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All Medicare fees are par, office, national unless otherwise noted.

CCI Version 20.2

Watch for new bundles for skin lesion, imaging and stent placement codes

Take care when reporting lesion destruction codes with other skin procedures because the latest quarterly update to the National Correct Coding Initiative (CCI), effective July 1, includes a number of new code pairs involving those codes.

For example, destruction of a single premalignant lesion (**17000**) now includes excision of malignant lesion codes **11606**, **11624** and **11626**, as well as malignant lesion destruction codes **17260-17286**. Similarly, destruction of 15 or more pre-malignant

*(see **Codes**, p. 6)*

Patient encounters

How to make good legally on spoiled visits to increase patient satisfaction

Solve big customer service headaches by offering to cover the patient's bill — but do it carefully to comply with Medicare regulations.

Patients expect a higher standard of customer service than they once did. "Gone are the days when the doctors could just float in on cloud," says Peter W. Rosenberger, who leads Standing with Hope, an organization focused on caregivers and caregiving.

Sometimes you'll have to make it up to patients who feel dissatisfied, says David Zetter, lead consultant, Zetter Healthcare

*(see **Visits**, p. 8)*

Coding

New modifier 59 guidance suggests crackdown, offers clues to beat it

Look to new CMS examples of appropriate use of modifier **59** (Distinct procedural service) to withstand likely scrutiny.

An MLN Matters article, "Proper Use of Modifier 59," that was revised in June has a section on "non-contiguous" sites — always a difficulty in 59 coding — that offers some clarity on the modifier's role in multi-site procedures, says Terry Fletcher, CPC, a health care coding and reimbursement consultant based in Laguna Beach, Calif.

"There is one code for large joint injection, **20610**," says Fletcher. "But the hip, shoulder and knee all fall under the 'large joint' definition." She interprets that to mean that because those are not contiguous sites, you could use 59 with 20610 for injections in the knee and hip.

Keep in mind that other modifiers might be appropriate in that case. "I prefer to use both 76 [Repeat procedure or service by same physician or other qualified health care professional] and 59 since you are telling a story numerically to the payer — same type of injection but in a different large joint," she says.

Also look at the CMS example of CPT codes **11055** (Paring or cutting of benign hyperkeratotic lesion [e.g., corn or callus], single lesion) and **11720** (Debridement of nail[s] by any method[s]; one to five), says Podiatrist David J. Freedman, DPM, of Foot and Ankle Specialists of the Mid-Atlantic in Silver Spring, Md. The agency says the codes "should not be used [with 59] if a nail is debrided on the same toe from which a hyprkeratotic lesion has been removed."

This example suggests "that any hyperkeratotic growth on the same digit would be bundled into CPT **11720**," says Freedman. But then CMS goes on to say that "modifier 59 may be reported with code 11720 if multiple nails are debrided and a corn that is on the same foot and that is not adjacent to a debrided toenail is pared."

"Many of our patients have multiple corns and calluses, so if that toe is disallowed [for 59], as long as there are two to four other anatomical locations, then that would not pose a problem," says Freedman.

Scrutiny of 59 ramps up

Modifier 59 is a frequent target of contractor scrutiny and a perennial on OIG's annual Work Plan *(PBN 4/28/14)*. Last December, several contractors also issued guidance on the modifier *(PBN 1/13/14)*.

The recent attention comes from what the feds consider "too much usage" of the modifier, believes Julie Sanchez, owner of RN Audit Specialist in St. Peters, Mo. "If modifier 59 is not applied, many services are bundled with the E/M, and there is no additional reimbursement for additional services," she says.

Sanchez suspects contractors will move on the new guidance and practices will take the brunt of the hit

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because they lack the resources that hospitals and large systems have to monitor their coding, such as staff certified as registered health information administrators (RHIA) and sophisticated claim edit technology built into their billing systems.

Tip: Review your use of modifier 59 with an eye toward misuses common in your specialty. "One example is a heart monitor being applied to a patient at the same time as an EKG" for cardio practices, says Sanchez. Some cardio combos are 59-appropriate, though, when they combine a diagnostic procedure and an intervention based on that procedure, says Fletcher — for example, a cardiac catheterization followed by percutaneous coronary intervention (PCI). — *Roy Edroso (redroso@decisionhealth.com)*

Resources:

- MLN Matters: *www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1418.pdf*
- Noridian modifier 59 guidance: *https://med.noridianmedicare.com/web/jeb/article-detail/-/view/10525/proper-use-of-modifier-59*

Front desk matters

Payers, practices pressed to find savings look to reduce administrative costs

Physician practices and insurers are focusing on ways to control administrative costs as doctors' reimbursement stagnates and the Affordable Care Act (ACA) requires insurance plans to spend at least 80% of premium dollars on the costs of care.

