Best of How to Get Paid: Coding and Billing Part II

A supplement to HCPro publications
Dear reader,

Last month you received the first installment of the “Best of How to Get Paid: Coding and Billing,” this month you hold the second part. Like the first edition, this special report explains how to handle some of the toughest coding and billing problems and how to receive the money that your practice deserves.

A special thanks to Barbara Eberly, for her assistance in reviewing the articles. She is the information technologies manager for the Central Penn Management Group in south central Pennsylvania, where she aids practice managers and physicians with efficiency issues.

Sincerely,

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Associate Editor, The Doctor’s Office

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Lickity-split care full of stumbling blocks
Coding, coverage guidelines for preventive exam claims

Paralegal Lois Howard hurried in for her routine physical exam recently in Lubbock, TX. The Medicare patient calls these checkups her “yearly calming.”

Her doctor’s office, meanwhile, calls them split-care visits (when doctors do a medically necessary exam with a preventive physical).

The office considers three billable codes for Howard’s split-care visit: G0101 for the pelvic exam, Q0091 for the pap collection, and the correct preventive code with the GY modifier.

It does not matter in what order you list these codes on the claim form, according to Sherry Straub, RHIT, CCS, CCS-P, coding and compliance manager for Esse Health in St. Louis.

“Just make sure you link the right diagnosis codes to the procedure codes,” she says.

Take malignant neoplasm of the cervix: Only link diagnosis code V76.2, a screening code, to Q0091 and G0101.

Here are four other considerations Straub says offices can’t study enough:

1. Use the preventive evaluation and management (E/M) code when the patient receives a physical exam that extends beyond a pelvic and breast exam, says Tammy Lee Arnold, practice manager for an Augusta, GA, family practice.

2. Attach modifier -25 to an E/M code, when you bill problem-oriented visits on the same days as either pelvic exams or preventive visits, usually 99397 for Medicare, says Straub.

3. Subtract your fee for the pelvic exam and/or the problem-oriented E/M code from the preventive E/M.

4. Charge the patient for the difference only.

Dee Heisel, compliance officer and medical records manager for Woman’s Healthcare Associates in Lafayette, IN, does head-to-toe exams for routine physicals.

“But we subtract the cost of the pelvic exam and pap collection from the preventive fee,” she reports.

This meshes with the Medicare Part B Carrier’s Manual for processing these claims.

Watch covered portions
Offices billing beneficiaries for routine physical examinations should consider the Centers for Medicare & Medicaid Services policy.

Medical offices can do the following when their doctors perform the exams with medically necessary visits:

- Bill Medicare for the visit’s covered portion as though that were the only service performed.

- Check limiting-charge rules. These apply to the covered portion of the visit on a nonassigned claim.

- Bill the beneficiary for the portion of the visit Medicare doesn’t cover.

An example: the difference between the physician’s current established charge for the entire visit and the current established charge for the Medicare covered portion of the visit.

- Bill the beneficiary for noncovered procedures, like routine chest x-rays.

Medicare determines payment for the visit’s covered portion based on whichever is smaller: the fee schedule amount or the physician’s charge for the covered portion of the visit.
A coder at a family medicine practice received a questionable doctor’s note for an x-ray of the right knee.

At issue was whether there was enough documentation in the note to support a separate evaluation and management (E/M) charge. The complete note appears below. Here is the coder’s assessment:

“It is my opinion that there is not enough documentation to charge a separate E/M using the -25 modifier,” says Tammy Farris of Family Medical Specialties, a small physician practice in the Northeast.

“The entire exam centers around the patient’s knee, and since the patient has had two aspirations before, the doctor was already very familiar with the problem.”

The doctor believes he had plenty of documentation because he noted the medications the patient was on and put anticoagulation in the impression list, according to Farris.

“I realize some carriers will pay if I used knee pain on the E/M with the -25 modifier; however, our Medicare carrier won’t. I have tried that many times before.”

