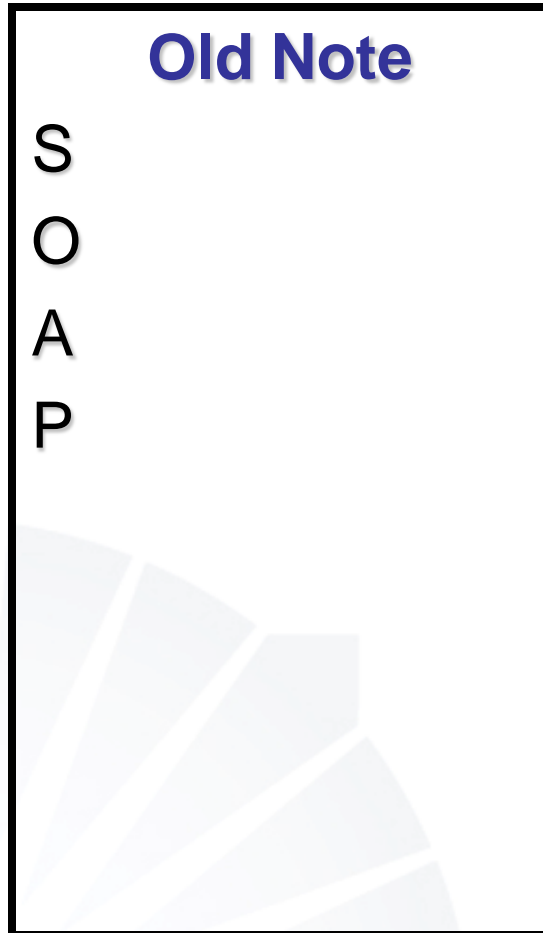
Coding E&M: Established Patient Office Visit

	99211	99212	99213	99214	99215
Decision Making	Presenting Problem is minimal	Straight-forward	Low	Moderate	High
History		Problem focused	Expanded problem focused	Detailed	Comprehensive
Exam*		Problem focused (1-5 elements)	Expanded problem focused (≥ 6 elements)	Detailed (≥ 2 elements from 6 systems OR ≥ 12 elements)	Comprehensive (All elements from ≥ 9 systems)



Meet 2 out of 3 requirements

E&M Documentation: Medical Note

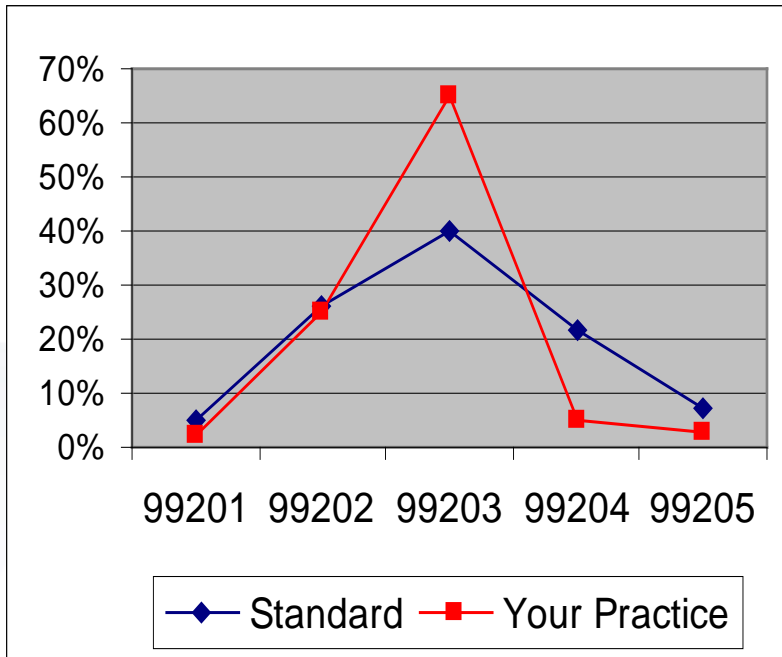


Doe, John 4/10/68

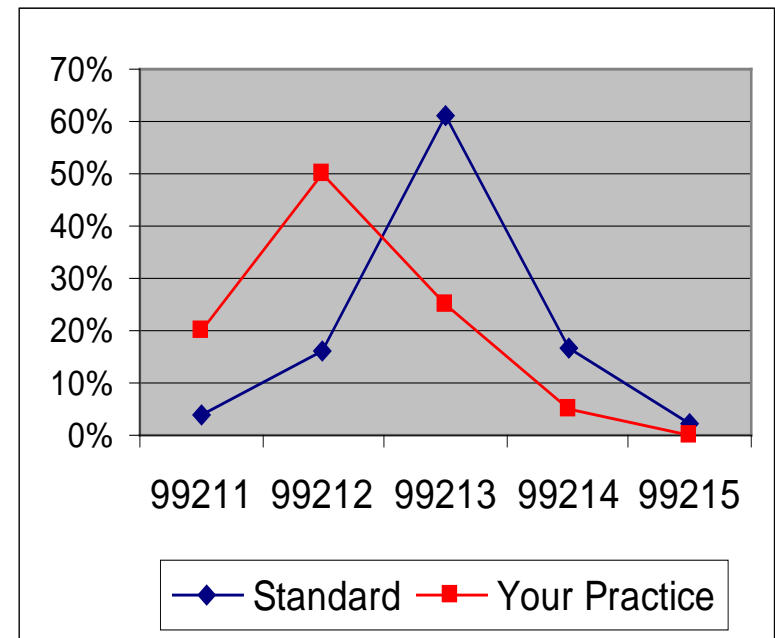
- S:** Patient returns, complains of sneezing, itchy/watery eyes and stuffy nose; no history of hay fever.
- N:** Low severity.
- O:** HEENT: Bilateral conjunctival cobblestoning with minimal erythema and no discharge. PERL. EOMs intact. Nasal turbinates boggy. Pharynx and ears nl.
- C:** Discussed diagnostic impression, risks/benefits of mgmt options with patient. (List time here – start time, end time - if more than half the visit.)
- A:** 1. Allergic rhinitis.
2. Allergic conjunctivitis.
- M:** Straightforward.
- P:** 1. Bleph-10 Ophthalmic Solution, 2 dp ou qid x 5 d.
2. Claritin-D, 1 po bid prn (#30 NR, but may call for refill of #30 x prn).
3. Follow-up prn.

E&M Frequency Distribution

NEW PATIENT



ESTABLISHED PATIENT



CPT Coding: Surgery

Global Package

Single fee which is billed for all necessary services normally furnished by the surgeon before, during and after the procedure. Major surgeries have a have follow up periods 90 days, while minor surgeries have 0-10 days.

