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CONSULT ELIMINATION

New Modifier AI Allows Multiple Docs to Bill Initial Hospital Care

▶ Modifier AI will denote the primary physician of record, now that consult coding is a thing of the past.

CMS will no longer reimburse you for consultations effective Jan. 1, but your physicians will still collect for initial inpatient visits — even if they didn't admit the patient — thanks to a new modifier.

In the past, only the admitting physician reported initial hospital care codes (99221-99223), and specialists who saw the patient separately often billed inpatient consults.

New way: Now that Medicare won't recognize the consult codes, multiple physicians may report initial hospital care during a patient's visit. Therefore, CMS released new modifier AI (*Principal physician of record*), which the admitting physician will append to the code for his initial visit with the patient.

In black and white: "In the inpatient hospital setting and the nursing facility setting all physicians (and qualified nonphysicians where permitted) who perform an initial evaluation and management may bill the initial hospital care codes (99221-99223) or nursing facility care codes (99304-99306)," according to CMS Transmittal 1875, issued on Dec. 14.

"As a result of this change, multiple billings of initial hospital and nursing home visit codes could occur even in a single day," the transmittal reads. "Modifier AI ... shall be used by the admitting or attending physician who oversees the patient's care."

Note: As in the past, each physician will be able to bill from the 99221-99223 code range only once, after which they'll report subsequent hospital care codes (99231-99233).

Although modifier AI will cure some confusion, coding these visits may still be difficult, particularly since some private insurers may opt to continue paying for consults.

In a hospital setting, "the physician often won't know which insurer the patient has, so they may not know whether to use the consultation codes or the initial visit codes," says **Suzan Berman (Hvizdash), CPC, CEMC, CEDC,** senior manager of coding and compliance in the departments of surgery and anesthesiology at the University of Pittsburgh Medical Center. "This will probably rest on the shoulders of the coders until all payers' processes are identified."

To read Transmittal 1875, visit www.cms.hhs.gov/transmittals/downloads/R1875CP.pdf. ■

CONSULT ELIMINATION

Let These 5 Facts Guide You Now That Consults No Longer Apply

▶ *Tip: ABNs won't help you collect for consults.*

January 1 is only a few weeks away, so you've got just a short window of time to give your E/M coding a quick facelift now that Medicare won't pay for consults anymore.

On Dec. 14, CMS released modifier AI (*Principal physician of record*) to assist you in coding multiple inpatient visits in cases where other physicians previously reported consult codes for the admitted patient (*see page 345 for more*). Memorize these five facts to make the most of your E/M claims.

1. The Modifier Consists of Two Letters. "Some people are interpreting the new modifier as A-one," says **Barbara J. Cobuzzi, MBA, CPC, CPC-H, CPC-P, CENTC, CHCC,** president of CRN Healthcare Solutions. "But it's two letters, A and I," she reminds coders.

2. Know 'Principal Physician.' CMS notes in Transmittal 1875 that "the principal physician of record is identified in Medicare as the physician who oversees the patient's care," and that it's "sometimes referred to as the admitting physician."

Make no mistake: Some coders believe the term "principal physician of record" refers only to a primary care physician, but that isn't the case.

"Even if a specialist is overseeing the patient's care, modifier AI still applies," Cobuzzi says.

3. ABNs Won't Help You. Physicians who provide consultations to Medicare beneficiaries cannot ask the patient to sign an ABN, nor can they bill the patient for the consult service.

"ABNs are applicable only where a denial of payment is anticipated on the grounds of medical necessity requirements under the Social Security Act," said CMS's **Whitney May** during a Dec. 16 CMS Open Door Forum. "Consultation codes 99241-99245 and 99251-99255 are now assigned status indicator I, which means that these codes are not valid for Medicare purposes," May said.

4. Consult Policy Doesn't Apply to Medicare Advantage. Although Part B MACs will no longer reimburse you for consults, that may not affect other insurers.

"This policy only applies to physicians billing the Medicare Fee-for-Service program — it does not apply to Medicare Advantage or a non-Medicare insurer," May noted. It is up to each payer to determine whether they'll continue paying for consults in 2010.

5. Don't Rely on Crosswalks. Because five levels of inpatient consults are now billed using three levels of inpatient E/M visits, some practices are seeking crosswalks that refer them from consult codes to E/M codes. But you should not rely on any such guides as the final word. Instead, when the practitioner performs an E/M service, report the code "that most appropriately describes the level of services provided," notes *MLN Matters* article MM6740, released Dec. 14.

For the MLN Matters article, visit www.cms.hhs.gov/MLNMattersArticles/downloads/MM6740.pdf. ■

PRIVACY

Maintain Your Privacy With These Safeguards

▶ *Health system puts over a million records at risk.*

If you've been putting privacy compliance on the back burner, it's time to bring it up front again, because investigators are paying attention, and you should, too.

Last month, officials of a health system in Connecticut announced that an unencrypted hard drive with about 1.5 million patients' information on it was stolen, potentially subjecting that protected health information (PHI) to abuse.

Stories like this are certainly eye-catching — and add to that the new focus in privacy with the introduction of the HITECH act — and you can be sure that patient privacy is gearing up to take center stage. And with employees taking work home and bringing laptops or cell phones with them to the office, you should be sure that your office's security is tight.

Encryption is a Best Practice

If you want to give your data a fighting chance of staying private, you should consider encryption — even though the government doesn't require it. "The HITECH Act does not require encryption, but a provision of the act addresses breach notification," says **Michelle Wilcox DeBarge, Esq.,** with Wiggin and Dana LLP in Hartford, Conn.

"Under HHS regulations, there are obligations to notify the patient, as well as HHS and the media in some cases, if a patient's PHI has been breached," DeBarge says. "However, if a breach occurs and the data was encrypted, the breach falls under a safe harbor, meaning that no notifications are necessary. Therefore, even though the law doesn't require encryption, it can help you avoid a lot of problems."

