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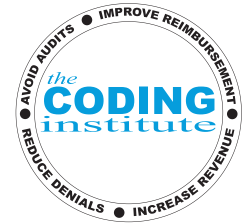

Part B Insider

News & Analysis on Part B Reimbursement & Regulation

November 2010, Vol. 11, No. 40 (Pages 313-320)

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2011 Fee Schedule

CMS Slashes 2011 Conversion Factor by Over 30 Percent Vs. Current Rates

Plus: Pay for Radiology, Urology, and Cardiology will drop even more.

Get ready for another year of nail-biting to find out whether your Medicare payments will be slashed. "The calendar year 2011 Physician Fee Schedule conversion factor is $25.5217," notes the 2011 Medicare Physician Fee Schedule Final Rule, printed in the *Federal Register* that will be published on Nov. 29. This amounts to a dismal 30 percent cut compared to the current rate of $36.8729.

"While Congress has provided temporary relief from these reductions every year since 2003, a long-term solution is critical," the Fee Schedule notes. "We are committed to permanently reforming the Medicare payment formula."

As most practices know, last June, Congress voted to not only stave off a 21 percent cut to your Medicare pay, but to increase your revenue by 2.2 percent. However, that vote only kept the cuts at bay through November 30 — and that date is right around the corner. Effective December 1, your Medicare pay is set to drop by over 23 percent, unless Congress intervenes to reverse the cuts. Add to that the fact that 2011 payments are due to drop even further starting January 1, and medical practices are facing a perfect storm of payment nightmares.

Part B practices are currently in the dark about what will take place not only at the end of this month, but also regarding what will transpire when the calendar turns to 2011. "We have no idea what will happen in Congress in January regarding the conversion factor," says **Michael A. Ferragamo, MD, FACS,** clinical assistant professor of urology at the State University of New York at Stony Brook. Some newly-elected Senators and House members will be in place in 2011, and it's unclear whether the current Congress will make changes affecting 2011 pay before January, or whether they'll leave the issues for the new Congress to handle, he says.

Some Specialties Will Suffer Further

In addition to dealing with conversion factor fluctuations, some specialties will face additional cuts. The hardest hit practices will be those that specialize in radiology. These cuts will most definitely have a significant impact on specialty practices that are already financially stretched.

The list below shows which specialties will face the biggest Part B cuts in 2011 based on changes to RVUs and other adjustments in these specialties. Keep in mind that

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these numbers do not include the impact of the December 2010 and January 2011 conversion factor changes, the Fee Schedule confirms:

- **Radiology:** Pay for radiology practices will drop by 14 percent next year, while interventional radiology will see a 9 percent cut, nuclear medicine will face 6 percent cuts, and radiation oncology pay will drop by 5 percent
- **Urology:** RVU changes will cause radiology practices to see a 7 percent decline in Medicare pay next year
- **Cardiology, Audiology, and Multispecialty Clinics:** These practices will face cuts of 5 percent in Medicare pay next year.
- **Oncology/hematology, Pathology, and Emergency Medicine:** Practices in these specialties will see pay drop by 2 percent in 2011.

Other Specialties Will See Gains

As predicted, the government is seeking to give primary care practices boosts next year, with family practices facing a four percent gain next year over 2010 RVU amounts, internal medicine specialists getting a three percent pay boost, and pediatricians facing two percent raises in RVUs.

Other practices that will see their pay rise will be hand surgeons, who will watch RVUs increase on average by six percent, and the following specialists that will see five percent gains next year: neurologists, otolaryngologists, dermatologists, plastic surgeons, and colorectal surgeons.

CPT Establishes Annual Wellness Visit Codes

The Fee Schedule also incorporates several provisions of the Affordable Care Act of 2010 that was passed in March. First and foremost, you'll see that coverage has been established for annual wellness visits for Medicare patients. "The rule we are issuing today is a major step toward improving the health status of Medicare beneficiaries by providing coverage for an annual wellness visit that will allow a physician and patient to develop a closer partnership to improve the patient's long term health," said CMS administrator **Donald Berwick, MD** in a Nov. 3 statement.