Included

- Services performed by the surgeon in the pre-op and post-op period
 - Dressing change, incision care
 - Removal of sutures, tubes, drains, etc.
 - Urinary catheters
 - IV lines, NG/rectal tubes
 - Change/removal trach tubes
 - Treatment of complications

Not Included

- Services of other physicians
- Treatment of underlying conditions
- Performance of extensive procedures
- Clearly distinct surgical procedures during post-op period
- Visits during post op that are not related to the recovery of surgery

CPT Coding: Surgery Modifiers

- -24, Unrelated E&M service during the postoperative period
- -25, Significant, separately identifiable E&M service the day of a surgical procedure
- -53, Discontinued procedure
- -55, Postoperative management only
- -57, Initial decision to perform major surgery
 - May be performed the day or the day before major surgery
- -59, Distinct procedural service
- -62, Two surgeons
- -80, Assistant surgeon

2010 CPT Coding Updates: Resequencing

- Resequenced codes can be found in applicable procedures/service sections based upon anatomy and key terms
- May not be in numeric order
- New codes
 - Assigned the closest number available to the applicable section
- Existing codes
 - Relocated to the applicable section

Resequencing Codes

- 27 codes resequenced, see Appendix N
- “#” = Resequenced code

#▲ 46320 Excision of thrombosed hemorrhoid, external

- Resequenced codes are notated
 - “Code is out of numerical sequence. See 28043-28175.”

2010 CPT Code Updates

Section	Added	Deleted	Revised
Anesthesia	0	1	0
E&M	0	0	0
Surgery	79	12	95
Radiology	14	11	3
Path/Lab	15	2	15
Medicine	21	4	16
Category II	79	14	12
Category III	11	19	0
Totals	219	63	141

2010 CPT Code Updates: Surgery

Section	Added	Deleted	Revised
Integumentary	2	1	1
Musculoskeletal	41	7	54
Respiratory	6	0	9
Cardiovascular	8	1	6
Digestive	7	4	18
Urinary	4	2	4
Reproductive	1	0	3
Nervous	10	5	0
Eye	0	0	0
Auditory	0	0	0

2010 CPT Updates

- **E&M**

- Consults
- Transfer of Care
- Concurrent Care
- Nursing Facility

- **Vaccines**

- **Surgery**

- Integumentary
- Musculoskeletal
- Respiratory
- Cardiovascular
- Digestive
- Urinary
- Nervous
- Radiology
- Pathology and Laboratory
- Medicine

Consultations

- Office/Outpatient (99241 – 99245)

- Inpatient (99251 – 99255)

- A consultation is a type of E&M service provided by a physician at the **request of another physician** or appropriate source
 - to recommend care for a specific condition or problem
OR
 - to determine whether to accept responsibility for ongoing management of the patient's care OR for the care of a specific condition or problem
- Medicare's Final Rule for 2010 eliminates the payment of consultation services for Medicare patients

Documenting Consultations: “ Three Rs”

- The written or verbal Request may be made by a physician or other appropriate source and documented in the patient’s medical record by either the consulting or requesting physician or appropriate source.
- The consultant’s Rendered opinion and any services that were ordered or performed must also be documented in the patient’s medical record.
- Such services must be communicated by written Report to the requesting physician or other appropriate source.

Transfer of Care

- The physician, who is providing management for some/all of patient's problems, **relinquishes this responsibility** to another physician.
- The other physician explicitly **agrees to accept this responsibility** (and does not provide consultative services.)
- The physician transferring care is no longer providing care for these problems, though may continue providing care for other conditions.
- The physician should code using the appropriate new or established patient E&Ms, not consultation codes.

Concurrent Care

- Concurrent care is the provision of similar services (hospital visits) to the same patient by more than one physician on the same day.
- When concurrent care is provided, no special reporting is required, but
 - Medical necessity is required
 - Documentation is crucial
- ✓ Report only the diagnosis for which the patient is being seen.

Nursing Facility Services

- Initial Nursing Facility Care (99304 - 99306)
- Subsequent Nursing Facility Care (99307- 99310)
- Annual Nursing Assessment (99318)

- Revised from “physician/patient face-to-face time” to “time spent on the patient's unit or floor”
- Codes recognize the time physicians spend on chart review, documentation and communication with the patient's family
- Time spent off the patient's floor is considered pre- or post-service work and is not included in floor time

Nursing Facility Services : Time as Factor

New Visit	Time	Subsequent Visit	Time
99304	25	99307	10
99305	35	99308	15
99306	45	99309	25
		99310	35
*99356	Add'l 1 hour	*99356	Add'l 1 hour
*99357	Add'l 30 minutes	*99357	Add'l 30 minutes

Vaccines

- Some vaccines and toxoids now include age and “preservative free” designations
- 90378, Respiratory syncytial virus now indicates that it is for reporting a recombinant monoclonal antibody rather than an immune globulin
- 90379, deleted, no longer available
- 90669, Pneumococcal conjugate vaccine now indicates that it is used to report a 7 valent
- 90670, Pneumococcal conjugate vaccine, 13 valent (pending FDA approval)
- 90644, Hib-MenCY-TT vaccine (pending FDA approval)

2010 Surgery Updates

- **Integumentary**

- Adjacent tissue transfer (14301 – 14302)

- **Musculoskeletal**

- Soft tissue tumor excisions, head (21011 - 21016)
- Soft tissue tumor excisions, neck (21552 – 21558)
- Soft tissue tumor excisions, back (21930 – 21936)
- Soft tissue tumor excisions, abd (22900 – 21905)
- ...etc.
- Application of multi-layer venous wound compression system, below knee (different than Unna Boot) (29581)

2010 Surgery Updates

- **Respiratory**

- Bronchoscopy (31622)
 - with placement of fiducial markers (31626)
 - With computer-assisted, image-guided navigation (31627)
- Removal of indwelling tunneled pleural catheter with cuff (32552)

- **Cardiovascular**

- Ventricular assist device (33981-33983)
- Ligation of perforator veins (37760-37761)

2010 Surgery Updates

- **Digestive**

- Laparoscopy, surgical, repair of paraesophageal hernia (43281 – 43282)
- Excision of rectal tumor, transanal approach (45171 – 45172)
- Anus, excision (ie, fissurectomy, hemorrhoidectomy) (46220 – 46280)

- **Urinary**

- Insertion of temporary prostatic urethral stent (53855)

2010 Surgery Updates

- **Nervous**

- Neurostimulator electrode (63661-63664)
- Paravertebral facet joint injections (64490-64495)

- **Radiology**

- CT colonography (74261-74263)
- Cardiac CT/MR (75565-75574)
- Myocardial perfusion imaging (78451-78454)

2010 Surgery Updates

- **Pathology/Lab**

- New reporting guidelines for panel codes (80047-80076)
- Immunoassay codes revised (83516-83520)

- **Medicine**

- Tympanometry (92550)
- Pacemaker codes revised (93279-93287)
- Nerve conduction (95905)

ICD-9 2010



What is it?

- Statistical classification system that arranges diseases and injuries into groups according to established criteria.