Tip: "By all means, encryption is by far the recommended means for protecting information on hard drives, especially removable hard drives and other media, such as USB keys, CDs, or any other type of medium that can easily be transported outside the organization," says **Gregory Michaels,** manager of security and compliance solutions at BluePrint Healthcare IT in Cranbury, N.J.

Don't Stop With Individual Files

If you're already encrypting your data, you've taken a great step — but if you're encrypting only certain files, you may be falling short of ensuring complete privacy.

"Any provider who is using their machine with access to PHI or any information that can be used for identity theft really should have the entire hard drive encrypted," says **Peter Courtway,** chief information officer for Danbury Health Systems in Connecticut. "It's commercially available, and it's not expensive."

Avoid easy passwords: Once you go to the trouble of encrypting your hard drive, don't compromise the data by using passwords that are easy to hack, Courtway says. "Let's say your drive is completely encrypted but instead of having a password that's complex, you have one that's the name of your dog or child — that's really the first thing that someone would try if they came across it," he says. Instead, he recommends using "strong passwords," which involve a series of letters, numbers, and/or symbols.

Keep an eye on removable media: If you are backing up a file from your laptop and it's encrypted there, just copying it onto a USB key or CD or backup drive does not automatically keep the encryption, Courtway says. "So you must take the necessary steps to encrypt the hard drive and/or the USB key."

Best practice: If data is being shared with offsite entities, such as billers or records management companies, each piece of removable media should have its own password. "At our organization, we had everyone turn in their USB key drives and we replaced them with drives that forced encryption to ensure that everyone is encrypting their data," Courtway advises.

Key: Ensure that your organization has policies in place keeping PHI private. "It's essential that an organization include in its privacy policy that any type of PHI can only be on removable media or portable laptops, etc., if it's properly protected," Michaels says. "Make the employees aware of the reasons for this and try to make the employees knowledgeable."

For a sample employee privacy policy, turn to page 348. ■

PRIVACY

Keep Your Remote Workers' Information Private With This Sample Document

▶ *Make sure your offsite workers are aware of security and privacy concerns.*

Your practice has tough decisions to make when allowing employees to handle patients' private health information (PHI) while working from offsite locations. You may require encryption, you may prohibit them from working on their personal laptops when dealing with PHI, or you may even only allow remote work when it's done for emergency reasons. But no matter what, you need to communicate your privacy expectations to your employees.

Consider this sample document as a guide, contributed by **Glenn Allen,** information security director with Fairview Health Services in Minneapolis, Minn:

Security Considerations/Guidelines for the Remote Worker: When working remotely, we expose [organization name] to increased risk of privacy and security incidents and breaches. [Organization name] takes great care in protecting the privacy and security of its paper and electronic systems in order to safeguard its patient (and other confidential) data. Remote workers need to take the same care.

• Only use a currently supported operating system (e.g., XP or Vista) with all available security patches.

• Use auto-updating antivirus software. Antivirus with outdated virus definitions has reduced effectiveness.

• Use a properly configured firewall. Also strongly consider having a properly configured router between your equipment and internet connection (which can greatly increase your protection as well).

• Be careful when using shared (family) computer equipment to access [organization name] resources. The computer you share can inadvertently be compromised by others. It may make sense to limit access to equipment used to connect to [organization name] unless you understand what others are using the computer for.

• Do not use any form of file sharing programs on equipment used to connect to [organization name] resources. Many file sharing programs can be used to open or share folders and files on your own computer (sometimes without the user meaning to).

• Get guidance from your operating system vendor on safe computing. Many OS vendors (like Microsoft) have great resources for both end-user and IT professionals.

• Never reply to, open links in or attempt to unsubscribe to unsolicited emails. Just following a link in an email to a hostile site can compromise your computer.

• Immediately report any security concerns to your manager or the IT department.

• It is required that comprehensive steps be taken to make sure that only programs directly related to the employee's business purpose are run while being connected to [organization name]'s network.

• Position your monitor so that unauthorized person/s cannot view the screen.

• User ID and/or passwords may not be shared or written, taped or stored on the computer/laptop, in the computer bag or in any location relative to the computer.

• Be careful when printing confidential documents. Be sure you are printing to the correct printer and that you are able to retrieve any confidential documents quickly.

• Be aware when using wireless hotspots. Some wireless hotspots may be run by unscrupulous individuals who are looking to steal/misuse data and equipment connected to the hotspot.

• [Organization name] may inspect and monitor data and communications at any time. This includes monitoring network usage (including contents), and examining files on any system that has been connected to the network.

• Be mindful when selling or getting rid of computer equipment. Remember to scrub or properly dispose of drives (including flash/thumb) so others cannot access confidential data. ■

PRIVACY

Follow 3 Tips When Handling Patient Privacy Concerns at Your Organization

▶ *Hint: Paper files can be breached just as easily as electronic files.*

You may be sure that you've dotted all of your i's and crossed all of your t's, but if you miss even a small piece of the privacy puzzle, you can compromise your entire system.

Take a look at these three reminders to ensure that you're starting 2010 with your privacy program on the right foot:

1. Don't Let Paper Get Lost in the Shuffle. You may think of patient privacy exclusively in terms of protecting electronic patient data, but paper files are just as likely to be compromised.

"With the advent of the HITECH changes, breaches occurring with paper records will be treated the same way as electronic data," says **Gregory Michaels,** manager of security and compliance solutions at BluePrint Healthcare IT in Cranbury, N.J.

"Doctors may take paper records home as opposed to USB keys, or they may take paper records in their car with them to the office or hospital, and obviously those things have the same value in terms of the information contained in them," Michaels advises.