Coding consultant Michelle Logsdon, CPC, CCS-P, of Cash Flow Solutions in Lakewood, NJ, agrees with Farris’ assessment.

“An office visit charge is not appropriate with a -25 modifier for this visit if you are going to bill for the injection, the drug, and the x-ray,” she says. “You aren’t left with a viable E/M even if you added some information and took out all of the knee related assessment.”

Here is Logsdon’s coding assessment:

- Use code 20610, 73560, and the Decadron code for the drug

“I worked in an orthopedic practice for some time and I finally got them to realize that repeat injections/aspirations were not billable with an E/M if it was the primary reason for the visit,” Logsdon says.

“They stopped arguing, and I had less headaches, appeals, and write offs.”

**X-ray: Right knee**

Two views of right knee reveal medial compartment narrowing—mild in severity. Soft-tissue swelling in the prepatellar bursa.

No fracture or other bony abnormalities are seen.

**Progress note:**

Comes in with increased pain and swelling in right suprapatellar bursa. Pt has had two aspirations previously.

Medications: Coumadin 5 mg, daily; Lipitor 10 mg, 5x weekly; Tenormin 50 mg, daily; Lanoxin 0.25 mg, daily.

**Physical examination:**

Vitals: Normal.

Extremities: Has a sizable right prepatellar bursitis. ROM of knee is normal.

X-rays of the right knee show mild narrowing of the medial compartment that is fairly minimal.

LAB: PT/INR – see report in chart.

**Impression:**

#1. Anticoagulation

#2. Right knee prepatellar bursitis
A primer on LASIK eye surgery

Due to recent media attention, some patients may come to your practice asking about LASIK eye surgery.

Be sure you let them know all of the facts—including the probability that they will have to pay for the procedure—before recommending them to a LASIK eye surgeon.

Used for treating myopia, hyperopia, and astigmatism, LASIK is refractive eye surgery that can benefit patients who don’t have serious vision problems.

The big difficulty with this surgery involves reimbursement, or more precisely, the lack of it.

“This is a voluntary procedure, which means it is something that is not normally covered by insurance,” says John Ciccone, director of communication for the American Society of Cataract and Refractive Surgery in Fairfax, VA.

“Normally the individual will pay for this out of his or her pocket, but under special circumstances, insurance will cover the bill.”

These special circumstances include the following:

• The United States military. Uncle Sam will foot the bill for special operation agents.
• Private companies with generous benefit policies.
• Businesses that realize their workers would function better without glasses or contact lenses.

Some insurers will elect to provide coverage for a portion of the surgery, some paying up to 25%. Dr. David Lampariello, an optometrist and clinical director of the TLC Laser Eye Center in Wal- tham, MA, knows some surgeons who provide a payment plan for their patients. Each month the patient pays a portion of the bill until it is completed.

The range in payments for LASIK eye surgery varies widely. There are some facilities that charge as little as $299 per eye, while others charge upwards of $2,500 per eye. But don’t let price be your guide.

“We do not recommend that patients select a physician based on price,” says Ciccone.

“LASIK surgery is real surgery and the thing that most patients should focus on is their relationship with their physician,” he adds.
Reimbursement somewhere over the rainbow

Multicolored codes ease billing, waiver rules

The Centers for Medicare & Medicaid Services (CMS) are on the prowl for providers who don’t use modifiers and advance beneficiary notices (ABN) correctly, or use them at all, a CMS official said recently. Several clinics are reworking internal policies to comply.

Meanwhile, billing specialist Denese Foltz of the Ankle & Foot Clinic in Everett, WA, suggests these color-coded tips:

- Flip through your HCPCS Level II books. “Our book is color-coded. Any codes in red are not valid for Medicare, so you know immediately that you have to find another code.”
- Don’t use an ABN for the orange-colored codes Medicare never covers. Collect from the patient.
- Bill the code to Medicare with the GY modifier, which Medicare automatically denies.
- Enter the reason for the claim submission in the claim’s appropriate field, such as “need denial for the patient.”