Purpose

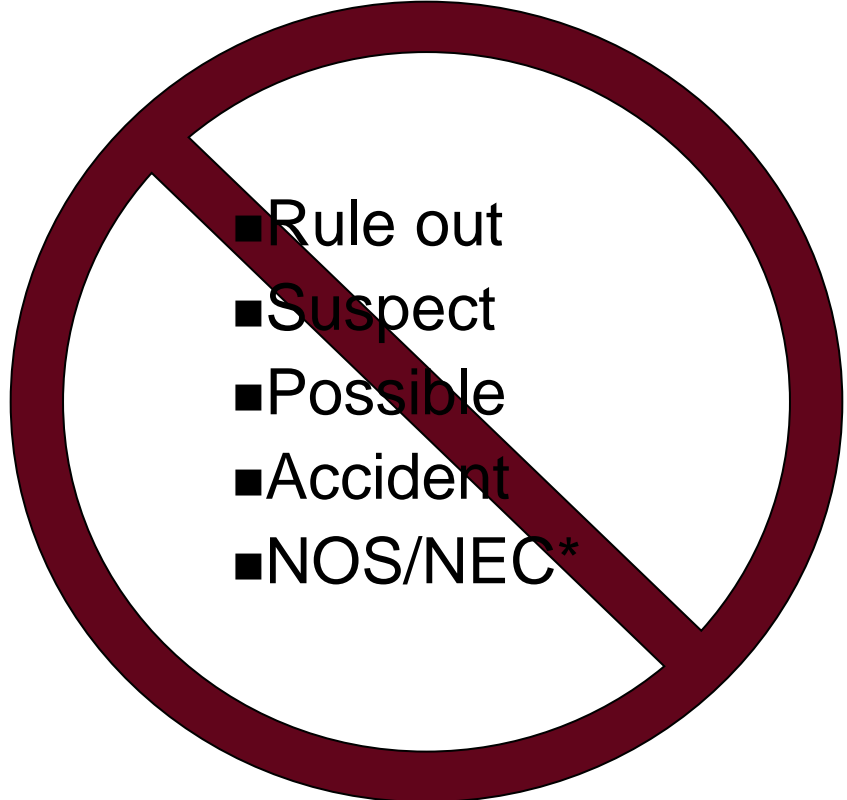
- To provide a classification of morbidity and mortality information for statistical purposes, for the indexing of medical records by disease and operations, for data storage and retrieval and most importantly, for billing purposes.

“Five Steps” for ICD-9 Coding

1. Locate the term in the Alphabetic Index.
2. Confirm the main term in the Tabular List.
3. Refer to all notes and instructions.
4. Take note of indented subterms indicating greater specificity.
5. Watch for exclusions, notes and fifth-digit instructions.

ICD-9 Coding

- 
- Disease/Injury
 - Sign/Symptom
 - Primary vs. Principle

- 
- Rule out
 - Suspect
 - Possible
 - Accident
 - NOS/NEC*

ICD-9 Coding

“Coding to the highest specificity” example

^{5th} <u>250.0</u>	Diabetes mellitus without mention of complication
	Diabetes mellitus without mention of complication or manifestation classifiable to 250.1-250.9
<u>250.00</u>	Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled
<u>250.01</u>	Diabetes mellitus without mention of complication, type I [juvenile type], not stated as uncontrolled
<u>250.02</u>	Diabetes mellitus without mention of complication, type II or unspecified type, uncontrolled
<u>250.03</u>	Diabetes mellitus without mention of complication, type I [juvenile type], uncontrolled

Otherwise medical necessity may be questioned

ICD-9 Coding: V codes

Encounters for circumstances other than a disease or injury or supporting factors that influence care

Use V codes when

- the patient is not “sick” and seeks services for a specific reason
- a diagnosis is not established
- to support the reason for the encounter
- a sign or symptom is being studied
- aftercare is sought for a resolving or chronic condition (i.e. dialysis, chemo, cast change)
- circumstances influence the patient’s health status but are not a current illness or injury
- Newborns, to indicate birth status

Categories

- Contact/exposure
- Inoculations/vaccinations
- Status
- History (of)
- Screening
- Observation
- Aftercare
- Follow-up
- Donor
- Counseling
- Obstetrics, Newborn, Infant, Child
- Routine and administrative exams

ICD-9 2010 Updates

- Avian and Novel Influenza Virus
 - 488.0, Influenza due to identified avian influenza virus
 - 488.1, Influenza due to identified novel H1N1 influenza virus
- Merkel Cell CA
- Neuroendocrine Tumors
- Retina and Choroid Neoplasms
- Gout
 - 271.01, Acute gouty arthropathy
- Tumor Lysis Syndrome
- ALPS
- Antineoplastic Chemotherapy-Induced Anemia
- Temporal Sclerosis

ICD-9 2010 Updates

- Inclusion Body Myositis
- Acute Chemical Conjunctivitis
- Venous Thrombosis and Embolism and Pulmonary Emboli
- Pouchitis
- Endometrial Hyperplasia
- Puerperal Infections
- Omphalocele and Gastroschisis
- Hypoxic-Ischemic Encephalopathy
- Fluency Problems
 - 784.42, dysphonia
 - 784.44, hyponasality
 - 784.43, hypernasality

ICD-9 2010 Updates

- Newborns/Infants
 - 789.7, Colic
 - 779.31, Feeding problems
 - 779.32 Bilious vomiting
 - 779.34, Failure to thrive
 - 799.82, Apparent Life-Threatening Event
- Signs and Symptoms Involving Emotional State
 - 799.21, nervousness
 - 799.22, irritability
 - 799.23, impulsiveness
 - 799.24, emotional lability
 - 799.25 demoralization and apathy

ICD-9 2010 Updates

- Inconclusive Mammogram—Nonspecific Finding
 - 793.82, was created to explain this finding and justify the need for further testing
 - 793 was changed to “Nonspecific (abnormal) findings on radiological and other examination of body structure
- Vomiting
 - 569.87, vomiting of fecal matter
 - 787.04, bilious emesis
- Torus Fracture
 - 813.46 torus or buckle fracture of the ulna
 - 813.47 radius and ulna
- Nursemaid’s Elbow
- Poisoning by Antidepressants and Psychostimulants
- Failed Sedation
- Traumatic Brain Injury

ICD-9 2010 Updates

- Underimmunization Status
 - V15.83, underimmunization status or delinquent immunization status
- Newborn Post-Discharge Health Check
 - V20.31 health supervision for newborn under age 8 days
 - V20.32 health supervision for newborn eight to 28 days old
- Other New V Codes
 - V26.42, Encounter for fertility preservation counseling
 - V60.81, Foster care (status)
 - V61.07, Family disruption due to death of family member
 - V61.08, Family disruption due to other extended absence of family member
 - V61.23, Counseling for parent-biological child problem
 - V61.42, Substance abuse in family
 - V72.60, Laboratory examination, unspecified
 - V72.62, Laboratory exam ordered as part of a routine general medical exam
 - V72.63, Preprocedural laboratory examination
 - V87.43, Personal history of estrogen therapy

ICD-9 2010 Updates:

Invalid Codes (sample list)

- 274.0, Gouty arthropathy
- 453.8, Other venous embolism and thrombosis of other specified veins
- 488, Influenza due to certain identified influenza viruses
- 784.5, Other speech disturbance
- 779.3, Feeding problems in newborn
- 799.2, Signs and symptoms involving emotional state (nervousness)
- 769.0, Poisoning by antidepressants
- V10.9, Unspecified personal history of malignant neoplasm
- V72.6, Laboratory examination
- V80.0, Special screening for neurological conditions

Access a complete list of new, deleted and revised codes:

http://www.cms.hhs.gov/icd9ProviderDiagnosticCodes/07_summarytables.asp

CPT and ICD-9 Sequencing and Linking

- Code coexisting conditions that affect the patient's treatment in that visit
- Link the appropriate ICD-9 codes to CPT code - establishes **medical necessity**
- Prioritize your ICD-9 codes for each CPT code
- Code chronic conditions only when they apply to the patient's treatment
- Don't code diagnoses that are no longer being treated or that don't affect your care of the patient
- List CPT codes in order of RVU value
- Code only what you know to be a fact

