MEDICAL BUSINESS JOURNAL

Volume 2 Issue 3 March 2011

NAVIGATING A SEA OF INFORMATION

Finding and Decoding Useful Information from ONC

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Medical Business Journal

ISSUE 3, VOLUME 2, MARCH 2011

Letter from the Editor

Dear Readers,

I would like to thank you for your continuing patronage to the Medical Business Journal. It is because of readers like you that we are able to continue to provide current, topical information about the medical industry. We strive to be your most valuable source of information: from healthcare reforms to coding updates and beyond.

This month we are beginning a series that aims to help you conduct your own research for free, online. By giving you some of the techniques that the MBJ uses to keep up to date on medical coding, we hope to expand your horizons—and your business opportunities. The series is titled Navigating a Sea of Information and we hope it helps give you more avenues for researching medical news.

We at the MBJ are constantly striving to improve our publication. Any feedback you can provide is invaluable to our continuing success. Additionally, we want to put you personally in touch with the entire professional community. If you have any questions, suggestions, or would like to appear in one of the MBJ's guest columns, then please contact us at news@mbjonline.com.

We also welcome advertisers who wish to utilize the MBJ as a market for their products. For advertising inquiries, contact info@mbjonline.com

Enjoy.

Sincerely,
Christopher Myers
Editor-in-Chief, *Medical Business Journal*

Medical Business Journal

Issue 3, Volume 2, March 2011

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The Revenue Cycle: AN INSIDERS VIEW

Are you looking to improve the performance of your revenue-cycle operations? Here are some tips and information from one of your peers about what makes her process a success.

The Revenue Cycle consists of 3 key elements:

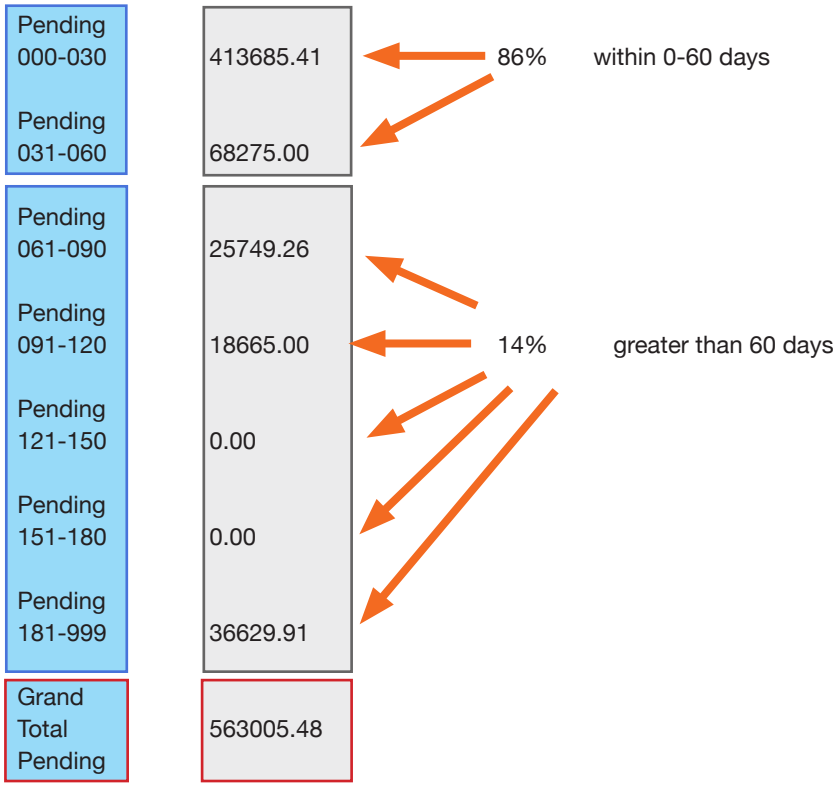
Patient Access
- pre-registration/scheduling
- establishing financial responsibility
- check-in /registration
- verification

Accounts Receivable Management
- prepare and transmit claims
- payment & collection analysis
- timely A/R follow up
- monitor payer adjudication
- comprehensive denial management
- timely generate patient statements
- account resolution & adjudication
- account placement
- agency tracking