If you perform a procedure that meets CMS's description of an annual wellness visit, you should not report a code from CPT's preventive medicine section to your Part B carrier, the Final Rule indicates. CMS does not pay for preventive medicine services billed under 99381-99397. Instead, report one of the following newly-established HCPCS codes:

- G0438 — *Annual wellness visit; includes a personalized prevention plan of service (PPPS), first visit*
- G0439 — *Annual wellness visit; includes a personalized prevention plan of service (PPPS), subsequent visit*

CMS has assigned 2.43 physician work RVUs to G0438 and 1.50 RVUs to G0439, and these codes will be effective on Jan. 1, 2011. Beneficiaries who have only been

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enrolled in Part B for 12 months will be eligible for an initial preventive physical exam, (also known as an IPPE, which is billed with G0402). "After the first 12 months of Part B coverage on or after Jan. 1, 2011, beneficiaries would be eligible for an annual wellness visit" as described by the new G codes, assuming that patient has not had an IPPE within the preceding 12 month period, the Fee Schedule states.

To read the 2,023-page Final Rule in the *Federal Register*, visit www.ofr.gov/OFRUpload/OFRData/2010-27969_PI.pdf. ❑

Reimbursement

5 Tips Help You Keep the Money Flowing Into Your Practice

Medicare conversion factor changes mean it's essential to collect every penny you can.

With CMS once again slashing the conversion factor and cutting pay to many specialists, you can't afford to let any pennies leak out of your practice. Follow these quick tips to ensure that you're bringing in maximum dollars to your practice:

1. Take Incident-To Seriously: Under Medicare's incident-to rules, qualified mid-level providers (MLPs) can treat certain patients and still bill the visit under the doctor's NPI, bringing in 100 percent of the assigned fee for the codes you report. To qualify for incident-to billing, the doctor must see the patient during an initial visit and establish a clear plan of care, and the physician must be in the immediate office suite while the MLP is performing the incident-to services.

You should bill incident to only for MLPs who have the credentials to perform the appropriate services. The MLP could be a physician assistant (PA), nurse practitioner (NP), or clinical nurse specialist (CNS) — as long as the MLP meets state and federal guidelines to report incident to. The provider must be "licensed by the state under various programs to assist or act in the place of the physician," according to the *Medicare Benefit Policy Manual*, Chapter 15.

If the MLP's service doesn't fit incident-to regulations, that doesn't mean you have to forego payment altogether. If you do not bill an MLP visit incident-to the physician, then you should code the service under the MLP's NPI number. Expect Medicare to reimburse you at 85 percent of the global, or full, fee.

2. Don't Ignore Modifier 22: Catch-22: If you're using modifier 22 (*Increased procedural services*) on almost all your surgical cases, you're headed for an audit. But if you're not using modifier 22 at all, you could be passing by avenues for ethical reimbursement. Some coding analysts have suggested that physicians should use modifier 22 in fewer than five percent of all surgical cases, meaning you should apply modifier 22 sparingly. That doesn't, however, mean you should never use this modifier at all.

Key: When a surgery may require significant additional time or effort that falls outside the range of services described by a particular CPT code — and no other CPT code better describes the work involved in the procedure — modifier 22 is your best option.

3. Don't Invest in Practice Management Software Just Yet: Keeping up-to-date practice management software on your practice's computers can be a great way to ensure that you're keeping your practice billing and collecting properly. But if you're considering buying an electronic health record (EHR) system for your practice, don't buy separate practice management software until you know what your EHR offers.

"If you're looking at an integrated EHR, it will probably come with practice management software within it, so don't buy a new software system until you select your EHR," advises **Barbara J. Cobuzzi, MBA, CPC, CENTC, CPC-H, CPC-P, CPC-I, CHCC,** president of CRN Healthcare Solutions, a coding and reimbursement consulting firm in Tinton Falls, N.J., and senior coder and auditor for The Coding Network. "Many EHRs also offers very sophisticated integrated practice management systems," she advises.

4. If You Are Non-Par With the Patient's Insurer, Always Collect At Time of Service: If you know that your practice does not participate with the patient's insurance company,

(Continued on Next page)

you also know that the payer will send the check directly to the patient. Therefore, you can collect the fee for your services directly from the patient while he is in your office. This policy should appear in the financial policy you give all patients, and you should put up a sign in the waiting area stating that payments are due at the time of service. You should also try to let patients know when they make their appointment (and when you call with an appointment reminder) what they will owe for the visit, as well as the payment methods your practice accepts.

5. Bill for No-Shows: Medicare used to frown upon no-show billing. However, in Oct. 2007 CMS changed the policy and since then you've been able to charge Medicare patients if they miss an appointment — with one major stipulation: Your no-show charge policy needs to apply to both your Medicare and non-Medicare patients. You cannot discriminate against Medicare patients by only charging them and not your other patients who miss appointments. You also have to charge the same amount to all of your patients.