Those efforts were highlighted at the America's Health Insurance Plans (AHIP) Institute in June in Seattle and address both traditional fee-for-service payments as well as emerging payment models including accountable care organizations (ACOs), patient-centered medical homes and other shared savings programs.

Emphasize collections

Getting patients to pay copays and deductibles always has been a challenge for physician practices. It was easier to let that slide when practices were in better overall financial health and the patients' share was a lower amount of the value of the service.

Those times have changed. Patient plans are increasingly complex and rely on a mixture of high-dollar deductibles and larger copays, says Bill Nordmark, senior vice president of sales and marketing for PaySpan, an Atlanta-based firm that processes $60 billion in annual payments from plans to providers.

Gaps in collections processes and difficulty determining patients' eligibility for services have the potential to slow down the revenue cycle and lead to missed opportunities for your practice to collect money, he points out.

Nordmark sees two opportunities for payers and practices to increase efficiency and cut administrative costs:

- Faster determination whether a patient is eligible for a service and
- The ability to determine, according to the patient's plan, an appropriate estimate of the cost of care.

Portals between payers and providers can give you faster insight into the patient's eligibility — not a prior authorization — and the payer's fee schedule reimbursement and plan terms for the service. When you can determine ahead of time an amount the patient owes, your chance to collect goes up, Nordmark believes.

Tip: Ask the patient at each visit to authorize a charge of a specific amount based on your expectation for the patient's share of the cost of care, Nordmark says. An adjustment can be made once the actual amount is known. When collections staff members express uncertainty to the patient about the cost of the care, the patient is more likely to try to defer payment until the actual charge is known, he believes.

Once the patient has had the service, the likelihood of collection decreases and the administrative cost of pursuing the payment increases.

Look for faster prior authorization

Payers also are being pushed to reduce cost and administrative hassle through the prior authorization process. A study in the *Journal of the American Board of Family Medicine* last year estimated costs of as much as $3,400 per physician handling prior authorization, not to mention the related delays in providing care.

Automation of prior authorization removes human error and delay because the authorizations are based on the payer's own utilization policies, says Steve Sandy, co-founder of Informatics in Context, a Boston-based company that creates portals for providers to check patient eligibility and for payers to automate approval of prior authorization requests made by providers.

Payers know it's a problem. In a survey of health plan CEOs, 81% of respondents said that automating processes was the most critical step payers needed to take to better control costs and operations, according to data presented by Ray Desrochers, executive vice president of software company HealthEdge, based in Burlington, Mass. The second priority was to eliminate or reduce paper, also a benefit of prior authorization.

Automation of prior authorization in a cloud-based solution facilitates instant approval of requests for coverage, as well as better utilization management by payers and providers, Sandy points out.

Example: A provider who frequently orders tests that the payer does not consider to be the most cost-effective ones for the patient's condition would get real-time feedback about the proper test for the circumstance, Sandy says. The provider could correct his behavior, but the patient would get the right care the first time without the delay for the denial of the prior authorization request of the expensive procedure, Sandy notes.

Real-time monitoring to lower costs

For integrated systems and larger providers moving toward patient-centered medical homes and shared-savings programs, devices that monitor the patient in her own home and transmit data back to the provider through the patient's wireless connection allow for better patient management at a lower cost, says Dan Prewitt, senior vice president of AMC Health, a New York City-based health technology firm.

Remote monitoring, which Prewitt believes will be more widespread in the years to come, allows practices to spot data aberrations, such as changes in vital signs or even signs and symptoms, then reach out to those patients to have them seek medical attention, Prewitt points out. — *Scott Kraft (pbnfeedback@decisionhealth.com)*

Compliance

Plan to fingerprint high-risk Medicare enrollees could impact practices

The recent announcement that Medicare would begin to fingerprint new enrollees defined as high risk — at their own expense — for background checks has the potential to implicate some physician practices, even though physician groups generally are not considered high risk.