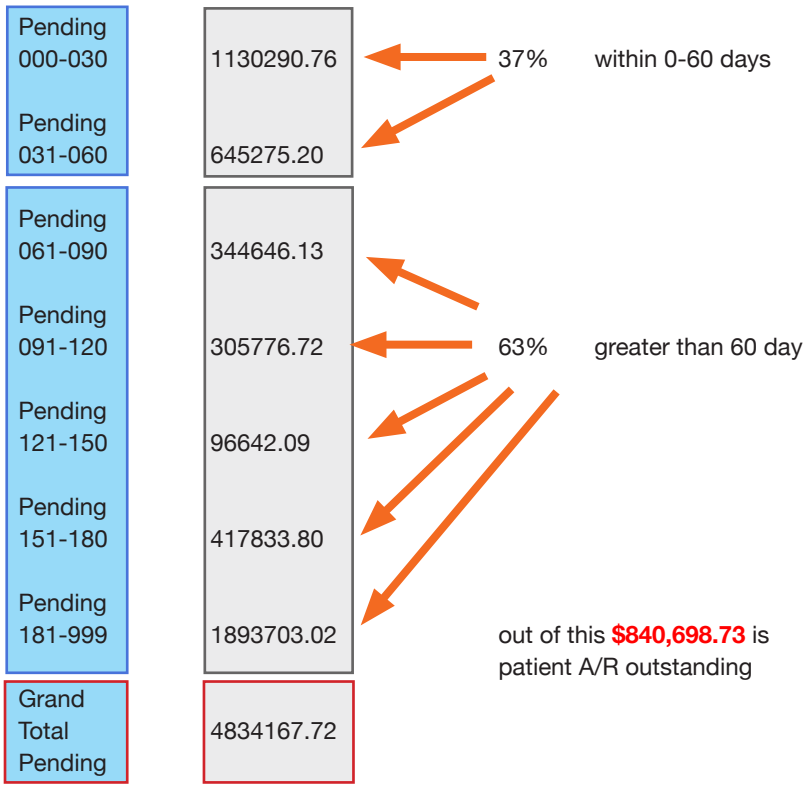
Charge Capture
- total charge capture
- coding & charge entry
- review coding & billing compliance
- charge reconciliation

In order to transform your entire revenue cycle process to maximize reimbursements follow these "best practice" benchmarking and key performance indicators: Average number of days revenue in A/R at a maximum of 45 days, A/R greater than 90 days less than 20% of total A/R, Net collection percentage 92% or greater

Sample A/R Report that Represents "Efficient" Reimbursement



Sample A/R Report that Represents Inefficient Reimbursement



Review your Benchmarks and key performance indicators monthly.

Analyze and identify positive and negative payer trends on a monthly basis. Ex: If BCBS likes modifier 51 for the same procedure then identify that trend so the proper modifier will be attached to that payer by creating a trending report for your registered medial coders. This will ensure your A/R stays within these benchmarks. Employ experienced and efficient staff with credentials that require continued education by their certifying organization. Use error proof software filters & top-of-the-line revenue cycle software. Ex: Using software that gives you effective A/R reports. That can assist with the A/R follow-up and a clearing house with claims scrubbing features that enforce clean claim submission.

Ruby Ramos, RMC, RMM

Ruby is the administrator for Allied Surgical Group and James Street Ambulatory Surgical Suite in Morristown, NJ. Her practice specializes in general surgery and oncology. Ruby has been in the field for over 15 years and is a certified-registered medical coder (RMC) as well as a certified-registered medical manager (RMM)

Playing Games with ONC Certification

"Certified" is the $44,000 buzzword prefixing electronic health records (EHRs) software. To qualify for Health Information Technology for Economic and Clinical Health (HITECH) Act incentive payments, you must use an EHR that is certified by the government. Additionally, you must use a system - or systems - that offer 100% of the functional and security capabilities required to meet "Meaningful Use" criteria.

Many EHR vendors are promoting their products as "certified," but the claim can be misleading. There are three ways they could lead you astray:

Alternative Certifications

Before the HITECH Act, two organizations certified medical software:

- Certification Commission for Health Information Technology (CCHIT) - CCHIT began certifying EHR software in 2006. Since then, they have released 10 Certification programs for ambulatory and inpatient EHRs.

- KLAS - KLAS is a private organization that has gathered ratings on EHRs since 1997. Every year they rank EHR vendors and bestow a "Best in KLAS" award the top 20.

In an effort to stand out from the other 300+ EHR systems on the market, vendors widely promote their CCHIT or KLAS credentials. They may even tack the word "certified" onto their CCHIT or KLAS approved product. This muddies the water for providers. They have to distinguish between CCHIT, KLAS and certification from an ONC-Authorized Testing and Certification Body (ONC-ATCB). While CCHIT and KLAS are meaningful credentials, they're not the certifications that qualify for incentive funds.