This guideline is for all noncovered codes, not just HCPCS codes.

For example: routine exams, hearing aids, and lab tests in absence of signs or symptoms. Get the patient to sign an ABN when you expect Medicare to deny an item or service as not reasonable and necessary. These are the blue codes in the HCPCS book. Yellow codes are for special coverage instructions/carrier discretion.

Memo prevents revenue loss for Kansas office

You can bill separately identifiable evaluation and management (E/M) services performed on the same day as the preventive visit, according to a memo a CMS education representative sent to a mid-size provider in Kansas. Use modifier -25 in this case, appending it to an E/M code billed on the same day as a preventive care visit, the memo said.

CMS will pay for medically necessary E/M services “as long as they clearly represent significant, additional work from the other service” your doctor provides during the preventive visit.

Don’t forget to mention that the patient either presented with a new problem before the E/M visit, or an old problem that suddenly resurfaced.

Government to cover breast cancer procedure

CMS will cover a diagnostic imaging procedure to assess the level of metabolic activity in people with breast cancer, according to a May 2, 2002, program memo. Coverage for Fluoro-D-Glucose Positron Emission Tomography (PET) began October 1, 2002.

CMS will pay for it in addition to other imaging modalities for staging and restaging for locoregional, recurrence, or metastasis. The agency will also pay for monitoring treatment of a locally advanced breast cancer tumor and metastatic breast cancer when you consider a change in treatment, the memo said.

CMS covers Fluoro-D-Glucose PET for the determination of myocardial viability as a primary or initial diagnostic study prior to revascularization. Check with your Medicare contractor for frequency limitations.

Pap smear diagnosis issue in limbo

While CMS investigates concerns that carriers have incorrectly rejected the diagnosis code for a low-risk screening for malignant neoplasm when providers link it to Pap smear collection or interpretation, the agency has issued these guidelines:

- Link diagnosis code V76.2 (special screening for malignant neoplasms every two years for low-risk patients) or V15.89 (other specified history presenting health hazards every year for high-risk patients) to collection code Q0091 for vaginal Pap smears on women with hysterectomies.
- Link V15.89 or V76.49 (low-risk screening for malignant neoplasm) to pelvic/breast exam code G0101 for the same date of service, according to CMS. ■
Be careful what you code

Simply using paraplegia as a catch-all code is not good business

When billing for a paraplegic patient, it is not good policy to simply attribute the debilating condition as the cause for the patient’s discomfort.

“The paraplegia is not the primary diagnosis for the patient coming into the office,” says consultant Jacqueline C. Langlois, RN, MSN, CRNI, of Canton, MA. “It would have to be the other symptoms that they would be treated for.”

Treat your paraplegic patients like you would any other patients for billing purposes. Pay attention to the problem the paraplegic patient has because even though some maladies are the indirect result of the condition, paraplegia is not the correct code to use. In order to receive your reimbursement, billers want specific scenarios, such as constipation, and the codes and documentation that go with it.

To articulate her point, Langlois describes the following real-life scenario:

An office manager was unsure about the diagnosis code to use when referring a paraplegic patient to another doctor. The patient suffered a fracture of the leg, and the manager thought that the paraplegia code alone would suffice.

Langlois disagrees. “I would use the fracture coding because it is the primary reason why this patient is being seen by another physician,” she says. “You have to take what the presenting problem is and make sure that the diagnostic tests are done.” Diagnostic tests can pinpoint exactly what is wrong with the patient and, in the end, provide the correct code.

Making sense of epicardial leads coding

The coding for a sternotomy and the insertion of two epicardial pacing leads can be a tricky proposition, as Monica J. Holodnik, CPC, accounts manager for the Pittsburgh Cardio Thoracic Associates found out recently.

A sternotomy is the actual splitting of the sternum bone. It follows a coronary artery bypass or a valve-type procedure. Most often, the epicardial leads are placed in the patient through a small incision in the rib or at the tip of the sternum. The codes listed in the manuals cover these two locations only.