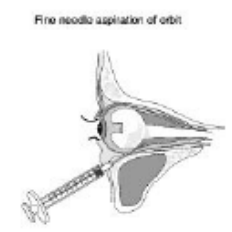
Case Study: Coding Patty Wood's visit

Coding Resources

- CCI edits
<http://www.cms.hhs.gov/NationalCorrectCodInitEd/NCCIEP/list.asp#TopOfPage>
- LCDs http://www.wpsmedicare.com/part_b/policy/active/index.shtml
- Provider handbooks from payors
- Coding Software
 - Doc Office Rx
 - Ingenix: EncoderPro
 - CodeCorrect
 - FlashCode
- Your EMR/PM system

General Code Information

CPT Code:	10021	Quarter: Jan - March 2010
Description:	Fine needle aspiration; without imaging guidance	
Lay Description:	<p>Fine needle aspiration (FNA) is a percutaneous procedure that uses a fine gauge needle (often 22 or 25 gauge) and a syringe to sample fluid from a cyst or remove clusters of cells from a solid mass. First, the skin is cleaned. If a lump can be felt, the radiologist or surgeon guides a needle into the area by palpating the lump. If the lump is non-palpable, the FNA procedure is performed under image guidance using fluoroscopy, ultrasound, or computed tomography (CT), with the patient positioned according to the area of concern. In fluoroscopic guidance, intermittent fluoroscopy guides the advancement of the needle. Ultrasonography-guided aspiration biopsy involves inserting an aspiration catheter needle device through the accessory channel port of the echoendoscope; the needle is placed into the area to be sampled under endoscopic ultrasonographic guidance. After the needle is placed into the region of the lesion, a vacuum is created and multiple in and out needle motions are performed. Several needle insertions are usually required to ensure that an adequate tissue sample is taken. CT image guidance allows computer-assisted targeting of the area to be sampled. At the completion of the procedure, the needle is withdrawn and a small bandage is placed over the area. Report 10021 if fine needle aspiration is performed without imaging guidance. Report 10022 if imaging guidance is used to assist in locating the lump.</p>	



MPFS Information Locality:00952-16 Chicago

Physician Fee Schedule Information - Nonfacility: RVUs					Physician Fee Schedule Information - Facility: RVUs						
Work:	PE:	Malpractice:	Total:	Conv:	Total \$:	Work:	PE:	Malpractice:	Total:	Conv:	Total \$:
1.3018	2.4084	0.2910	4.0012	36.0846	144.38	1.3018	0.4968	0.2910	2.0896	36.0846	75.40

Color Codes:

P2 ASC Payment Indicator - P2	80 Assist-at-Surgery Allowed With Documentation	CC CCI Comprehensive Code	T OPSI Code - T
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CMS Modifiers:	Ingenix Modifiers:
80	52 53 58 59 73 74 76 77 78 80 81 82 99 AQ AR AS GA GC GR GY GZ KX Q5 Q6 QJ

CCI Component:	CCI Mutually Exclusive:	CCI Greater PX:
19298 36000 36410 87202 62318 62319 64415 64416 64417 64450 64490 64493 76000 76001 76942 77002 77012 77021 96360 96365 96372 96374 96375 96376 J2001		

	032.89	039.8	074.8	075	078.5	084.9	095.8	116.0	125.0	125.1	125.2	125.3	125.4	125.5	125.6	125.7	125.9
Anesthesia Cross Codes:	135	155.0	155.1	155.2	157.0	157.1	157.2	157.3	157.4	157.8	157.9	158.0	158.8	158.9	159.8	162.2	162.3
Not Applicable	162.4	162.5	162.8	162.9	163.0	163.8	163.9	164.2	164.3	164.8	164.9	172.5	172.6	172.7	172.8	173.5	174.0
	174.1	174.2	174.3	174.4	174.5	174.6	174.8	175.0	175.9	176.4	180.9	182.0	183.0	183.2	183.8	185	186.0
	186.9	187.5	188.9	189.0	189.1	193	195.1	195.2	196.0	196.1	196.2	196.3	196.5	196.6	196.8	196.9	197.0
	197.1	197.2	197.6	197.7	197.8	198.0	198.81	198.82	198.89	199.0	199.1	199.2	200.00	200.01	200.04	200.05	200.08
HCPCS Cross Codes:	200.10	200.14	200.15	200.18	200.20	200.21	200.24	200.25	200.28	200.30	201.00	201.01	201.04	201.05	201.08	201.10	201.14
Not Applicable	201.15	201.18	201.20	201.24	201.25	201.28	201.40	201.44	201.45	201.48	201.51	201.54	201.55	201.58	201.60	201.61	201.65
	201.68	201.70	201.71	201.74	201.75	201.78	201.90	201.91	201.94	201.95	201.98	202.00	202.01	202.04	202.05	202.08	202.10
CPT Cross Codes:	202.11	202.14	202.15	202.18	202.20	202.21	202.28	202.30	202.31	202.34	202.35	202.38	202.40	202.41	202.44	202.45	202.48
Not Applicable	202.50	202.51	202.54	202.55	202.58	202.60	202.61	202.64	202.65	202.68	202.80	202.81	202.84	202.85	202.88	202.91	202.94
	202.95	202.98	209.00	209.01	209.02	209.03	209.10	209.11	209.12	209.13	209.14	209.15	209.16	209.17	209.20	209.21	209.22
ICD9 V3 Procedure Cross Codes:	209.23	209.24	209.25	209.26	209.27	209.29	209.30	209.40	209.41	209.42	209.43	209.50	209.51	209.52	209.53	209.54	209.55
Not Applicable	209.56	209.57	209.60	209.61	209.62	209.63	209.64	209.65	209.66	209.67	209.69	209.70	209.71	209.72	209.74	209.79	211.5
	211.6	211.7	211.8	211.9	212.3	212.4	212.5	212.8	214.0	214.1	214.2	214.3	214.4	214.8	214.9	215.0	215.2

Medicare Updates

- Deductible: \$155 (Part B)
- Coinsurance: 20%
- Medicare conversion factor is frozen for 60 days (2/28/10)
- Effective Jan 1st, Medicare will no longer pay for consultation code, hence use another E&M code
- Medicare has “revalued” other E&M codes
 - Outpatient Visits, Work RVUs increased by 6%
 - Inpatient Visits, Work RVUs increased by 2%
- Reimbursement increased for Medicare OP Psychiatric Services