This is especially confusing because CCHIT is now one of six organizations approved to certify EHRs for the HITECH Act. So, if an EHR vendor claims they have CCHIT certification, you'll need to clarify which one. Is it ONC-ATCB certification, or one of CCHIT's independent credentials?

Complete EHR vs EHR Module

Software vendors can receive ONC-ATCB certification for a complete EHR or an EHR module. This means a product does not need to meet all criteria for Meaningful Use - instead, it can be partially certified if one or more functions meet a subset of requirements. For example, a vendor could certify their e-prescribing application or their patient portal.

This under-publicized detail could cost you thousands of dollars; by itself, a certified EHR module won't make you eligible for incentive payments. You must use two or more modular EHRs that, when combined, meet 100% of the ONC criteria. So while vendors can officially promote a module as having ONC-ATCB certification, it may fall short of making you eligible.

Guaranteed Incentive Payments

Be mindful of guaranteed incentive payments. It is reasonable for a vendor to guarantee they'll meet certification criteria. In fact, you might make it a requirement in your purchase decision.

However, guaranteeing incentive payments is altogether different. Technology alone won't make you eligible. EHRs are just a means to an end. Ultimately, you are responsible for achieving Meaningful Use status. So be wary of this type of guarantee. Read the fine print and find out how you are reimbursed if you don't qualify for incentive payments. Does the vendor reimburse you the full amount of lost incentive payments? Or do you just get reimbursed for the cost of the software? You shouldn't purchase a system based on this guarantee alone.

Five Key Questions to Ask Vendors

To help you avoid these pitfalls, we put together a list of 5 questions to ask vendors. Answering these will put you in a good position to become eligible for incentive payments.

1. Which certification does the EHR have: CCHIT, KLAS or ONC-ATCB? You must use an EHR that is ONC-ATCB certified in order to be eligible for incentive payments.
2. Which product version has been certified? Ask the vendor for complete details of their ONC-ATCB 2011/2012 certification, including: product name and version, date certified, unique product identification number, the criteria for which they are certified, and the clinical quality measures for which they were tested.
3. Does the vendor have certification for a complete EHR or an EHR module? If module, you will need to use more than one to be eligible for incentive payments. The ONC has created a handy website that allows you to build a list of EHR modules that meet 100% of ONC criteria.
4. Will the vendor resubmit their EHR for final certification in 2012? The current certification is temporary and only lasts through 2011. Make sure your vendor has plans to reapply in 2012, and find out if they will certify a complete EHR or just a module.
5. Are you purchasing through a reseller or other business partner that renamed the product? If so, make sure the renamed product has been approved by the ONC-ATCB. Even if it is the same version with identical features and functionality, it won't make their Certified HIT Products List unless the original vendor reports it to an ONC-ATCB.

This article was written by Houston Neal of Software Advice. To view the original article, visit www.softwareadvice.com

EHR Legacy Certification Program Underway

CCHIT OPENS EACH PROGRAM

Beth Israel Deaconess Medical Center (BIDMC) Boston, is the first hospital to have its self-developed electronic health record (EHR) technology Office of the National Coordinator for Health Information Technology (ONC) certified as a complete EHR for meaningful use. This comes as part of the pilot program launched by the Certification Commission for Health Information Technology (CCHIT).

The program, titled EHR Alternative Certification for Hospitals (EACH™), aims to give hospitals the option to certify both legacy EHR technology, which they already have in place, and self-developed or customized EHRs. The ONC-Authorized Temporary Certification Body (ATCB) certification label allows for hospitals to receive incentive funds by assuring that their technology has the capability to achieve meaningful use.

In addition to certification, the EACH program offers self-paced, online learning courses, inventory and self-assessment tools, and hands-on support provided by CCHIT staff. CCHIT also plans to launch a similar program for physicians in the upcoming months.

For more information about CCHIT and the EACH program, visit their website at: each.cchit.org/web/each/home/

CMS Releases April 2011 Physician Fee Schedule Update

On February 4, the Centers for Medicare and Medicaid Services (CMS) released transmittal 2150, outlining the April updates to the Medicare Physician Fee Schedule Database (MPFSDB). Here is a brief overview of the changes.

