



Current Events Update July 2005

New ICD-9 Diagnosis Codes Effective April 1, 2005

New ICD-9 diagnosis coding guidelines to help you avoid denials and get paid correctly for the services you provide will take effect on April 1, CMS recently announced. The biggest changes to the guidelines address diagnosis coding rules for patients with diabetes mellitus, and those with conditions related to asthma and chronic obstructive pulmonary disease (COPD).

Changes to the ICD-9-CM diagnosis coding guidelines are made periodically to account for changes in laws, billing rules and regulations. The American Hospital Assn., the American Health Information Management Assn., and the National Center agreed upon all changes for Health Statistics and CMS.

New instructions on how to use diagnosis codes for patients with diabetes has been added to the coding guidelines on endocrine, nutritional and metabolic diseases and immunity disorders. The section previously contained no guidance.

Smoking Cessation Counseling

Medicare's national coverage for smoking cessation counseling, has not issued rules regarding how you advise a patient to quit smoking. Medicare has yet to issue specific guidelines or requirements.

There is a standard that you can use: the Public Health Service's Clinical Guideline: Treating Tobacco Use and Disorder (www.surgeongeneral.gov/tobacco/treating_tobacco_use.pdf).

This guideline offers strategies that range from brief intervention to recommended drug therapies. CMS recommended participating physicians follow the guideline's "5 A's for Brief Intervention" when counseling Medicare patients.

Coverage Expanded for Implantation of Cochlear Implants

Medicare for cochlear implantation, **69930** (\$1,246.45, par, national, facility), more frequently, based on a new CMS decision that expands coverage.

The new coverage took effect April 4. The agency relaxed the degree of hearing loss patients must have suffered for Medicare to cover the device and its implantation. Under



the old policy, coverage was for patients with open-set recognition test scores of 30% correct or worse. Now, coverage is available to patients with a score of up to 40%. Medicare also will cover this for patients with scores between 40% and 60% if they participate in clinical trials that meet CMS's coverage requirements.

Medicare Global Period Surgery Payment

Medicare bundles the following things into a global surgery package, according to Chapter 12, Section 40.1 of the Claims Processing Manual. These services are included in the payment for the surgery and are not separately billable:

- **Pre-op visit:** A pre-op visit after the surgery decision has been made, beginning with the day before the day of surgery for major procedures (90-day global) and the day of surgery for minor procedures (10-day global).
- **Intra-op services:** Services that are a usual and necessary part of the surgery itself.
- **Complications:** All additional medical or surgical services required of the surgeon during the post-op period of the surgery because of complications that do not require additional trips to the operating room.
- **Post-operative services:** Follow-up visits during the post-op period of the surgery that is related to recovery from the surgery.
- **Post-surgical pain management:** Pain management services done by the surgeon.
- **Supplies:** Most supplies used are included in the global payment.
- **Miscellaneous:** Includes dressing changes, incisional care, removal of operative pack, removal of sutures, staples, lines, wires, tubes, drains, casts and splints. Insertion, irrigation and removal of urinary catheters, routine IV lines nasogastric and rectal tubes and change and removal of tracheotomy tubes are also included.

Medicare Claims Appeals

The recently announced revamping of the Medicare appeals process incorporated changes mandated by the Medicare Modernization Act (MMA) to allow claims with "minor errors or omissions" to be corrected outside of the formal appeals process.

The process of correcting these minor errors and omissions is called a reopening of the claim. You or your carrier have up to one year to request a reopening of a claim for any reason, and up to four years if you can demonstrate good cause. The carrier may reopen a claim at any time if fraud is suspected.

Reopening rights are already established in Chapter 12, Section 80.3.2 of the Medicare Claims Processing Manual for claims with incomplete or missing information. Carriers are directed to return these claims for correction and resubmission. CMS will issue further instructions to carriers to clarify when to consider claims, as candidates for reopening over



minor errors and omissions, and carriers will train their own staffs on implementing those policies, the agency says.