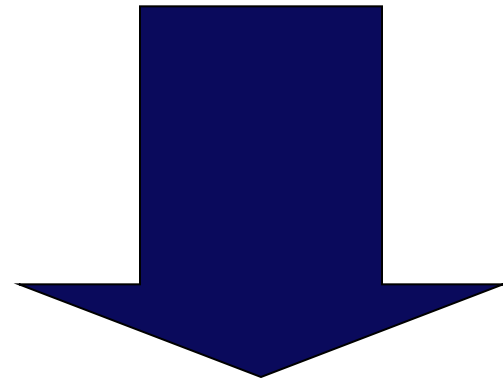
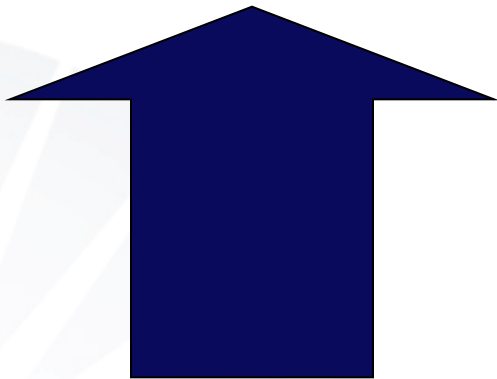
Consultation Crosswalk Table

Consult	New Patient	Established Patient
99241	99201	99212
99242	99202	99213
99243	99203	99214
99244	99204	99215
99245	99205	99215 + 99354

Inpatient Consult Codes	Hospital Inpatient Services
99251- 99255	99221 – 99233 + 99356

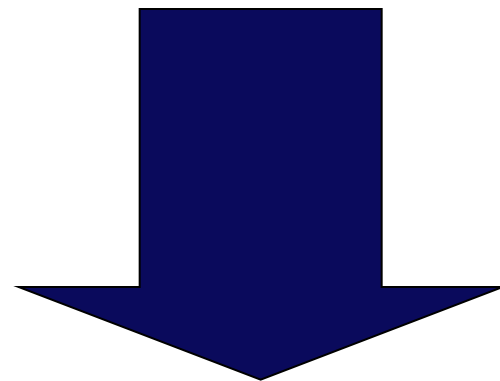
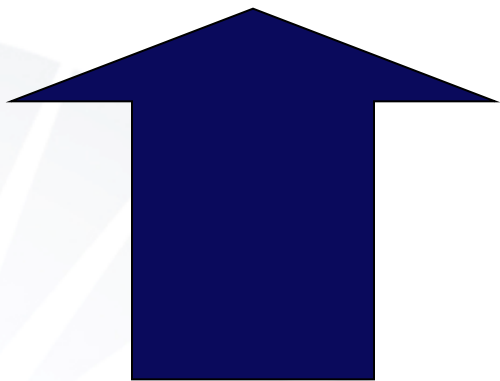
Medicare Reimbursement

- New Patient Visits
- Established Patient Visits
- Initial Hospital Care
- Initial Nursing Facility Care
- Some Surgical Procedures (because of post op care)
- Inpatient Consults
- Outpatient Consults who return with new injury/illness within three years of a previous visit



Projected Reimbursement Impact

- Ophthalmology +5%
- Family Practice +4%
- General Practice +3%
- Geriatric +3%
- Internal Medicine +2%
- Interventional Radiology -3%
- Urology -4%
- Radiology -5%
- Cardiology -8%
- Nuclear Medicine -18%



Office Visit Reimbursement Comparison*

NEW PATIENT	2009 (local 16)	2010 (local 16)
99201	\$39.77	\$41.35
99202	\$68.36	\$71.57
99203	\$99.46	\$103.85
99204	\$152.24	\$160.63
99205	\$191.90	\$201.70
ESTABLISHED PT.	2009 (local 16)	2010 (local 16)
99211	\$20.23	\$20.30
99212	\$40.16	\$41.35
99213	\$65.32	\$69.37
99214	\$98.45	\$104.07
99215	\$133.29	\$140.16

Hospital Service Reimbursement Comparison*

CPT Code	2009 (local 16)	2010 (local 16)
99221	\$95.43	\$103.11
99222	\$130.46	\$138.99
99223	\$191.29	\$203.54
99231	\$39.54	\$41.04
99232	\$70.54	\$73.85
99233	\$101.12	\$105.92

Modifier “AI”

- Identifies admitting physician’s service for initial hospital care (“physician of record”)
- Append to initial hospital service or initial nursing facility service
- Only one (1) physician can use the modifier
- This is important when consulting physicians are used

SAMPLE

Date of Service

02/19/2010

CPT

99223-AI

Medicare Preventive Services

- Quick reference guide

http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp

- This version is from January 2009. A few changes have been made and are listed on the website. The guide has not yet been updated for 2010.
- “Welcome to Medicare” exam (G0402)
 - Work RVUs have increased
 - Benefit period extended
 - Available during the first 12 months of Medicare eligibility



Quick Reference Information Medicare Preventive Services

SERVICE	HCPCS/CPT CODES	ICD-9-CM CODES	WHO IS COVERED	FREQUENCY	BENEFICIARY PAYS
Initial Preventive Physical Examination (IPPE) <i>Also known as the "Welcome to Medicare Physical Exam" or "Welcome to Medicare Visit"</i>	Effective January 1, 2009 G0402 – IPPE G0403 – EKG for IPPE G0404 – EKG tracing for IPPE G0405 – EKG interpret & report <i>Important – Effective for dates of service on or after January 1, 2009, the screening EKG is an optional service that may be performed as a result of a referral from an IPPE</i>	No specific diagnosis code required for IPPE	All Medicare beneficiaries whose first Part B coverage began on or after January 1, 2005	Once in a lifetime benefit per beneficiary <i>Must be furnished no later than 12 months after the effective date of the first Medicare Part B coverage begins</i>	Copayment/coinsurance Deductible applies prior to January 1, 2009 No deductible applies for code G0402, effective for dates of service on or after January 1, 2009 Deductible still applies for G0403, G0404, and G0405
Ultrasound Screening for Abdominal Aortic Aneurysm (AAA)	G0389 – Ultrasound exam AAA screen	No specific code <i>Contact local Medicare Contractor for guidance</i>	Medicare beneficiaries with certain risk factors for abdominal aortic aneurysm <i>Important – Eligible beneficiaries must receive a referral for an AAA ultrasound screening as a result of an IPPE</i>	Once in a lifetime benefit per eligible beneficiary, effective January 1, 2007	Copayment/coinsurance No deductible
Cardiovascular Disease Screenings	80061 – Lipid Panel 82465 – Cholesterol 83718 – Lipoprotein 84478 – Triglycerides	Report one or more of the following codes: V81.0, V81.1, V81.2	All asymptomatic Medicare beneficiaries <i>12-hour fast is required prior to testing</i>	Every 5 years	No copayment/coinsurance No deductible
Diabetes Screening Tests	82947 – Glucose, quantitative, blood (except reagent strip) 82950 – Glucose, post-glucose dose (includes glucose) 82951 – Glucose Tolerance Test (GTT), three specimens (includes glucose)	V77.1 <i>Report modifier "TS" (follow-up service) for diabetes screening where the beneficiary meets the definition of pre-diabetes</i>	Medicare beneficiaries with certain risk factors for diabetes or diagnosed with pre-diabetes <i>Beneficiaries previously diagnosed with diabetes are not eligible for this benefit</i>	<ul style="list-style-type: none"> 2 screening tests per year for beneficiaries diagnosed with pre-diabetes 1 screening per year if previously tested but not diagnosed with pre-diabetes, or if never tested 	No copayment/coinsurance No deductible
Diabetes Self-Management Training (DSMT)	G0108 – DSMT, individual session, per 30 minutes G0109 – DSMT, group session (2 or more), per 30 minutes	No specific code <i>Contact local Medicare Contractor for guidance</i>	Medicare beneficiaries at risk for complications from diabetes, recently diagnosed with diabetes, or previously diagnosed with diabetes <i>Physician must certify that DSMT is needed</i>	<ul style="list-style-type: none"> Up to 10 hours of initial training within a continuous 12-month period Subsequent years: Up to 2 hours of follow-up training each year 	Copayment/coinsurance Deductible
Medical Nutrition Therapy (MNT)	97802, 97803, 97804, G0270, G0271 <i>Services must be provided by registered dietitian or nutrition professional</i>	<i>Contact local Medicare Contractor for guidance</i>	Medicare beneficiaries diagnosed with diabetes or a renal disease	<ul style="list-style-type: none"> 1st year: 3 hours of one-on-one counseling Subsequent years: 2 hours 	Copayment/coinsurance Deductible
Screening Pap Tests	G0123, G0124, G0141, G0143, G0144, G0145, G0147, G0148, P3000, P3001, Q0091	V76.2, V76.47, V76.49, V15.89, V72.31	All female Medicare beneficiaries	<ul style="list-style-type: none"> Annually if high-risk, or childbearing age with abnormal Pap test within past 3 years Every 24 months for all other women 	Copayment/coinsurance for Pap test collection <i>(No copayment/coinsurance for Pap lab test)</i> No deductible
Screening Pelvic Exam	G0101 – Cervical or vaginal cancer screening; pelvic and clinical breast examination	V76.2, V76.47, V76.49, V15.89, V72.31	All female Medicare beneficiaries	<ul style="list-style-type: none"> Annually if high-risk, or childbearing age with abnormal Pap test within past 3 years Every 24 months for all other women 	Copayment/coinsurance No deductible
Screening Mammography	77052, 77057, G0202	V76.11 or V76.12	All female Medicare beneficiaries age 40 or older	Annually	Copayment/coinsurance No deductible