Remember: Even if your contract allows you to bill for no-show visits, that doesn't mean you can bill the payer. You need to bill the patient for the missed appointment. If you do bill a missed appointment to Medicare, for example, your claim will be denied citing reason code 204 (*This service/equipment/drug is not covered under the patient's current benefit plan*). ❑

HIPAA Compliance

Just Because Lawyers Request Records Doesn't Mean You Must Send Them

3 steps help you avoid violating HIPAA laws in these situations.

Picture this: An attorney working on a legal case calls you and asks you to immediately send him a Medicare patient's medical records that are related to the case. He even follows up the call with a fax demanding the records. Do you send them?

Absolutely not. First, you must ensure that the attorney has authorization from the patient to release the personal health information (PHI), or has other legal documentation proving that you can send the information.

"Covered entities and business associates should exercise great caution when responding to such requests," advises **Abner E. Weintraub**, president of The HIPAA Group, Inc., a HIPAA training and consulting firm. "The best advice here is to take your time, investigate, and be sure of what you are doing," he says.

"Law firms are often *intentionally* intimidating in their phone or written requests for documents and data," Weintraub says. "And while it may feel awkward NOT to respond immediately with the requested information, disclosing PHI to a law firm or attorney unlawfully can itself be a costly HIPAA violation. With the recently increased HIPAA penalties instituted by the HITECH Act, the consequences for unlawful disclosures can be devastating," he reminds practices.

The following steps can help you determine when you should — and shouldn't — comply with an attorney's request for medical records.

Step 1: Check for Patient Release

Once an outside party asks you for access to a patient's records, you should check the patient's HIPAA release form to determine whether she has authorized you to share the records with the requesting party. In many cases, a patient will only authorize you to share her medical records with her spouse, children, or caregiver, and not any outside parties. In the absence of such a form, ask the requesting attorney if he has a signed HIPAA release form on hand.

"If the law firm represents itself as being the patient's law firm, it should provide the practice with a HIPAA compliant authorization for the release of medical records executed by the patient," advises South Florida-based health care attorney **Deborah A. Green, Esq.** "Just to make extra sure, I would recommend contacting the patient to find out whether it is actually the patient's signature. If so, keep the authorization in the patient's file and send the records."

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Step 2: Determine Whether A Court Order Exists

If you don't have a release form from a patient, you should then find out whether the records request falls under a court order. "HIPAA imposes restrictions on the circumstances in which records can be released in a legal proceeding," says **Heather Cook Skelton, Esq.,** a health care attorney in Charlotte, N.C.

"A release is permitted if (1) it is pursuant to a court order and the practice only discloses what is specifically included in the order or (2) in response to a subpoena or discovery request that is not accompanied by an order if the practice receives 'satisfactory assurances' from the party seeking the information that reasonable efforts have been made to inform the patient of the request," Skelton says.

What that means: "'Satisfactory assurances' is defined as written confirmation that the requesting party has made a good faith attempt to notify the patient in writing, which should contain an explanation of the proceeding and a description of the protected health information that has been requested in enough time for the patient or his or her legal representative to object," Skelton says.

In absence of such satisfactory assurances, if a subpoena is coupled with a qualified protective order (QPO) that has been agreed to and presented to the court, or has been requested from the court by the attorneys seeking the records, then the attorney has the right to request the patient's records, Weintraub says.

Step 3: Only Disclose The "Minimum Necessary" PHI

Even if an attorney has the legal authorization to request a patient's PHI, he may not have legal access to the entire patient record, Weintraub says. When creating the HIPAA laws, the Department of Health and Human Services wrote, "A covered entity making a disclosure…may of course disclose only that protected health information that is within the scope of the permitted disclosure."

If a court order does not specify which parts of a patient's records you should send to the attorney, you must "make reasonable efforts to limit the information disclosed to that which is reasonably necessary to fulfill the request," the law states.

For instance, if an attorney requests information about a patient's bleeding episode that followed a hip replacement, you would most likely not need to also send the law firm information on a facial lesion that the patient had removed the prior year.

One last tip: If you have grounds to refuse to provide the attorney with medical records, you should also refuse any verbal requests that they might make. One practice manager tells *Part B Insider* that after she refused to send a patient's

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medical records to an attorney, the lawyer asked her, "Well then can you just tell me if there is anything in the record about alcohol abuse?"