Even in facilities where paper records are stored securely, there's still a chance that the information on them might be exposed.

"In some hospitals, the main medical record area is very well secured, but other departments may have access to records, take them from the room, and store them temporarily while using them, and may not be keeping them secure," he says. "Even if we can move to 50 or 60 percent of medical practices being fully electronic in the next few years, we're still looking at a long time before paper is eliminated, so make sure any PHI stored on paper in your office is secure."

Even before the HITECH Act came into existence, practices were always advised to handle PHI securely — whether it was on paper or stored electronically.

"It has been the case for a long time, and it's still the case, that health care providers should not throw PHI into the trash," says **Michelle Wilcox DeBarge, Esq.,** with Wiggin and Dana LLP in Hartford, Conn. "Proper disposal practices should be in place (for instance, shredding)," she says. "And now under HITECH, the breach notification requirements don't just apply to breaches of electronic information — oral or paper disclosures fall under the Act as well," she advises.

2. Know That Patients Are Aware. You've asked patients to sign a HIPAA privacy form, now they're content, right? Not necessarily.

"The HITECH Act imposed an affirmative obligation on the government agency overseeing the HIPAA program to investigate compliance breaches," DeBarge says. "Previously it was driven by complaints only, but they now have an obligation to affirmatively audit and monitor."

Plus: The government has been hiring people to ensure compliance and will be providing education programs to the public, "and we're expecting a lot of awareness, and for patients to be asking more questions about the use of their private health information going forward," says **Peter Courtway,** chief information officer for Danbury Health Systems in Connecticut.

"There is also a provision under HITECH that will allow individuals who have been harmed by a breach to have a share in the proceeds of the penalties," DeBarge says. "We don't have the details yet, but this is another reason that patients will have incentive to pay attention."

3. Don't Forget the Front Lines. You may be compromising patient data in other ways besides electronic and paper breaches. Perform a walkthrough in your practice or organization to ensure that no other leaks exist.

For instance: One compliance officer walked through her practice and was pleased to see that computer monitors at the front desk had been turned so that patients in the waiting area could not see the screens.

However, upon going to the elevators, she realized that the monitors were viewable through the glass entryway, and that anyone in the building's lobby could see the data. ■

ORTHOPEDICS

3 Questions Point You to Correct Joint Aftercare Codes

▶ *Shift gears to different V codes after the global period.*

You know to report V codes for your patients after they have total joint replacement, but selecting the best codes for aftercare — and knowing when to stop using them — can be tricky. Snag the correct V code combination every time when you're armed with these answers.

Is the Patient Under Current Treatment?

When you're coding for care that's still part of the surgical package, you'll need to employ two V codes. Hip and knee joint replacement surgeries have a 90-day global period. The patient will visit your office several times during that period — and beyond — so be sure to code these encounters correctly.

Two diagnosis code families apply to these patients during the global period:

• V54.81 — *Aftercare following joint replacement*

• V43.6x — *Organ or tissue replaced by other means; joint*.

"We use the V codes for hips and knees throughout the postoperative period and every visit thereafter," explains **Gloria Moran,** practice manager for Jacksonville Orthopedic Institute in Florida. "We feel it helps to represent the whole story of the patient to the insurance company."

"Aftercare covers situations when the initial treatment of a disease or injury has been performed and requires continued care," says **Judy Donahue, CPC,** a coder with Norfolk Medical Group in Nebraska. According to ICD-9 guidelines, aftercare codes also apply when the patient "required continued care during the healing or recovery phase, or for the long-term consequences of the disease."

Benefit: Extra documentation can be good from your payer's standpoint because it gives a clearer picture of the situation. "I've had insurance companies tell us they appreciate the additional codes when patients have a hip fracture versus a total joint arthroplasty," Moran says.

Have You Passed the Global Period?

After the global period expires, you'll switch from aftercare to a follow-up V code — but keep the replacement code.

"Follow-up care should use V67.09 (*Follow-up examination; following other surgery*)," Donahue says. She and Moran agree that you'll also continue to report the appropriate choice from the V43.6x family as your secondary diagnosis.

Drop V54.81: "Follow-ups are continuing surveillance following completed treatment of the disease, condition, or injury," Donahue says. "If the patient is coming in for a follow-up after they know the healing process is complete, then you shouldn't use V54.81. V67.09 should be the primary code."

Are You Coding Prosthetic Repair?

Your V code strategy might change if you're coding for care following a prosthesis placed for a fracture rather than original total joint replacement.

• If the prosthetic procedure is due to trauma, Moran reports the traumatic fracture diagnosis (such as 996.44, *Peri-prosthetic fracture around prosthetic joint*) and includes the appropriate code from V43.6x to indicate the specific joint involved.

• If you have documentation of a pathologic fracture of a prosthetic joint resulting from an underlying condition (such as osteoporosis or a neoplasm), you should code a bit differently. Submit a pathologic fracture diagnosis (733.1x, *Pathologic fracture*) with the appropriate V43.6x choice as a secondary diagnosis.