SERVICE	HCPCS/CPT CODES	ICD-9-CM CODES	WHO IS COVERED	FREQUENCY	BENEFICIARY PAYS
Bone Mass Measurements	G0130, 77078, 77079, 77080, 77081, 77083, 76977	Contact local Medicare Contractor for guidance	Medicare beneficiaries at risk for developing Osteoporosis	Every 24 months <i>More frequently if medically necessary</i>	Copayment/coinsurance Deductible
Colorectal Cancer Screening	G0104 – Flexible Sigmoidoscopy G0105 – Colonoscopy (high risk) G0106 – Barium Enema (alternative to G0104) G0120 – Barium Enema (alternative to G0105) G0121 – Colonoscopy (not high risk) G0122 – Barium Enema (non-covered) G0328 – Fecal Occult Blood Test (alternative to 82270) 82270 – Fecal Occult Blood Test	Use appropriate code Contact local Medicare Contractor for guidance	<ul style="list-style-type: none"> Medicare beneficiaries age 50 and older Screening colonoscopy: Individuals at high risk; no minimum age requirement No minimum age for having a barium enema as an alternative to a high risk screening colonoscopy if the beneficiary is at high risk 	<ul style="list-style-type: none"> Fecal Occult: Annually Flexible Sigmoidoscopy: Every 4 years or once every 10 years after having a screening colonoscopy Screening Colonoscopy: Every 24 months at high risk; every 10 years not at high risk Barium Enema: Every 24 months at high risk; every 4 years not at high risk 	<p>No copayment/coinsurance or deductible for Fecal Occult Blood Tests</p> <p>For all other tests copayment/coinsurance apply No deductible</p>
Prostate Cancer Screening	G0102 – Digital Rectal Exam (DRE)	V76.44	All male Medicare beneficiaries 50 or older (coverage begins the day after 50th birthday)	Annually	Copayment/coinsurance Deductible
Prostate Cancer Screening	G0103 – Prostate Specific Antigen Test (PSA)	V76.44	All male Medicare beneficiaries 50 or older (coverage begins the day after 50th birthday)	Annually	No copayment/coinsurance No deductible
Glaucoma Screening	G0117 – By an optometrist or ophthalmologist G0118 – Under the direct supervision of an optometrist or ophthalmologist	V80.1	Medicare beneficiaries with diabetes mellitus, family history of glaucoma, African-Americans age 50 and over, or Hispanic-Americans age 65 and over	Annually for beneficiaries in one of the high risk groups	Copayment/coinsurance Deductible
Influenza Virus Vaccine	90655, 90656, 90657, 90658, 90660 – Influenza Virus Vaccine G0008 – Administration	V04.81 V06.6 – <i>When purpose of visit was to receive both influenza virus and pneumococcal vaccines</i>	All Medicare beneficiaries	Once per influenza season in the fall or winter <i>Medicare may provide additional flu shots if medically necessary</i>	No copayment/coinsurance No deductible
Pneumococcal Vaccine	90669 – Pneumococcal Conjugate Vaccine 90732 – Pneumococcal Polysaccharide Vaccine G0009 – Administration	V03.82 V06.6 – <i>When purpose of visit was to receive both pneumococcal and influenza virus vaccines</i>	All Medicare beneficiaries	Once in a lifetime <i>Medicare may provide additional vaccinations based on risk and provided that at least 5 years have passed since receipt of a previous dose</i>	No copayment/coinsurance No deductible
Hepatitis B (HBV) Vaccine	90740, 90743, 90744, 90746, 90747 – Hepatitis B Vaccine G0010 – Administration 90471 or 90472 – Administration (OPPS hospitals only)	V05.3	Medicare beneficiaries at medium to high risk	Scheduled dosages required	Copayment/coinsurance Deductible
Smoking and Tobacco-Use Cessation Counseling	99406 – counseling visit; intermediate, greater than 3 minutes up to 10 minutes 99407 – counseling visit; intensive, greater than 10 minutes	Use appropriate code Contact local Medicare Contractor for guidance	Medicare beneficiaries who use tobacco and have a disease or adverse health effect linked to tobacco use or take certain therapeutic agents whose metabolism or dosage is affected by tobacco use	2 cessation attempts per year; Each attempt includes maximum of 4 intermediate or intensive sessions, up to 8 sessions in a 12-month period	Copayment/coinsurance Deductible

Medicare: E-prescribing Bonus

Incentive program for eligible professionals who are successful electronic prescribers

- Earn an additional 2% bonus
- Report 25 e-prescribing events during the reporting period
- Use new code created (G8553)
 - “At least one prescription created during the encounter was generated and transmitted electronically using a qualified e-prescribing system”*
- Nursing and home care services are now eligible
- For more information, <http://www.cms.hhs.gov/ERXincentive/>

Medicare: PQRI Bonus

- The Centers for Medicare and Medicaid Services (CMS) initiated the **Physician Quality Reporting Initiative (PQRI)**
- PQRI offers incentive bonus payments to physicians who report quality data
- In 2010, by reporting quality data, a practice may earn a 2% bonus on all services paid by Medicare
- For more information, www.cms.hhs.gov/pqri

HIPAA Update, effective 2/18/10

An Individual's Right to Access to PHI — 13405(e) of ARRA

BEFORE: Patients have a right to access/receive a copy of their medical record.