"Releasing PHI verbally is also a violation of HIPAA," says **Michael F. Schaff, Esq.,** with Wilentz, Goldman and Spitzer in Woodbridge, N.J., "Any disclosure of PHI which is unauthorized is a violation of HIPAA, even if a lawyer says it's part of a lawsuit," Schaff asserts. "You'd need written authorization before you could release the information verbally, in writing, electronically, or otherwise," he says. ❑

Reader Questions

Look for Local Treatment to Report Sunburn Pay

Question:
A patient presented to our office with swelling and minor blisters on the tops of his feet. The doctor diagnosed sunburn and treated it with a cold, wet compress on the area. He discussed several factors with the patient (the sunburn, expected progression, proper treatment, pain management, prevention). Should I use an E/M code for the burn treatment?

Answer:
Because the burn care involved treatment, you can report 16000 (*Initial treatment, first degree burn, when no more than local treatment is required*) for the service. You can also report an E/M code if the physician's documentation supports a significant, separately identifiable service. Choose the appropriate E/M code, such as 99212 (*Office or other outpatient visit for the evaluation and management of an established patient …*).

Append modifier 25 (*Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service*) to 99212 (or other appropriate E/M service), and you should expect full pay for both the E/M service and sunburn care. ❑

Use 33212-33213 for Pacemaker Battery Change

Question:
Which CPT and ICD-9 codes apply to changing a pacemaker battery?

Answer:
A pacemaker battery is known as a pulse generator. You report it based on the type of generator: 33212 (*Insertion or replacement of pacemaker pulse generator only; single chamber, atrial or ventricular*) for a single chamber or 33213 (*… dual chamber*) for a dual.

Diagnosis: The diagnosis for pacemaker replacement depends on what led to the procedure. If you have documentation of a mechanical breakdown, report 996.00 (*Mechanical complication of cardiac device, implant, and graft; unspecified device, implant, and graft*). If the battery had reached the end of its expected life, report V53.31 (*Fitting and adjustment of other device; cardiac pacemaker*). If the battery stopped working before its expected end of life, submit 996.01 (*Mechanical complication of cardiac device, implant, and graft; due to cardiac pacemaker [electrode]*). ❑

49080 Lavage is Part of Catheter Insertion

Question:
A surgeon places a peritoneal dialysis catheter (49421) and at the completion of this surgery, he infuses and extracts a liter of fluid to assess the patency of the catheter and to ensure the abdominal cavity is of adequate size to ensure a proper dialysis treatment. Can we bill a peritoneal lavage for this process (49080) at the same setting with the catheter insertion?

Answer:
No, you should not report 49080 (*Peritoneocentesis, abdominal paracentesis, or peritoneal lavage [diagnostic or therapeutic]; initial*). That code is for percutaneous peritoneocentesis, not for lavage (or any other type of fluid instillation into the abdomen) during another procedure.

Bottom line: The peritoneal lavage is not separately codeable with the catheter placement (49421, *Insertion of intraperitoneal cannula or catheter for drainage or dialysis; permanent*). The lavage was basically just the surgeon checking his work and is part of the procedure. ❑

Symbols and Chart Explain V Code Order

Question:
What rules apply to reporting V codes with E/M office visits? Can we report screening codes as a primary diagnosis?

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Answer:
You can report some V codes as a primary diagnosis with an E/M visit, but others are only used as additional diagnoses. Symbols beside codes designate the category for each V code. For example, ICD-9 directs you to list V70.3 (*Other general medical examination for administrative purposes*) as a first diagnosis; submit V69.0 (*Problems related to lifestyle; lack of physical exercise*) as a primary or additional diagnosis; only report V15.82 (*Other specified personal history presenting hazards to health; history of tobacco use*) as an additional diagnosis.

Tip: Check the guidelines section of your ICD-9 book for a V code table outlining when you should report each diagnosis.
ICD-10: When your coding system changes from ICD-9 to ICD-10 in 2013, your codes will change as follows:

- V70.3= Z02.89, *Encounter for other administrative examinations*;
- V69.0- = V72.3, *Lack of physical exercise*
- V15.82 =Z87.891, *Personal history of nicotine dependence.* ❑

99214: Take into Account Discussion with Patient

Question:
As a pulmonologist and sleep specialist, I spend a lot of time discussing management, CT scan results, sleep studies, and management of sleep disorders. Most of these are time-based. How do we do that best?