Push/Infusion Reimbursement Update

The major change in the new Medicare guidance to carriers is that an arterial or intra-arterial push can be defined as either an injection, where the nurse or other health care professional is “continuously present” to observe the patient or an infusion of 15 minutes or less.

The second half of the sentence, about infusions of 15 minutes or less, was added and means oncology nurses will not have to be consistently at the patient’s bedside for pushes and will free them up to move from patient to patient.

The clarification for “push” suggests practices can report **G0359** (chemotherapy IV infusions, initial, one hour, \$177.61, par., national, physicians office), instead of G0357 (chemo. admin IV *push*, \$125.69), when the service is longer than 15 minutes. That’s \$51.92 more in reimbursement per infusion that you could see as a result of the change. You will have to bring these coding changes to your carrier’s attention if you want payment adjustments, but the transmittal indicates the guidance is retroactive to 2005 dates of service. Check with your carrier to see how it wants to handle these claims.

Annual Coding and Documentation Audit

An understanding of unique billing situations that confront various specialties can go a long way toward making sure your internal audit is effective and prepares you to pass a random outside audit.

The HHS Office of Inspector General (OIG) recommends you audit at least annually the top 10 services billed by the practice, 10 charts per physician and the top 10 services denied by your carrier to determine how to correctly code and bill claims in the future, according to OIG guidelines issues by the agency for physician practice auditing.

Here are some tips to improve your internal audit process:

- **Know that set of E/M guidelines works best for your practice**
- **Don’t forget diagnosis code auditing**
- **Look closely at the annual OIG work plan**
- **Audit based only on what’s in the documentation**
- **Seek outside professional coding and documentation reviews**



Denial of Duplicate Claims

Medicare carriers will deny automatically any unchanged duplicate of a claim if the carrier asked for and failed to receive documentation for the original claim, CMS says (Medicare Program Integrity Manual Transmittal 104).

Starting sometime in July, your carrier will issue an automatic “duplicate non-paid” message when it receives a duplicate claim of an original claim that was under pre-payment medical review, was previously denied or for which the carrier requested documentation but did not receive it.

You can’t appeal what the carrier considers duplicate denials unless you document that the service wasn’t really a duplicate because it was performed more often than indicated in the original line.

Medicare Advantage Plans (MA) – Part C Medicare

If you contract with a MA plan, your reimbursement rates will be what you negotiated. If you did not contract with an MA plan for Medicare PPO patients, then under Part C rules the MA PPO plan would have to reimburse you Medicare FFS rates.

Under Medicare rules, “the regional PPOs must have a network of contracting providers that have agreed to a specific reimbursement for covered benefits”. Keep this in mind come contracting time. The plan may very well need your practice. But also remember MA plans are free to “refuse to grant participation” to providers “in excess of the number necessary” for the plan. The only exception to this rule is private fee-for-service plans.

Each MA plan must provide, at a minimum, all the benefits available under original Medicare (FFS), so they must cover all Parts A and B services, including home health. And each plan must offer at least one MA-PD plan – prescription drug coverage under Medicare Part D.

Here are two other provisions of the Part C rule:

- **You couldn’t balance bill the patient** if you participate in Medicare. Non-participating physicians would be limited to charging 115% of the non-par fee schedule allowable. Medicare requires the [non-contracted] provider to accept the FFS payment amount as payment in full for services provided to Medicare beneficiaries, including those enrolled in any type of MA plan.
- **You should get payment from a plan whether or not the member has met his copay responsibilities.** An MA organization may not delay reimbursement until an enrollee first pays deductible or cost sharing.



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Watch out for patient co-sharing limits. MA regional plans are required to provide a catastrophic limit on both in-network and out-of-network benefits. Plans should alert you when a Medicare MA patient bumps up against these limits, which would mean no more copays for the rest of the year.

Avoid Theft by Improving Internal Controls

Here are tips to prevent theft at your practice:

- **Do background checks on all new hires**
- **Number your superbills and encounter forms sequentially**
- **Make sure one person doesn't have full control of any part of money handling**
- **Seek outside professionals to conduct an internal control review**
- **Take a close look at the employee who may seem too dedicated**

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