NOW: If a practice has an electronic health record (EHR), its patients have a right to receive an electronic copy of their records via CD-ROM, USB drive, Web site, or similar options. Further, a patient has a right to direct a practice to transmit an electronic copy of her record to another entity or person.

Business Associates — 13401, 13404, 13408

BEFORE: No direct regulation of Business Associates. Covered entities required to have agreements with Business Associates

NOW: Business Associates must directly comply with applicable HIPAA law, regardless if present Business Associate agreements require such. Health Information Exchanges, e-Prescribing portals, and Regional Health Information Exchanges are classified as Business Associates. Business Associates subject to enforcement, civil, and criminal penalties.

HIPAA Update, effective 2/18/10 (con't)

Marketing/Sale of PHI — 13405(d), 13406(a)

BEFORE: Practices have been able to use or share patient PHI, without patient authorization, in certain marketing efforts.

NOW: Practices are prohibited from receiving direct or indirect remuneration in exchange for a patient's PHI without the patient's authorization.
Practices are prohibited from selling PHI for marketing purposes.
There are exceptions to these prohibitions that may be found under Section 13405(d) and 13406(a).

Patient-Directed Privacy Restrictions — 13405(a)

BEFORE: Patients may request restrictions to the release of their Protected Health Information (PHI); however, practices are not required to agree to such restrictions.

NOW: Practices *cannot* disclose self-pay (i.e., paid in full by patient) services to health plans if a patient objects to such.

Criminal Penalties — 13409

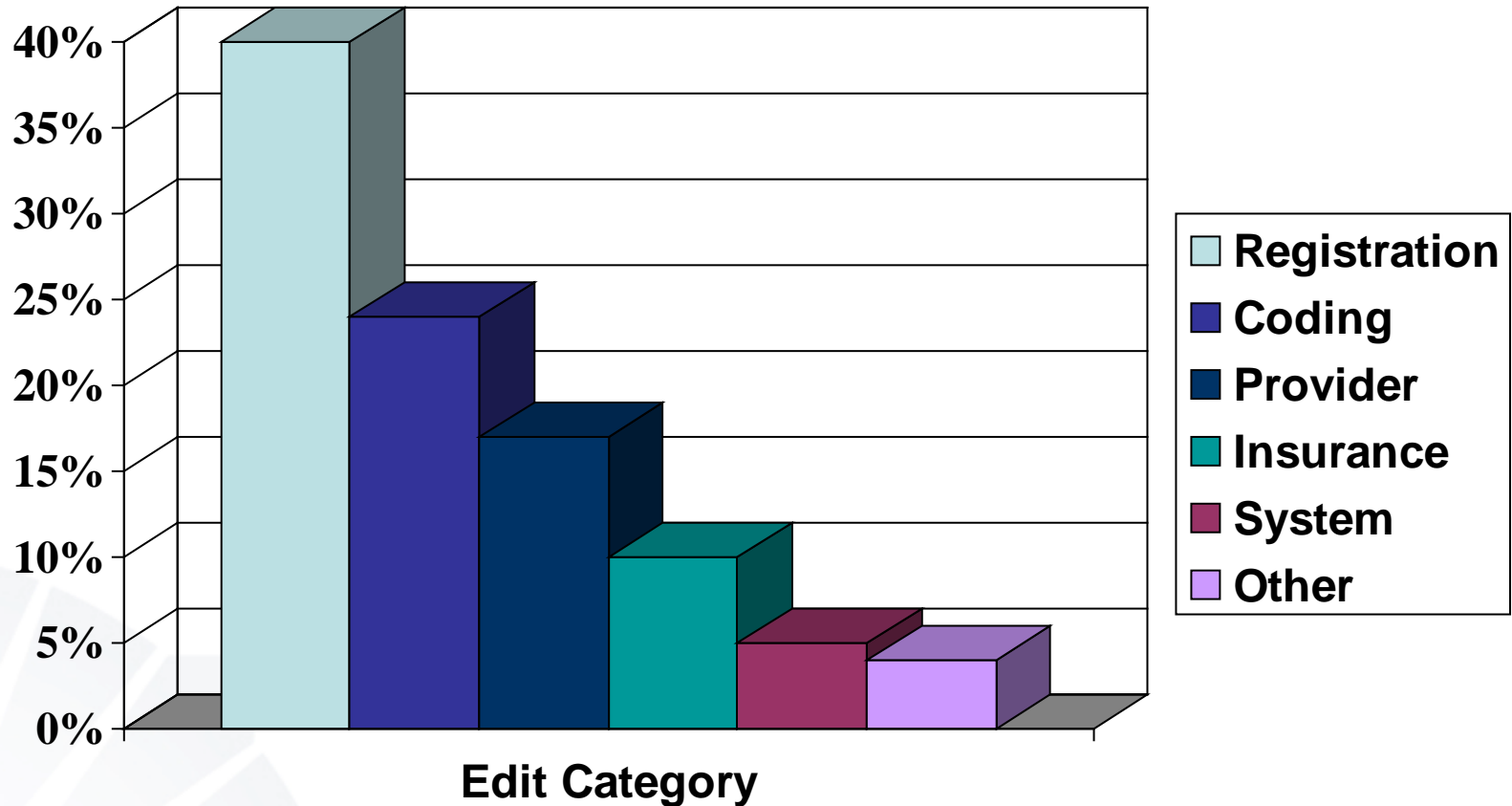
BEFORE: Only covered entities are subject to criminal penalties.

NOW: Individuals — including employees of covered entities — also are subject to criminal penalties.