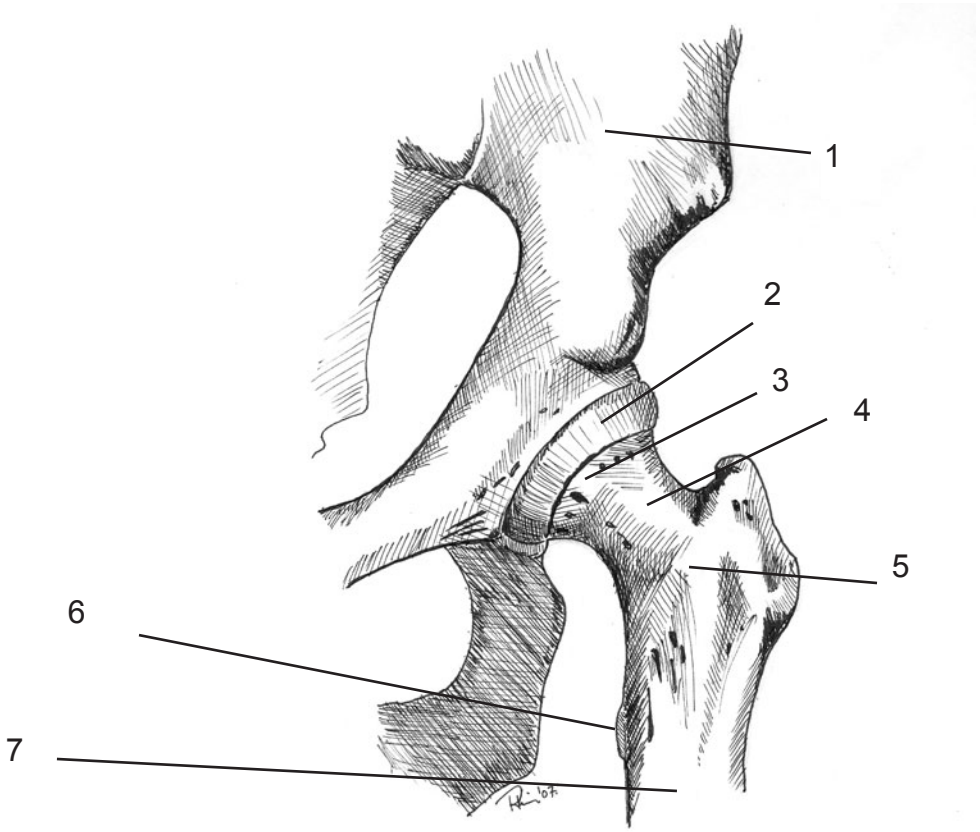
To get the lowdown on billing for one type of joint disorders (hip), turn to page 351 for a quick cheat sheet.■

CLIP-AND-SAVE

Use This Chart to Select the Right Hip Codes — Every Time

▶ *Match the site to the documentation to choose the correct options.*

When it comes to joint replacement, the code choices can make your head spin. Get to know the specifics of hip anatomy, and you won't have to worry about how to differentiate the codes for femoral head and femoral neck. The following anatomy drawing and chart can help you perfect your hip claims.



Location on Chart	Anatomic Site	Common Diagnoses	Applicable ICD-9 Codes
1	Pelvis (iliac wing)	Fractured pelvis	808.2-808.9
2	Labrum of the acetabulum (socket that holds the femoral head)	Fractured acetabulum	808.0-808.1
3	Femoral head (ball that fits into the acetabulum)	Hip dislocation, Femoral head fracture	835.00-835.13; 754.30-754.35; 820.09
4	Femoral neck	Fracture of neck of femur	820.00-820.9
5	Greater trochanter	Intertrochanteric fracture	820.21; 820.31
6	Lesser trochanter	Subtrochanteric fracture	820.22; 820.32
7	Femur	Femur fracture	821.00-821.39

PART B REGS

CMS Transitioned Over 230,000 Providers' NPIs Into PECOS

▶ *Plus: Medicare officials stress that you should start ICD-10 readiness preparations sooner rather than later.*

CMS intends to help your transition to using the PECOS system, even if it means additional legwork on their part.

Providers who order/refer many services and supplies must be enrolled in Medicare Provider Enrollment, Chain, and Ownership System (PECOS) by April 5 or the entity billing the claim will face denials.

Previously, CMS had indicated that the deadline for PECOS updates by ordering/referring providers would be Jan. 4, but a Nov. 23 directive delayed the deadline by three months "to try to give the physicians and non-physician practitioners who can order and refer an opportunity to get their enrollment records into PECOS," said CMS's **Pat Peyton** during a Dec. 16 CMS-sponsored Open Door Forum.

If you bill an item or perform a service that was ordered or referred by another practitioner, your claim must include the referring or ordering practitioner's national provider identifier (NPI) and that number must be in the PECOS system.

"A lot of them [the providers] are in Medicare but have not updated their records in six or more years, and they need to revalidate their information in order to get them into PECOS," Peyton said on the call.

Currently, if you submit claims for services or items ordered/referred and the ordering or referring physician's information is not in the MAC's claims system or in PECOS, you'll get an informational message letting you know that the practitioner's information is missing from the system — but come April, that message will be in the form of a denial.

Even if the record is in PECOS, if the NPI is not recorded, you'll get that informational error message, Peyton said. Therefore, the weekend of Dec. 12, CMS input the NPIs of over 230,000 practitioners into the PECOS system on providers' behalf, "so many of those informational messages should not be going out anymore," Peyton said.

Internet listing coming: CMS also intends to create an internet-based list of physicians and non-physician practitioners who can order and refer within Medicare. The listing will include the practitioners; with their legal names and NPIs, Peyton said. "We still are going to do that, it's probably going to be January, but we will let you know when that is going to be there and how to access it at the appropriate time," Peyton said.

Get Ready for ICD-10

With 2010 just around the corner, CMS officials want to stress that 2013 isn't that far behind. And with 2013 comes a slew of new diagnosis codes that your systems will have to accept.

"The transition date for ICD-10 codes is Oct 1, 2013," said CMS's **Stewart Streimer** during the call. "That's really the drop-dead date for those of you that have familiarized yourselves with the Final Rule regarding ICD-10 ... but there are a lot of things that must happen before then and I expect many of the payers may even require ICD-10 codes before then so a sufficient amount of testing can take place," he suggested.

Vendors are already working to prepare their systems to accommodate ICD-10 codes, Streimer said. "A lot has to be done not only from the systems perspective, but also a lot has to be done from practitioner offices in terms of how to bill a claim or how to send information onto your vendors for your clearinghouses."