CMS detailed its plans in an MLN Matters announcement in mid-April. It was not a surprise — the fingerprint proposal was mandated by Congress under heightened enrollment standards in the Affordable Care Act (ACA) *(PBN 10/4/10)*.

While the agency is focusing its initial efforts on newly enrolled durable medical equipment (DME) providers and home health agencies, the DME provider provision likely will ensnare physician groups that are enrolled to furnish DME to patients, says Leslie Witkin, president of Physicians First in Orlando, Fla.

Among the specialties most likely to feel the impact are orthopedists and podiatrists because they often furnish DME, Witkin believes. While the initial rollout of the fingerprinting initiative is focused on new enrollees, nothing in the announcement would bar CMS from expanding its plans, she adds.

For providers who are affected, the implementation will be phased-in with an ultimate goal of fingerprinting anyone with a 5% or more ownership stake in a high-risk provider, CMS says. But, at the outset, everyone who potentially could be required to do a background check with fingerprints will not be required to do so.

High-risk providers also might include any provider with a member who had previously been excluded or restricted from billing Medicare, the agency adds.

You will be notified by letter if you are required to be fingerprinted for background check purposes, CMS says in its explanation of the proposal. You will have 30 days to get fingerprinted by contacting a federal contractor named in the notice to ensure the fingerprints successfully get to that contractor.

The contractor will forward the fingerprints to the FBI for processing, and the FBI will return background check information within 24 hours. The contractor then will make a recommendation to CMS about whether to proceed with the enrollment, though CMS will have the final say, the agency says. — *Scott Kraft (pbnfeedback@decisionhealth.com)*

Resource:

- CMS background check announcement: *www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1417.pdf*

Benchmark of the week

Modifier 50 causes problems with bundled services in 2012

Be careful of bundled codes when trying to use modifier 50 (Bilateral services) or risk costly edits. Medicare administrative contractor (MAC) Palmetto recently gave a heads-up on modifier use with bilateral procedures, reminding providers that the modifier cannot be used with codes that are "inherently bilateral by their description."

Modifier 50 can be troublesome. In recent months, *Part B News* has given guidance on its applicability to cerumen removal in both ears, transforaminal injections and chemodenervation *(PBN 5/19/14, 2/3/14, 1/20/14). (For guidance on modifier **59**, see p. 2.)*

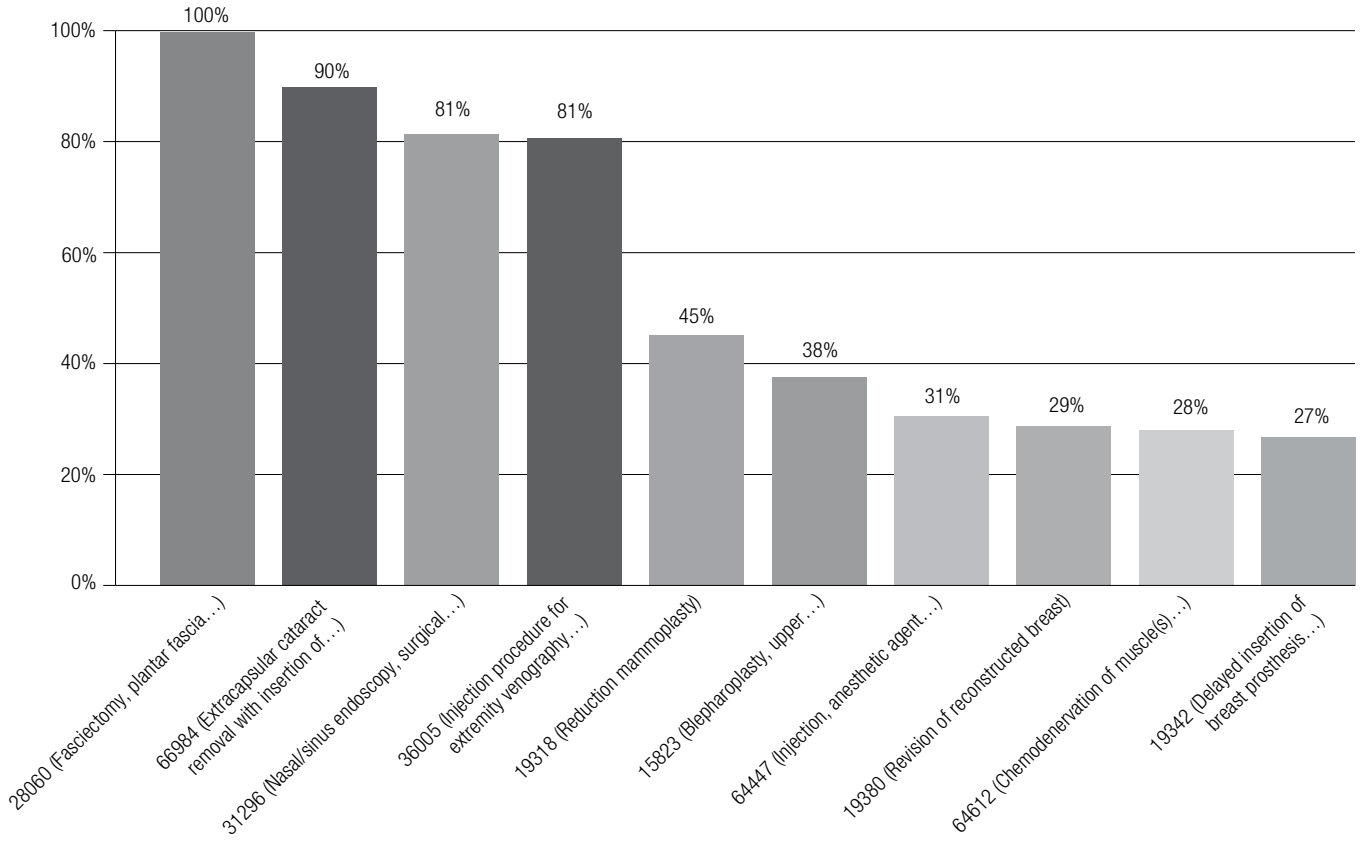
Below are the codes claimed in 2012 that were most often denied with 50 and for which there were more than 1,000 claims. That year, 416 codes had 100% denial rates, but the majority were claimed rarely — some just a few times — suggesting careless errors. But the most often denied code, **28060** (Fasciectomy, plantar fascia; partial [separate procedure]), had a service count of 6,017. Fasciectomy is commonly performed with other foot surgeries and bundled when it is.