Practice Improvement Tools

1. Claim edit tracking
2. Denial management
3. Adjustment report
4. Compliance plan

Claim Edit Tracking

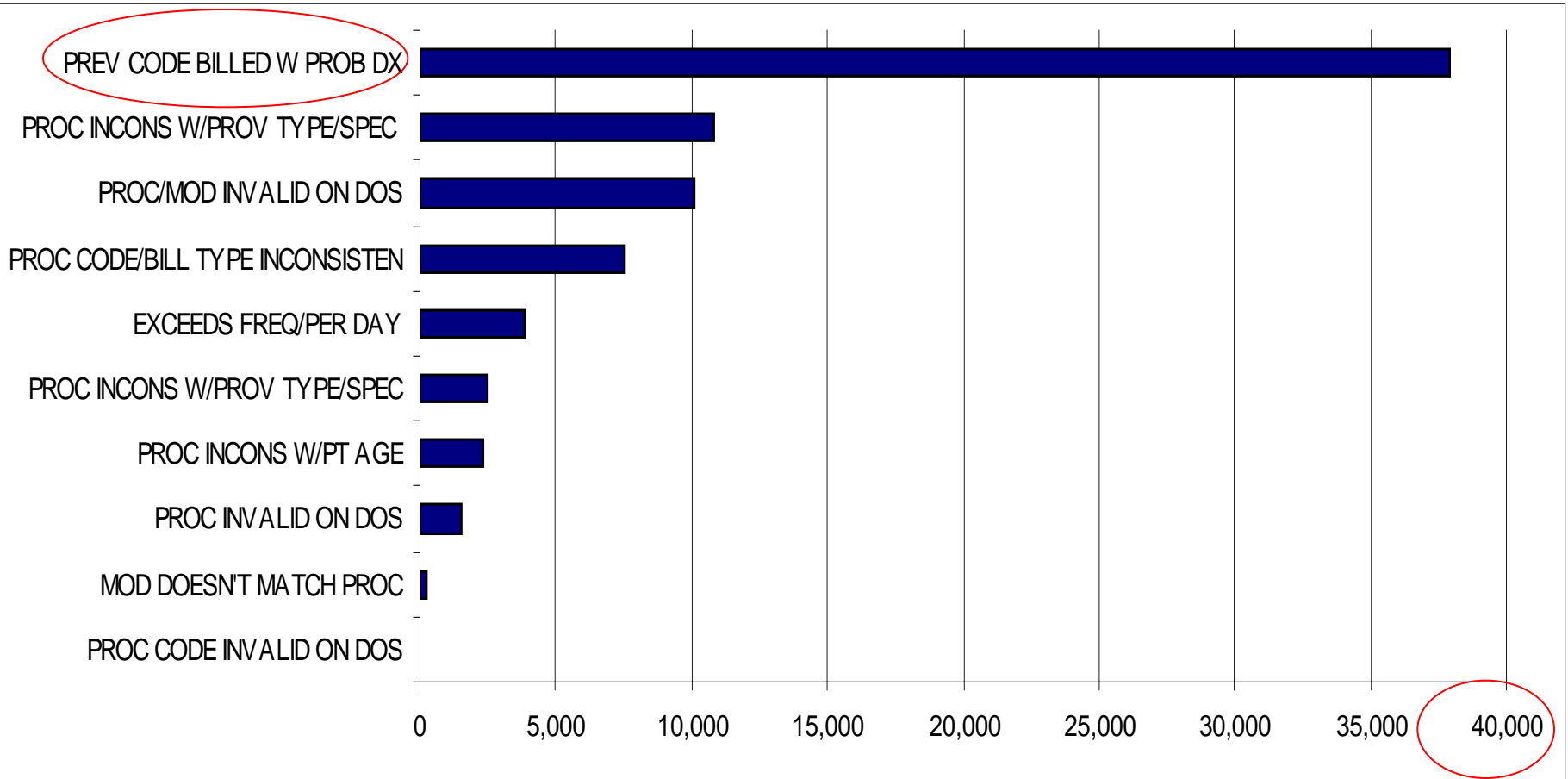


Denial Management

	Qty	%
Coverage	25	49%
Improper coding	16	31%
Coordination of benefits	5	10%
Pre-cert / Pre-auth	3	6%
Medical Necessity	1	2%
Unclean claims	1	2%
TOTAL	51	

Total claims	325
Total denials	51
Denial rate	16%

Adjustment Report



Compliance Plan

1. Internal monitoring & auditing
2. Compliance & practice standards
3. Compliance officer or contact person
4. Education/training
5. Respond to offenses
6. Open lines of communications
7. Enforce disciplinary standards

Source: <http://oig.hhs.gov/authorities/docs/physician.pdf>

Plan for ICD-10 Implementation

- In 2013, a new version of ICD will be used to report diagnoses (ICD-10 CM set). Total number of codes expands from about 4,000 to 87,000. Codes are alphanumeric and 7 digits in length.
- Work with your and PM software and EDI vendor and ask:
 - Can the system accommodate both data collection and transaction conduction for HIPAA ASC X12, version 5010?
 - Will there be an increase in fees?
- Start testing end of 2010 beginning of 2011
- Modifications will need to be made to clinical documentation (EMR), superbills, PM system, payor contracts and quality reporting.
- Train your staff

S51521A Torus fracture of lower end of right radius, initial encounter for closed fracture

Coding Resources

- Medicare http://www.wpsmedicare.com/amaclick_b.html
- Medicaid www.hfs.illinois.gov/handbooks/
 - Illinois Health Connect
www.illinoishealthconnect.com/providereducation.aspx
- Specialty societies
 - AAFP, ACOG, etc.
- BCBS <http://www.bcbsil.com/provider/>
- AMA www.ama-assn.org
- AHIMA www.ahima.org
- AAPC www.aapc.com
- PAHCS www.pahcs.org

Your Action Plan

Goal	Actions / Initiatives	Deadline	Responsible Party	Outcome / Status

Summary

1. Review 2010 changes and determine if you need to make any changes
2. Be prepared for any shifts in reimbursement
3. Track your coding errors
4. Participate in e-prescribing and PQRI initiatives
5. Train your staff
6. Create a plan and take action

Lucy Zielinski
Vice President
Health Directions, LLC
541 North Fairbanks Court
Suite 2740
Chicago, IL 60611
Phone: 312.396.5400
Fax: 312.396.5401
lzielinski@healthdirections.com

Disclaimer

This presentation is a tool to assist physicians and their office staff. Every reasonable effort was made to ensure the accuracy of the information, however, the physician has the ultimate responsibility for correct coding and submission of claims. Health Directions bears no liability for results or consequences of misuse of the information.

Questions and Answers

Q: A new patient is seen by the cardiologist for a visit and stress test. How is this visit billed?

A: A significant, separately identifiable E/M service was performed by the same physician on the same day as another procedure/service.

99204-25 Office visit, new patient	428.0 Congestive heart failure, unspecified
93015 Cardiovascular stress test	428.0 Congestive heart failure, unspecified

Q: Dr. Jones is covering for Dr. Smith under a reciprocal arrangement. The patient presents with possible CTS and Dr. Jones refers the patient to the orthopedist. Who is listed as the referring physician?

A: For consultative purposes, the referring physician is considered to be Dr. Smith. A modifier is appended to the procedure code (Q5, service furnished by a substitute physician under a reciprocal billing arrangement).

Q: Does the physician need to register to participate in PQRI?

A: “Individual eligible providers do not need to sign-up or pre-register in order to participate in the PQRI.”

Source: <http://www.cms.hhs.gov/pqri/>

Q: Will Medicare deny claims if the procedure code and billed amount on the primary insurer's EOB do not match the procedure code and billed amount on the Medicare claim?

A: No. Medicare has updated their processing instructions for MSP claims to allow MSP claims to process even when the procedure code and billed amount on the primary insurer's EOB do not match the procedure code and billed amount on the claim submitted to Medicare.

Q: A Medicare patient is in observation status at the hospital. The internist sees the patient and reports the OB code. The Cardiologist is asked to perform a consult. How should the consultant bill the visit?

A: 99201 – 99215 – Outpatient Visit, New Patient

Q: What are the new CLIA waived tests, effective 4/1/10?

A:

CPT Code	Effective Date	Description
80101QW, G0430QW	July 1, 2009 for 80101QW, January 1, 2010 for G0430QW	Inverness Medical Innovations Signify ER Drug Screen
82274QW, G0328QW	September 9, 2009	Germaine Laboratories AimStep Immunological Fecal Occult Blood Test (iFOBT)
81003QW, 82044QW, 82570QW	September 14, 2009	Siemens Clinitek 50 Urine Chemistry Analyzer
87880QW	September 15, 2009	CLIA waived inc Rapid Strep A Test
82044QW	October 26, 2009	Genzyme Diagnostics OSOM ImmunoDip Urinary Albumin Test

<http://www.cms.hhs.gov/transmittals/downloads/R1905CP.pdf>