The CMS Web site offers resources for preparing for ICD-10 at www.cms.hhs.gov/icd10. ■

RADIOLOGY

Apply 36145's Replacement Codes Correctly With These Tips

▶ *Reporting 75790 for shunt evaluation goes the way of the dodo in a few weeks.*

If you've noticed a trend toward guidance-inclusive procedure codes, you're right.

Along those lines, CPT 2010 adds AV shunt cath placement and angiography to that growing list.

Keep in mind: The code changes are effective Jan. 1, so take steps now to be sure you're ready to apply the new codes from day one.

Watch Initial vs. Additional for Clean Claims

CPT 2010 ousts 2009 codes 36145 (*Introduction of needle or intracatheter; arteriovenous shunt created for dialysis [cannula, fistula, or graft]*) and 75790 (*Angiography, arteriovenous shunt [e.g., dialysis patient], radiological supervision and interpretation*) and instead instructs you to consider the following new surgical codes.

Crucial: These new codes include imaging:

• 36147 — *Introduction of needle and/or catheter, arteriovenous shunt created for dialysis (graft/fistula); initial access with complete radiological evaluation of dialysis access, including fluoroscopy, image documentation and report (includes access of shunt, injection[s] of contrast, and all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava*)

• +36148 — *... additional access for therapeutic intervention (List separately in addition to code for primary procedure).*

Code +36148 is like all add-on codes. "These services are always performed in addition to the primary service or procedure and must never be reported as a standalone code," says **Marvel Hammer, RN, CPC, CHCO,** owner of MJH Consulting, a reimbursement consulting firm in Denver.

What to do: Report +36148 together with 36147 if the initial evaluation (36147) prompts a therapeutic intervention requiring a second shunt catheterization (+36148), state CPT guidelines.

Fortunately, the 36147 descriptor is clear, and coding catheter placement with a diagnostic angiography should continue to be straightforward, says **Kim French, CIRCC,** director of interventional coding and reimbursement Crouse Radiology Associates in Syracuse, N.Y. CPT's wording for +36148 also shouldn't cause confusion, says French.

Avoid Misguided Guidance Coding

In 2009, you could report 36145 and 75790 together for catheter placement and diagnostic angiography. But CPT 2010 deletes 75790, and reporting new code 36147 covers both services.

These changes raise the question of when to use all new AV shunt angiography code 75791 (*Angiography, arteriovenous shunt [e.g., dialysis patient fistula/graft], complete evaluation of dialysis access, including fluoroscopy, image documentation and report [includes injections of contrast and all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava], radiological supervision and interpretation*).

Solution: Notes with 75791 tell you to use the code only if the physician performs the radiological evaluation through an already existing shunt access or an access that isn't a direct shunt puncture. If the service requires catheter introduction, choose from 36140 (*Introduction of needle or intracatheter ...*), 36215-36217 (*Selective catheter placement, arterial system ...*), and 36245-36247 (*Selective catheter placement, arterial system ...*).

And just to be extra clear, notes instruct you not to report 75791 along with 36147/+36148.

Prediction: The CPT committee will continue to look at codes that are performed together by the same physician on the same day of service 95 percent of the time, said **Barbara S. Levy, MD,** AMA/Specialty Society Relative Value Scale Update Committee (RUC) chair, at the AMA's CPT and RBRVS 2010 Annual Symposium in Chicago. ■

PART B REVENUE BOOSTER

Ensure Tetanus Payment With 5 Guidelines

▶ *Get familiar with Medicare's rules from medical necessity to choice of products.*

Medicare's tetanus injection coverage riddle boils down to one issue: Is there an injury?

When administered as a preventive vaccine, Medicare does not cover a tetanus shot. However, if the patient needed a tetanus injection to treat a wound, you've hit coverage criteria. "Medicare will not pay for tetanus shots given to Medicare patients unless there is a current injury diagnosis reported," according to **Lisa Curtis, CPC, CEMC,** of Boulder Medical Center in Colorado.

Tip: Any wound that causes a break in the skin potentially will need a tetanus shot. "Vaccinations or inoculations are excluded as immunizations unless they are directly related to the treatment of an injury or direct exposure to a disease or condition, such as anti-rabies treatment, tetanus antitoxin or booster vaccine …" according to the *Medicare Benefit Policy Manual,* Chapter 15, Section 50.4.4.2. Examples of cases that will require tetanus vaccination include:

- patients who suffer from a deep or puncture wound
- wounds contaminated with dirt
- burn injuries
- chemical burns
- painful skin abrasions.

Show Wound Diagnosis

As appropriate, use an injury-related ICD-9 code to indicate that the vaccine was given for a medically necessary reason rather than as a preventive service. When filing claims for the toxoid product with 90703 (tetanus toxoid only) or 90702, 90714, or 90718 (tetanus toxoid in combination with diphtheria toxoid), you'll need two ICD- 9 codes, relates **Rebecca Woodward, CPC, CEMC,** of MedVentures LLC in High Point, N.C. The primary diagnosis should be one of the ICD-9 V codes that indicates the need for prophylactic vaccination against bacterial diseases or combinations of diseases (V03.7, *Tetanus toxoid alone* or V06.5, *Tetanus-diphtheria*). Report an injury-related ICD-9 code as the secondary diagnosis.