Coders may make this mistake in some cases because they miss that the codes were bundled in a Correct Coding Initiative (CCI) edit. For example, **31296** (Nasal/sinus endoscopy, surgical; with dilation of frontal sinus ostium [e.g., balloon dilation]), claimed more than 15,000 times and denied 81% of the time, was bundled into the endoscopy codes **31231-31294** in CCI 17.0 back in 2011.

Also, the much-discussed cerumen removal code, **69210**, had a denial rate with 50 in 2012 — but only 47 claims were made with that modifier. — *Roy Edroso (redroso@decisionhealth.com)*

Editor's note: *For more information on modifiers, buy the webinar on CD **2014 Modifier Maze: Master your use of modifiers 59, 76 and more to minimize Medicare denials** at* https://store.decisionhealth.com/Product.aspx?ProductCode=TA2488CD.

10 most denied codes with modifier 50, 2012 (more than 1,000 service count)



Source: Part B News *analysis of Medicare claims data*

Codes

(*continued from p. 1*)

lesions (**17004**) now includes shave excision of skin lesion codes (**11300-11313**), benign lesion excision codes (**11400-11446**), sweat gland excision (**11450-11471**), malignant lesion excision (**11600-11646**) and destruction codes 17260-17286.

All of the new skin code pairs will permit use of a modifier to override them. However, the new pairs will serve to complicate already difficult coding for treatment of multiple skin lesions, meaning you'll need to consult CCI whenever you code those procedures.

On the imaging front, your spinal myelography procedures (**72240-72270**) now are bundled components of CT neck chest and lumbar studies (**72125-72133**), though the code pairs have a "1" modifier indicator, meaning you can unbundle them with the appropriate modifier when warranted.

Fluoroscopy codes **76000** and **76001** are bundled components of femoral fracture treatment code **27245**, which shouldn't come as a shock because CPT also includes imaging in surgical fracture reduction.

Also, in a heads-up for your private payers that use CCI, electrothermal annuloplasty codes **22526** and **22527** also now include 76000 and 76001. Note that the codes' descriptions state that they include fluoroscopic guidance, so that should not impact your billing unless you are doing an unrelated fluoro study. If that is the case, the edits will permit you to override them by appending a modifier to the fluoroscopy codes. Medicare does not cover codes 22526 and 22527.