The following HCPCS codes have MPFSDB indicator changes

HCPCS Code	Short Descriptor	Indicator
31579	Diagnostic laryngoscopy	Global Surgery: 000
57155	Insert uterine tandem/ovoids	Co-Surgeons: 2
64613	Destroy nerve neck muscle	Bilateral Surgery: 2
64614	Destroy nerve extrem / trunk musc	Bilateral Surgery: 2
77071	X-ray stress view	Bilateral Surgery: 2
92511	Nasopharyngoscopy	Global Surgery: 000
93464-26	Exercise w/hemodynamic meas	Multiple Surgery: 0

The following HCPCS codes have Practice Expense RVU changes:

HCPCS Code: 93503

HCPCS Code: 93224

HCPCS Code: 93225

HCPCS Code: 93226

The following HCPCS code will be added:

HCPCS Code: Q2040

The following HCPCS codes are or will be discontinued

HCPCS Code	Short Descriptor	Termination Date
90470	Immune admin H1N1 imm nasal	December 31, 2010
90663	Flu vacc pandemic H1N1	December 31, 2010
Q1003	NTIOL category 3	March 31, 2011
S2270	Insertion vaginal cylinder	March 31, 2011
S2344	Nasal/sinus endoscopy e.g. balloon sinuplasty	March 31, 2011
S3905	Electrodiagnostic test w/ auto handheld device	March 31, 2011

Seven States Awarded "Early Innovator" Grants

HHS INTENDS FUNDS TO HELP DEVELOP HEALTH INSURANCE EXCHANGES

The Department of Health and Human Services (HHS) awarded $241 million to seven states to help them develop and implement an information technology (IT) infrastructure necessary to operate Health Insurance Exchanges.

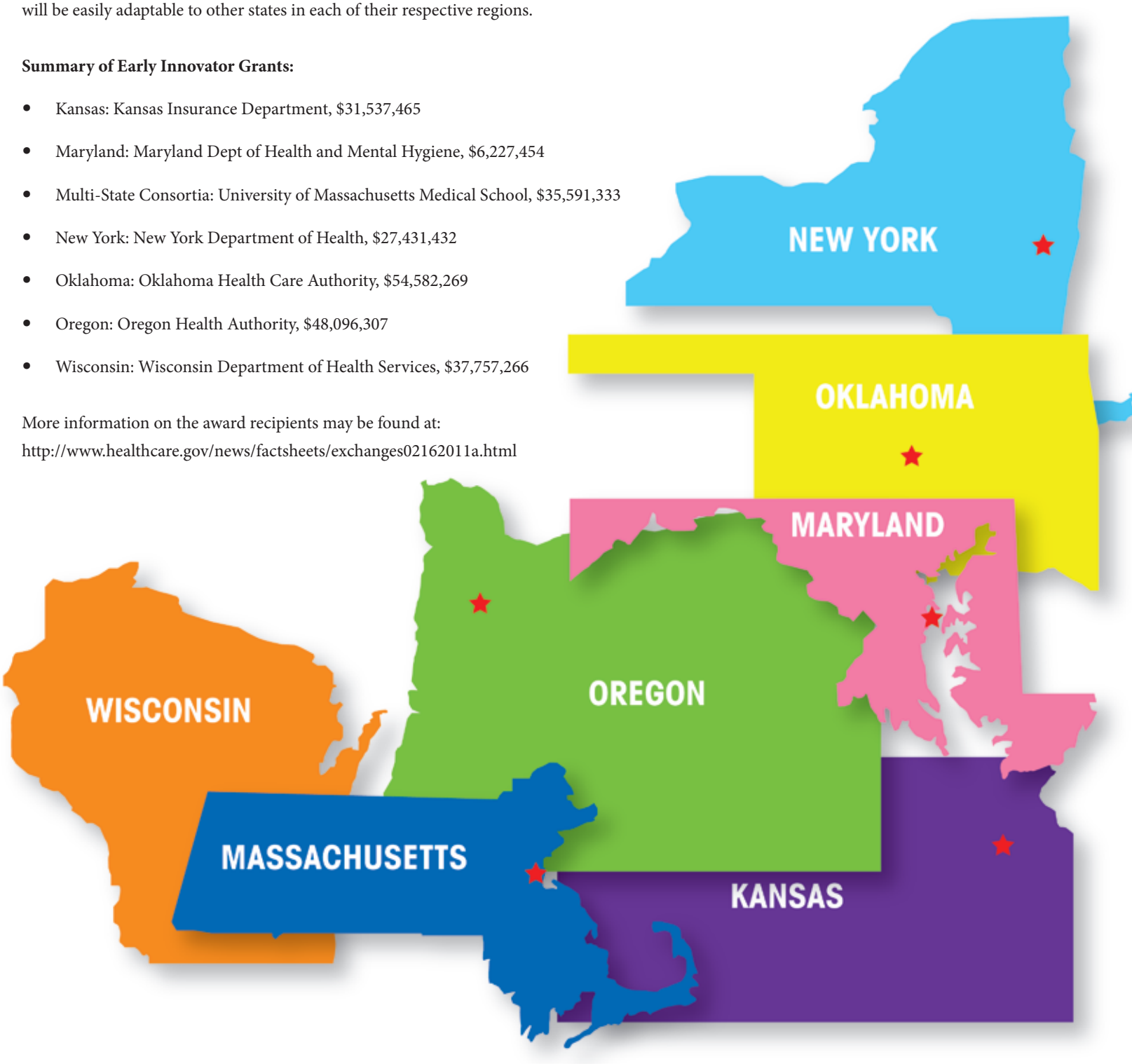
Health Insurance Exchanges, launching in 2014, will provide a one-stop marketplace where small businesses and individuals can shop for health insurance.