Example: A nurse administers tetanus toxoid to a patient who suffered minor injuries after stumbling and getting pricked in the neck with small shards of wood. Code this encounter's diagnoses as:

- V03.7 — *Need for prophylactic vaccination ... Tetanus toxoid alone*
- 910.6 — *Superficial injury of face, neck, and scalp except eye; superficial foreign body (splinter) without major open wound and without mention of infection.*

Use Matching Product Code

For allowed vaccine and vaccine associated charges, report the CPT code for the product that staff administered. The following CPT codes represent different formulations of the tetanus toxoid or tetanus-diphtheria combination:

- 90702 — *Diphtheria and tetanus toxoids (DT) adsorbed when administered to individuals younger than 7 years, for intramuscular use*
- 90703 — *Tetanus toxoid adsorbed, for intramuscular use*
- 90714 — *Tetanus and diphtheria toxoids (Td) adsorbed, preservative free, when administered to individuals 7 years or older, for intramuscular use*
- 90718 — *Tetanus and diphtheria toxoids (Td) adsorbed when administered to individuals 7 years or older, for intramuscular use.*

Warning: If staff used a different product, do not try to use one of the codes above. Instead, use the CPT code that correctly describes the complete combination given. If you use CPT codes that are inconsistent with your medical record documentation, on audit you may be liable for fraud.

Also, don't forget to bill the appropriate administration code in addition to the vaccine product code.

Choose the immunization administration code based on the patient's age and physician counseling. For vaccine administration to a patient eight years of age and younger when the physician counsels the patient/family, you'll use 90465 or +90466. For older patients or encounters without physician counseling, assign 90471 or +90472 depending on the number of injections.

Don't miss: When a vaccination is excluded from coverage, your Medicare contractor will not cover any related charges, including administration and office visit. ■

READER QUESTIONS

Know When to Report Fluoro Separately

▶ *Plus: Rein in wireless network access, and more.*

Fluoro May Be Separately Billable

Question: *Our hand surgeons use fluoroscopic guidance when they perform wrist injections (such as 20526). Should we report the fluoroscopy code in addition to the injection code, or are they included?*

Answer: You should report 77002 (*Fluoroscopic guidance for needle placement [e.g., biopsy, aspiration, injection, localization device]*) in addition to 20526 (*Injection, therapeutic [e.g., local anesthetic, cortico-steroid], carpal tunnel*). The Correct Coding Initiative (CCI) does not bundle either procedure into the other, and most insurers will reimburse you for both procedures at the same visit.

If the surgeon uses fluoroscopic guidance with a ganglion cyst injection, however, you should not report 77002 separately, because the CCI does bundle fluoroscopy into 20612 (*Aspiration and/or injection of ganglion cyst[s] any location*).

Use 1 Code for 4 Transfers

Question: *Which codes should we report for flexor carpi ulnaris tendon transfers to the common extensor tendons of the index finger, long finger, ring finger, and small finger?*

Answer: You don't need to report multiple codes for the surgeon's work, even though he transferred tendons to four fingers.

Code 26498 (*Transfer of tendon to restore intrinsic function; all four fingers*) describes the entire procedure and includes all fingers.

Watch Wireless Network Access

Question: *A neighbor in our office building recently told us that she unintentionally encountered our wireless network while looking for available connections within her own office. Should we be concerned about information leaks? Are there any steps we can take to secure our wireless network?*

Answer: Yes, you should be concerned, but there are also options to tighten up network security.

While many unwelcome guests may come across your network while searching for easy access to a high-speed Internet line, your patient's protected health information (PHI) could also be theirs for the taking.

Network controls to secure PHI are especially pressing for practices that share office space or are close to other computer users. Consult with your technology professional on some of these tips to keep your practice's network under lock and key.

Change your SSID: Your service set identifier, or SSID, is the name of your network as it appears to outside users. Many network systems allow you to block the SSID from being broadcast, effectively closing your network to the outside world.

Protect with passwords: Most network systems ship with a default password that can be easily cracked by experienced computer users. Change this password as soon as possible. Also require each user of your wireless network to sign on using an approved username and password. That way, outsiders who casually encounter your network will be deterred from browsing, or worse.

Survey the site: Strolling around the parking lot and neighborhood with laptop in hand can help to gauge how wide your wireless network spreads and how well your network controls are working.

Grab 'High-Risk' Diabetes Pay

Question: *Which glucose tests will Medicare cover for diabetes screening, and how should I code?*

Answer: Medicare requires V77.1 (*Special screening for diabetes mellitus*) as your primary diagnosis when ordering a diabetes screening glucose test for low-risk patients.

Medicare will cover one of three tests for diabetes screening each year: the fasting blood glucose test (82947), the post-glucose challenge test (82950), or the glucose tolerance test (82951). Medicare pays for only one test, so you should submit only one of the above codes.

Don't miss: For high-risk patients who exhibit "prediabetes," physicians can order the screening test twice a year. Medicare requires 277.7 (*Dysmetabolic syndrome X*) as the ordering diagnosis in these cases. ■

READER QUESTIONS

Know What You Can Report With Rhinoplasty

▶ *Plus: Nail down how to report ketorolac tromethamine injection, and more.*

Use Primary Rhinoplasty for Patient's First Surgery

Question: *Our surgeon performed rhinoplasty (30410) and harvested a septal graft for the reconstruction. Should an additional septal graft code go with the rhinoplasty code?*

Answer: CPT code 30410 (*Rhinoplasty, primary;complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip*) does not include the harvest of the septal graft because the graft is obtained through a separate surgical incision. You are right with your theory.

Thus: If your surgeon's documentation mentions the harvest of the septal graft, you may report 20912 (*Cartilage graft; nasal septum*).

The graft harvest is separately reportable because there is no work performed on the septum in the situation you describe, such as a septoplasty. However, if a septorhinoplasty were performed then the septal graft would not be separately reported.

Tip: You use primary rhinoplasty codes for a patient's first nasal surgery. Otherwise, a secondary rhinoplasty applies (30430, *Rhinoplasty, secondary; minor revision [small amount of nasal tip work]*; 30435, *... intermediate revision [bony work with osteotomies]*; or 30450, *... major revision [nasal tip work and osteotomies]*).