Answer:
When a physician spends more than 50 percent of total visit time (face-to-face in the outpatient setting, or on the inpatient unit/floor after a face-to-face patient encounter), he can bill based on time instead of the key components (history, exam, and medical decision making). The patient should be involved in the discussion. Document the details of the discussion as well as the time.

For example, "25 minutes spent with the patient discussing CT scan results, sleep studies, and management of sleep disorders." Fill in the remaining details, as appropriate. Report 99214 (*Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family*). ❑

G0121 Accepts No Other ICD-9 But V76.51

Question:
A 73-year-old established Medicare patient with average risk for colorectal cancer presents for a screening colonoscopy on Feb. 11, 2010. The patient's records reveal his last covered screening to be on Jan. 31, 2000. How should I report this scenario?

Answer:
On the claim, you should report G0121 (*Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk*). But make sure there is no need or any therapeutic intervention during the colonoscopy.

Heads up: Diagnosis coding for all G0121 claims require only one ICD-9: V76.51 (*Special screening for malignant neoplasms; colon*). If the chart indicates a diagnosis of colitis, for example, then you shouldn't be reporting a screening. If you don't want a word from OIG and RAC auditors, you should make the chart notes and the procedure consistent. ❑

Focus on Bone, Not Joint, for 'Fracture'

Question:
Is there a diagnosis code for an SI joint fracture?

Answer:
Not exactly. A patient can fracture a bone, but not a joint, so you need to check the documentation for the precise bone or bones involved.

For a "sacroiliac (SI) joint fracture" consider the following possibilities: A sacral fracture at the SI joint (806.6x, *Fracture of vertebral column with spinal cord injury; sacrum and coccyx, closed*; or 805.6, *Fracture of vertebral column without mention of spinal cord injury; sacrum and coccyx, closed*) a fracture of the ilium (808.41, *Fracture of pelvis; other specified part, closed; ilium*).

Before you report this, however, you should check to make sure that this is a true fracture and not a stress fracture because this distinction can change your diagnosis coding. If this is a stress fracture, you'll report 733.95 (*Stress fracture of other bone*) as well as an external cause code, if possible. ❑

Physician Notes

Intermediaries Won't Field ZPIC Questions

Plus: Feds bust organized crime Medicare fraud scheme.

The lines may get blurry when it comes to ZPIC (Zone Program Integrity Contractors) requests for documentation, but don't expect help from your intermediary on the matter. "Although **Palmetto GBA** adjudicates claims once the review is complete, Palmetto GBA does not conduct the medical reviews requested by the ZPIC," the intermediary explains in a Zone Program Integrity Contractor update on its Web site.

"Since these reviews are being done by an entity other then Palmetto GBA, questions and correspondence related to the review and results of the review need to be directed to the source of the request."

Palmetto does adjudicate the claim — recoup funds — once the ZPIC makes a claim determination, Palmetto says, and the carrier hears the appeals for ZPIC-denied claims. "The process for filing a redetermination based on a ZPIC decision is unchanged," the intermediary says.

But providers "should include a copy of the overpayment letter from Palmetto GBA and the spreadsheet from the ZPIC or the Program Safeguard Contractor (PSC) when requesting the redetermination," Palmetto adds.

In other news…

The feds have taken down one of the huge Medicare fraud schemes of the type that is making your life harder. Law- and policy-makers have been issuing new compliance rules based on the crimes like those allegedly committed by an organized crime syndicate. Seventy-three defendants were charged in indictments unsealed Oct. 13 in five judicial districts with various health care fraud-related crimes involving more than $163 million in fraudulent billing, says the **Department of Justice**, **FBI**, and OIG in a release.

The defendants allegedly stole the identities of doctors and thousands of Medicare beneficiaries and operated at least 118 different phony clinics in 25 states, the release says. The criminal operation is "the largest Medicare fraud scheme ever perpetrated by a single criminal enterprise and charged by the Department of Justice."

"The emergence of international organized crime in domestic health care fraud schemes signals a dangerous expansion that poses a serious threat," said Acting Deputy Attorney General **Gary G. Grinder** in a statement. "These syndicates are willing to exploit almost any program, business or individual to earn an illegal profit."

Fifty-two arrests for the fraud scheme occurred in five states — California, Georgia, New Mexico, New York, and Ohio, the DOJ said. "We want to restore the confidence in the nation's health care system and assure practitioners we will not stand by and let their identities be used for criminal gain," **Kevin Perkins**, FBI Assistant Director of the Criminal Investigative Division, noted in the release. ❑

part B insider

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