Because the seven "early innovator" awardees represent a diverse cross section of the country, the hope is that they will be able to develop models that will be easily adaptable to other states in each of their respective regions.

Summary of Early Innovator Grants:

- Kansas: Kansas Insurance Department, $31,537,465
- Maryland: Maryland Dept of Health and Mental Hygiene, $6,227,454
- Multi-State Consortia: University of Massachusetts Medical School, $35,591,333
- New York: New York Department of Health, $27,431,432
- Oklahoma: Oklahoma Health Care Authority, $54,582,269
- Oregon: Oregon Health Authority, $48,096,307
- Wisconsin: Wisconsin Department of Health Services, $37,757,266

More information on the award recipients may be found at:
http://www.healthcare.gov/news/factsheets/exchanges02162011a.html



Navigating a Sea of Information

Finding and Decoding Useful Information from ONC

By Christopher Myers

Between an ever-expanding virtual landscape and complex government jargon, it is often difficult for normal people to make any sense of the free, informative services provided by the government. In this series I intend to provide readers with a compass and map of various government websites and resources. My hope is that, armed with these tools, billing professionals may learn to navigate through the chaos to find new regulations, incentive programs, and teaching tools that are provided for free by the various US government agencies.

A fitting starting point for this journey into information technology is the Office of the National Coordinator for Health Information Technology (ONC). Their website, **healthit.hhs.gov**, strikes you as a simple, organized combination of blue, yellow and white, but looks can be deceiving. This is your resource for almost anything related to new health information (HI) technology, specifically Electronic Health Records (EHR), privacy and security issues, and electronic prescriptions.

Your most important resource is the "What's New" category at the bottom right of the page. Whenever ONC releases a new regulation, requests comments, or updates EHR product lists, they will post it here. The problem is that, without dates associated to the posts, it is hard to tell how new a subject is, and when an old staple subject like EHR products is updated. Your best bet is to keep on your toes and check the site regularly, so you don't miss out on what could be a major financial incentive.

Here is an example of how to utilize the information. Let's say that your practice recently adopted a certified EHR product and you are trying to find out what steps are necessary to receive incentive payments. It is usually possible to find a link to the newest EHR incentive program news in the "What's New" section. Whatever the actual subject, it should direct you straight to the EHR section of FAQ. It may seem counterintuitive, but most of the information for the EHR incentive program is categorized as Incentive Programs for EHRs (meaningful use) **under** ONC Regulation FAQ, within the larger category of Regulation and Guidance (as opposed to ONC initiatives for examples). Now that you are on the right page, you can find a link to the registration page, as well as full walk throughs of the entire process.

Another important resource, located in the "What's New" category, is the Certified EHR Product List. This page will give a list of every ONC certified EHR product on the market. The list is updated weekly, so you can be sure to find the latest products. Once you click the link, first you will be prompted to select what type of practice you have, such as inpatient or ambulatory. Then it will give you the option to browse the entire list, or narrow your search by the product name, the product number or the vendor number. An important thing to note on the list is the "Product Classification," which will tell you whether the product is a complete or modular EHR. You can even place a series of modular EHRs into your cart and then the website will tell you if they will qualify as a complete bundle.