Know Technique for Ketorolac

Question: *How should we bill the procedure and medication for a ketorolac tromethamine injection?*

Answer: Ketorolac tromethamine is available for intravenous or intramuscular administration, so double check your provider's technique before reporting either:

- 96372 — *Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular*
- 96374 — *Intravenous push, single or initial substance/drug.*

If your physician administered the injection in conjunction with an anesthetic, the injection would be bundled into the routine postoperative care and included in the anesthesia global fee.

If, however, you're able to report the injection separately, choose the appropriate procedure code and report the medication with J1885 (*Injection, ketorolac tromethamine, per 15 mg*).

Calculation: Be sure to capture the correct number of billing units for J1885. The common dosage is 60mg intramuscularly for the initial injection, which equals 4 billing units.

Save Post-Op Codes for Surgeon

Question: *An orthopedic surgeon put a pin in a patient's second toe on her left foot to correct a deformity. The patient decided she wanted a second opinion from another doctor during her post-op, so she came to our office as a new patient. Should I report an E/M code or should I report a post-op visit using the procedure code and a modifier?*

Answer: You should report an E/M code. Specifically, you should report the appropriate new patient office visit codes (99201-99205, *Office or other outpatient visit for the evaluation and management of a new patient ...*) based on the level of service your doctor performed.

Assuming your physician is not part of the same practice (reporting under the same tax identification number) as the orthopedic surgeon, you can report the E/M service without any modifiers or additional coding.

Because your physician was not involved in the surgical planning and is providing only a second opinion, not post-op care, you should not report the procedure code with a modifier. ■

READER QUESTIONS

Heed the 'Re-' Term in 96521's Descriptor — It Refers to 'Refill'

▶ *Know the CCI edits when attempting to report chemotherapy administration along with portable pump refills.*

Question: *Are we able to bill 96521 and 96416 on the same date? We had one payer who reimbursed both, but Medicare has been denying our claims. Do we need to use a modifier?*

Answer: You should not report 96416 (*Chemotherapy administration, intravenous infusion technique; initiation of prolonged chemotherapy infusion [more than 8 hours], requiring use of a portable or implantable pump*) on the same date as 96521 (*Refilling and maintenance of portable pump*).

Why: Any payers that adopt Medicare's Correct Coding Initiative (CCI) edits prohibit reporting 96521 with 96416.

96416: You should report pump initiation (96416) when the provider initiates prolonged infusion with a portable or disposable pump in the office.

To meet code requirements, the infusion (whether continuous or intermittent) must last a minimum of eight hours. Because the patient leaves the office for the duration of the infusion, you may not know the precise completion time, but you should record the disconnect time when the patient returns to the office. A treatment plan indicating pump run time and a record of the drug details is also a good idea.

96521: In contrast, 96521 is appropriate when portable pumps require periodic refilling and maintenance. Do not report the initial infusion code (96416) for subsequent infusions using the same pump. And do not use refill code 96521 for initiation.

Exception: When a patient's pump has been completely disconnected — such as in an intermittent regimen where the patient is instructed to discontinue the pump at home when administration is complete — and later the patient presents for another infusion, you may use 96416. That's because this is a true initiation rather than a continuation of a previous service. ■

PART B CODING COACH

Is Your Ob-Gyn Practice Up to Date? Take This 5-Part Challenge to Find Out

▶ *If your physician documents 'puerperal infection,' you've got 4 new options.*

This year, ICD-9 2010 brought new hyperplasia, mammogram, and fertility preservation codes. In some cases, these codes simply expanded on existing options, and it's up to you to spot when you should report the new versus old alternatives.

Dig in to these five scenarios to see if you can choose the proper code for services performed on or after Oct. 1.

Scenario 1: Pick Apart New Puerperal Options

Your ob-gyn documents "a puerperal infection," a bacterial illness following childbirth. How would you report this?

A. 670.0 — *Major puerperal infection*

B. 670.1x [0,2,4] — *Puerperal endometritis*

C. 670.2x [0,2,4] — *Puerperal sepsis*

D. 670.3x [0,2,4] — *Puerperal septic thrombophlebitis*

E. 670.8x [0,2,4] — *Other major puerperal infection*

Answer: Trick question. Your ob-gyn must document more specifically the infection type. That means with more information, your best options are B-D.

You'll need to include a fifth digit for these codes. A fifth digit of "0" represents "unspecified as to episode of care or not applicable." A fifth digit of "2" means"delivered with mention of postpartum complication." Your other option, a fifth digit of "4," represents "postpartum condition or complication" (which you would report only after the ob-gyn discharges the patient after delivery).

Watch out: Prior to Oct. 1, you would lump all puerperal infections into one code (670.0). You can still report this for unspecified puerperal infections, but here's the problem: If the patient requires hospitalization, your payer will most likely deny your claim at your first submission. That means wasted time appealing the claim.

Scenario 2: Don't Overlook 671 Category Notes

You're reporting a code from the 671 (*Venous complications in pregnancy and the puerperium*) category, but you need to provide what additional information? Select one of these options:

A. If the patient has deep phlebothrombosis, either in the antepartum (671.3x) or postpartum (671.4x) period, you should also apply a secondary diagnosis from code category 453 (*Other venous embolism and thrombosis*).

B. If the patient has been using anticoagulants for a long time and is currently using them, report V58.61 to indicate this.

C. Both of the above, if applicable.

D. None of the above.

Answer: C. ICD-9 added some notes under the 671 category to clarify that your ob-gyn's documentation needs to supply additional information, and your coding must reflect that. In other words, if you report a code from the 671 category and the patient has been using anticoagulants, you need to include V58.61. Otherwise, your payer could reject your claim.