CCI edits bundle certain services billed by the same provider on the same patient on the same calendar day. The edits, which are used by Medicare as well as commercial payers, are updated quarterly.

CCI cracks down on multiple, same-day E/Ms

Medicare permits you to report only one E/M code on a patient on one calendar day, and now CCI includes new code pairs to enforce that rule. For example, new patient office visits (**99201-99205**) include established patient office visits (**99211-99215**). Similarly, established patient visits (99212-99215) include lower-level established patient visits. For example, 99212 includes 99211, 99213 includes 99211-99212, etc. All of those new pairs will allow use of a modifier to override, but use caution when doing so, advises coding consultant Terry Fletcher, CPC, in Laguna Beach, Calif.

"For example, when a nurse sees a patient for a blood pressure check and then the patient sees the physician during the same encounter, it would be incorrect to code both a 99211 and a 99213," she explains. But if the patient reports for a nurse visit in the morning for a medicine check, then later has an episode requiring a separate and unscheduled office visit the same day, "you may be able to add the modifier **25** [Significant, separately identifiable E/M] to the lower-valued visit," Fletcher says. "You still may have to appeal this if one of the visits is denied, but you will have two documented encounters to support the modifier override."

CCI Version 20.2 scorecard

Changes effective July 1, 2014.

(For more on CCI Version 20.2 edits, see story, p. 1.)

Code range	CCI code pairs added	CCI code pairs deleted	Mutually exclusive code pairs added	Mutually Exclusive Code pairs deleted
0001T - 0999T	27	0	0	0
00000 - 09999	272	0	0	0
10000 - 19999	1139	8	81	0
20000 - 29999	4734	0	0	0
30000 - 39999	4016	11	0	0
40000 - 49999	2505	0	3	0
50000 - 59999	2117	0	0	0
60000 - 69999	2488	0	0	0
70000 - 79999	146	8	0	8
80000 - 89999	22	0	2	0
90000 - 99999	1043	185	4	0
A0000 - V9999	2415	0	10	0
Totals	**20,729**	**212**	**100**	**8**

Note: Code range is based on the comprehensive code of the edit.

Source: Part B News *analysis of CCI 20.2 changes.*

In such cases, the Medicare Claims Processing Manual instructs you to document that the visits were for unrelated problems that could not be provided during the same encounter (100-04, Chap. 12, Sec. 30.6.7.B).

Mind those retroactive CCI edits

In particular, watch for two new edits, retroactively effective Jan. 1, that prevent you from billing transvascular stent placement add-on codes **37237** and **37239** with the wrong primary code. Note that you are to use **37237** with **37236** (Initial arterial placement of transcatheter stent) to report stents placed in additional arteries. Similarly, code 37239 should be reported with only **37238** (Initial venous placement of transcatheter stent).

The new edits bundle 37239 as a component of 37236 and 37237 as a component of 37238. The code pairs will permit you to append a modifier to the add-on codes to override when appropriate. The new CCI edits enforce CPT coding guidance, but if you reported the new codes in error after they debuted in January, you may end up paying for it after July 1.

The new edits help clarify that when placing stents in a vein in addition to an arterial stent, you would not report an additional add-on code, just the appropriate primary code, Fletcher reminds. For example, when stenting a right renal artery and a right iliac vein, you would report the two primary codes, 37236 and 37238, she explains. "There would not be a need for an add-on code here."

In contrast, for a bilateral renal artery stent, it would be appropriate to report the arterial primary and add-on codes 37236 and 37237, Fletcher adds.

Blood vessel repair codes bundled. Look for numerous new code pairs bundling blood vessel repair codes (**35201-35286**) as components of a wide range of procedures including pacemaker and defibrillator implants (**33206-33249**), insertion of ventricular assist device (**33990**), embolectomy or thrombectomy (**34001-34051, 34401, 34451** and **34471**), endovascular repair of abdominal aortic aneurysm (**34800-34805** and **34825**) and fenestrated endovascular repair of the visceral and infrarenal aorta (**34841-34848**).

In particular, note the new edits bundling the blood vessel repair codes with catheter placement codes such as **36010-36015** and **36200-36217**, carotid codes **36227-36228** and selective catheter placement **36245-36247** and **36260-36262**. Codes **35201-35286** also are bundled components of many cardiac catheterization, stent placement and electrophysiology codes.