This put Holodnik, who works for an open-heart surgery practice, in a pickle—she had to figure out how to code a procedure for placing the leads on the heart’s surface during a sternotomy. “The cardiologists are asking us, at the time of bypass, to put in epicardial leads,” she says.

“These leads will eventually be hooked to a biventricular pacer. However, we are not putting in a generator,” she says.

The reason the cardiologists hook these leads without the generators, according to Holodnik, is that cardiologists know in advance that patients have a pacem or rhythm problem. This is why they want the epicardial leads placed on the heart’s surface while the chest cavity is open.

After doing some research, Holodnik came to the realization that the following three sets of codes work for coding this procedure (Note: Pay close attention to documentation to help you determine which codes to use and check with local carriers in your area):

- **Codes 33200 and 33201.** Use these codes for epicardial leads for a pacemaker. These are standard epicardial leads for pacemakers, which include a generator. So, use the reducing modifier 52 to tell insurance providers of this fact.
- **Code 33999.** Use this code for a biventricular lead, Holodnik says.
- **Code 33245.** Use this for automatic inserted cardio verder defribulator.
Orchiectomy billing is tricky: Here’s how it works

When a doctor makes a coding mistake, make sure you’re there to correct it. Consider the case of Liz Tamiso, CPC, the office manager for Faculty Practice Plan Pediatric Surgery and Urology at the Children’s Medical Center in Hartford, CT.

A doctor there recently gave Tamiso the following documentation:

Diagnostic laparoscopy, left inguinal orchiectomy

Left undescended testicle

The patient was taken to the operating room and placed in the supine position on the table. After general anesthesia was placed, an IV was started. A periumbilical incision was made in the abdomen. The laparoscopy was attempted using a Hasson trocar; however, there were significant intra-abdominal adhesions evident. The abdomen was attempted to be insufflated several times but we were unsuccessful. Because of this, the laparoscopy was aborted and a left lower quadrant incision was made.

The doctor insisted that he could bill for both the laparoscopy and the orchiectomy, but Tamiso found proof to the contrary.

“If you start off with a laparoscopy, but you convert it to an open procedure [like an orchiectomy], it is bundled and you can’t bill for both,” she says. “Working for a pediatric surgical practice, bundling does play an issue because frequent times the doctors do multiple procedures at the same operative visit.”

Based on the documentation above, the doctor can bill for the orchiectomy only—or the removal of a testicle—which corresponds with CPT code 54530.

The laparoscopy procedure, meanwhile, involves a small incision and the doctor’s use of a lighted tube filled with fiberoptic material. The tube is called an endoscope, which the doctor maneuvers through the patient’s body. Use CPT code 49320 for this procedure.

The doctor in this case converted the surgery into an open procedure only after realizing that the amount of adhesions made surgery with the laparoscope impossible. This conversion created a bundled procedure.

Your job as a coding sentry
Checking the documentation on claim forms as they go out the door takes up a large part of Tamiso’s day. Vigilance is the key, she says, as sometimes doctors hear incorrect coding information from their colleagues. This causes reimbursement problems down the line.

Most doctors don’t intentionally unbundle procedures, Tamiso says. “Some procedures, by correct coding rules, are bundled and the doctors don’t always know that,” she explains. “They tell you what they did and it’s my job to tell them what they can actually bill for.”

Stay on guard by keeping the following tips in mind:

- Look for more than one procedure performed in a particular organ system. Tamiso says if a lot of smaller jobs are being done in one body section, chances are good that they might be part of a bundled code.

- Don’t waste your time with procedures that obviously have nothing to do with each other, such as an appendectomy and the removal of a mole.

- Be aware of coding edits. They are released quarterly by the Centers for Medicare & Medicaid Services (CMS). You can obtain them by contacting CMS or your local carrier, and by staying tuned to TDO.