Scenario 3: Update Your Hyperplasia Codes

Your ob-gyn diagnoses a patient with endometrial hyperplasia (either endometrial intraepithelial neoplasia [EIN] or benign hyperplasia). How would you report these conditions? Choose two of the options.

A. For EIN, you would use either 233.2 (*Carcinoma in situ of other and unspecified parts of uterus*) or 621.33 (*Endometrial hyperplasia with atypia*)

B. For benign hyperplasia, use 621.30 (*Endometrial hyperplasia,*

PART B CODING COACH

unspecified) or 621.31 (*Simple endometrial hyperplasia without atypia*).

C. 621.34 — *Benign endometrial hyperplasia*

D. 621.35 — *Endometrial intraepithelial neoplasia (EIN)*

Answer: C and D. You should use new codes 621.34 and 621.35.

"ICD-9 introduced these new codes because pathologists increasingly use a disease classification that distinguishes the benign hormonal effects of unopposed estrogens (benign hyperplasia) from emergent precancerous lesions (EIN)," explains **Melanie Witt, RN, CPC, COBGC, MA,** a coding expert based in Guadalupita, N.M.

Heads up: If you chose A and B, you're not entirely incorrect. You can still use the old codes in answer A or B. Older physicians still use the older, four-tier hyperplasia statements, but "over time, the more accurate distinctions between types of hyperplasia will replace the old," Witt says. A note in ICD-9 will instruct providers to use newer codes rather than the older ones.

An additional note accompanying the EIN diagnosis indicates that if the ob-gyn diagnoses the patient with malignant neoplasm of endometrium with endometrial intraepithelial neoplasia, you should report the code for the malignancy (182.0, *Malignant neoplasm of body of uterus; corpus uteri, except isthmus*) instead.

Scenario 4: Mark New Mammogram Code

A routine mammogram proves questionable due to the patient's breast density. You could consider this an:

A. abnormal finding, so payers will cover further testing.

B. inconclusive mammogram.

Answer: B. Dense breasts may require testing beyond a mammogram to confirm no malignancies, and the request for an appropriate code to describe this resulted in the new ICD-9 code 793.82 (*Inconclusive mammogram*).

"The new code may help get insurance companies to pay for additional testing," says **Cheryl Scott, CPC, CPC-H, CCS, CCS-P,** with HealthTexas in Dallas. "Prior to the 2010 code, the choices were to bill it as screening or to code dense breasts as an 'abnormality'" — which they aren't, she says.

And precisely because these inconclusive mammogram findings are not "abnormal," ICD-9 2010 will revise the 793.0-793.7 range so that "abnormal" findings aren't a requirement for using these codes:

• 2009: *Nonspecific abnormal findings on radiological and other examination of ...*

• 2010: *Nonspecific (abnormal) findings on radiological and other examination of ...*

Codes 793.89 and 793.99 will have the same change, adding parentheses:

• 2010: 793.89 — *Other (abnormal) findings on radiological examination of breast*

• 2010: 793.99 — *Other nonspecific (abnormal) findings on radiological and other examination of body structure.*

Scenario 5: Fine-Tune Fertility Preservation Dx

Your ob-gyn performs an ovarian transposition (58825, *Transposition, ovary[s]*) to preserve ovarian function prior to radiation. In addition to the cancer diagnosis, report this with:

A. V26.42 — *Encounter for fertility preservation counseling*

B. V26.82 — *Encounter for fertility preservation procedure*

Answer: B. Reporting V26.82 in addition to the cancer diagnosis supports medical necessity.

ICD-9 added these two new codes at the request of the American Society for Reproductive Medicine (ASRM) and the American College of Obstetricians and Gynecologists (ACOG). They will help substantiate visits and procedures aimed at preserving fertility for women who will undergo chemotherapy, surgery, or radiation therapy that might otherwise leave them sterile. ■

PHYSICIAN NOTES

Congress Votes to Postpone the 21.2 Percent Conversion Factor Cut

▶ *Plus: Know hospice claims reporting requirements, or expect added scrutiny.*

With just days to go until the government slashes the conversion factor by 21.2 percent, Congress has stepped in to try and delay that cut.

On Dec. 16, the House of Representatives voted to approve an amendment to HR 3326 (the Dept. of Defense Appropriations Act) that would freeze Medicare payments at current levels through the end of February. The Senate followed suit on Dec. 18 and approved the bill as well. This temporary fix is being considered as a "bridge" to help physician payments stay stable while a more permanent fix is still up in the air, as Congress hasn't made a decision on whether to permanently change the sustainable growth rate (SGR) formula.

Now that the House and Senate have passed the bill, it just awaits the president's signature before it becomes law. If the president signs it into law, you won't face the 21.2 percent conversion factor cut until March 1, 2010. Medical societies are hopeful that a permanent solution will be put into place by then.

To read the amendments to HR 3326, visit http://appropriations.house.gov/pdf/FY2010_Defense_Bill_Text.pdf.

In other news ...

• Don't miss the newest instructions from the feds on how to accurately comply with hospice claims reporting requirements.

In a new set of questions and answers, CMS has clarified how to report time on hospice claims, said CMS's **Katie Lucas** in a Dec. 2 Open Door Forum.

For example: When a social worker makes a phone call as part of a patient visit, do not report that call on the claim. "Only report phone calls that are not made during a reportable visit," CMS explains in a Q&A posted to its Web site Nov. 20.

Hospices should report documentation time as part of their visit, however, CMS says in a separate Q&A. "Documentation time (such as the updating of medical records) which occurs during, and as part of, an otherwise covered and billable visit to a patient can be included in the time reported for the visit," the Q&A says. "Documentation time which occurs outside the context of such a visit is not reportable."

Resource: *For a link to the Q&As, go to CMS's hospice Web site online at www.cms.hhs.gov/center/hospice.asp.* ■

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