Two Medicare coding policies are behind those new pairs, Fletcher points out. First, for pacemakers and defibrillators, the implant codes have 90-day global surgery periods that include numerous component services, including blood vessel repair. "These bundling edits are not really new information, as they are rarely coded together, but Medicare must have been alerted to a few claim submissions with incorrect code pairings, thus warranting a CCI clarification," Fletcher observes.

In addition, for the catheter placement codes, both CPT and Medicare coding policies do not allow separate billing for closure of the access point of arterial or venous catheters. "Remember, the doctor makes the hole to access the patient. There is no extra reimbursement to close it," she explains. "The facility may be reporting a G code such as **G0269** [Placement of an occlusive device into either a venous or arterial access site], but that is for inventory control and has no reimbursement value."

New CCI pairs for ob/gyn services

- Vulvectomy with lymph node removal codes **56632** and **56637** include lymph node needle biopsy (**38505**) as a component. "The reason is that the lymph nodes will be biopsied as a precaution or for suspicious areas routinely, and the value of 38505 is included in the RVUs for the removal," Fletcher says.
- Pelvic abscess drainage (**57010**) includes perineum repair (**56810**) with no modifier allowed to override it.
- Removal of vaginal lesion (**57135**) includes **57000** (Exploration of vagina).
- Colpopexy (**57282-57283**) now also includes 56810. — *Laura Evans (levans@decisionhealth.com)*

Visits

(*continued from p. 1*)

Management Consultants, Mechanicsburg, Pa. At one practice client, if a customer complains about service such as lateness or rudeness and the practice manager judges the problem sufficiently egregious, the practice will ring up the encounter as a no-charge, he says.

The practice reviews "each patient situation individually," Zetter says. If the patient has a bad experience, the practice will evaluate what happened and whether it is appropriate to provide the service at no cost. Just don't bill the insurance company. "It's completely free care to patients dissatisfied with service," he says.

Neither Zetter nor his client is "in the habit of providing free care," he says. But they are in the business of optimizing practice profits, and "customer-patient satisfaction has to be a high priority, so we do what we need to — without breaking laws — to make them happy."

Don't bill insurance for free care

In situations with disgruntled patients, writing off the service is "generally OK" as long as the practice does not charge the insurance carrier, says William Maruca, a health care attorney at Fox Rothschild in Pittsburgh.

But Maruca warns that "a policy, formal or otherwise, that uses free visits to lure patients away from other practices — e.g., 'Every fourth visit free!' — could run afoul of patient inducement prohibitions under the civil monetary penalties law." The Office of Inspector General (OIG) expressed its concern with providing free goods or services with patients if they are "likely to influence those customers' future purchases," in a 2002 special bulletin. Make sure your customer is expecting and returning for good service rather than freebies.

While waiving a charge over customer service is one thing, waiving it over a perceived shortfall in medical care is another, warns Michael G. Cassatly, DMD, president of the consultancy MedAchieve Inc. in Jupiter, Fla. "If it's something the patient could get litigious over, waiving the fee could be construed as an admission of guilt," he says.

Have a written policy for those no-charge visits because the relevant statutes, such as the anti-kickback statute, are "intent-based," and a policy helps establish that the charge-back has a legitimate reason, suggests Amanda K. Jester, a partner at Waller Lansden Dortch & Davis LLP in Austin, Texas. She also recommends that you check state law and your private payers' contract terms to make sure you're not violating them.

3 no-cost alternatives

If you don't want to comp visits, soothe patients with words and attention — not to mention proper service — instead:

- **Train the front desk staff to watch the clock.** Have them "keep patients abreast of any unusual wait time so that they can wait or be rescheduled," say Santosh Pandit, M.D., a cardiologist in Pittsburgh, and his wife and Practice Manager Sunita Pandit.
- **Tell the truth.** "We tell them exactly why the doctor is running late," say the Pandits.

"Be honest; don't try to get by with double-speak," says Rosenberger. "If there's a problem with waiting, let them know: 'This got away from us on the schedule' — and tell them why. Make sure the relationship is maintained."

- **Stick up for yourself if you're right.** Perception is important, so if the doctor is delayed by a patient emergency, reception should clarify that it's the emergency that's delaying appointments, not the practice's problems. "Have reception say: 'We're sorry, but the doctor has a patient in pain, which had to be addressed immediately. We appreciate your patience, and if you ever have the same problem, we will certainly do the same for you,'" says Cassatly. — *Roy Edroso (redroso@decisionhealth.com)*

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