The more you use websites like this, the better you will become at navigating them. A lot of it really is trial and error; so don't get discouraged if you can't find the correct information right away. If you have any specific questions, feel free to write the Medical Business Journal at news@mmiclasses.com. I would be glad to provide any assistance I can on this matter.

Wall Street Journal Sues Over Right to Access Medicare Database

COMPLETE RECORDS OF MEDICARE PAYMENTS TO DOCS CURRENTLY CLOSED TO THE PUBLIC

Dow Jones & Company Inc., publisher of the Wall Street Journal, is attempting to dissolve a 1979 injunction that prohibits disclosure of the annual Medicare earnings of individual physicians. This comes after the Journal published a series of five articles based on a limited sample of the Limited Data Set (LDS) Files, a repository of charges paid by Medicare.

The Series, entitled Secrets of the System, targeted potential fraud and waste in the Medicare system. The Journal now seeks to access the entire LDS file, which they say would allow them a much greater ability to expose abnormalities in Medicare and report them. Specifically, the Journal wants access to the LDS's Carrier Standard Analytic File (Carrier File), a subset of the LDS, which contains all fee-for-service Medicare Part B claims.

"The Series has been a success," said front-page editor Michael Allen in a written declaration to the court. "But the limits HHS imposes on access to the LDS Files, based on the injunction from 1979 in this case, have significantly interfered with our reporting in two key ways."

The main condition under which the Journal received these files is that they do not disseminate any information that could be used to deduce an individual doctor's identity, unless they were able to verify it completely independently of the files. This led not only to the Journal being prevented from reporting certain findings, but also prevented the Journal from discussing and confirming key information found in the files during the course of reporting.

Additionally, the Journal was only provided with a random 5 percent sample of the Carrier File. From this sample, the Journal could only deduce a ballpark estimate of an individual provider's total Medicare reimbursement in the most extreme cases. Much of the information for the Series had to be obtained from other sources besides the Carrier File.

The 1979 injunction came in response to the Secretary of the Department of Health Education and Welfare (HEW), now the department of Health and Human Services (HHS), proposing to release the annual total earnings of individual doctors from Medicare. Subsequently, the Florida Medical Association, later joined by the American Medical Association (AMA), filed an injunction against HEW to prevent the release of these files.

The court reasoned that "the Secretary's proposed disclosure of a list of annual reimbursements to individually identified providers of services under the Medicare Act (1) is exempt from required disclosure under the FOIA because it would 'constitute a clearly unwarranted invasion of personal privacy'; (2) is prohibited by the Privacy Act from disclosure, without the prior written consent of each affected individual; and (3) if the guidelines and regulations of [the Office of Management and Budget] OMB and HEW would otherwise authorize and allow such disclosure, they are contrary to the Privacy Act and without force and effect."

The court believed that the annual reimbursement revenues of Medicare providers fell within exemption 6 of the Freedom of Information Act (FOIA), in that they were classified under the term "similar file" in the line preventing the disclosure of "personnel and medical files and similar files" when the disclosure of such information "would constitute a clearly unwarranted invasion of personal privacy."

Consequently, the court issued the 1979 injunction barring indefinitely the release of Medicare payment information that would individually identify the reimbursements paid to individual providers.

The court also noted that "public concern is no further advanced by revealing the identity of individual providers and their annual reimbursement amounts; neither is that concern diminished by omitting such personally identifying details."

This is a main point of contention brought up in the upcoming lawsuit. The Journal contends that in its Secrets of the System series it illustrated a clear public interest in having this information disclosed. In their Exhibit Motion to Intervene, the Journal claims that "public interest cannot be served without disclosure of the Medicare claims data, disclosure would not harm any provider or violate any provider's Statutory or Constitutional rights, and masking provider identities would not serve the public interest."

The Journal goes on to note that since the publication of the Series, they have received requests from government officials and legislators on how to use the Carrier File in order to combat fraud, that individual citizens have praised them and used the information in their course of care, and in one instance the Series prompted a Medicare fraud investigation.

"The Medicare system is funded by taxpayers and yet taxpayers are blocked from seeing how their money is spent," said Robert Thomson, editor in chief of The Wall Street Journal. "It is in the interests of law-abiding practitioners that those who are gaming the system are exposed. Unless funds are used efficiently and intelligently, the health of the nation, physically and fiscally, will be undermined."

The main question that remains is that, even if disclosure of such information would serve a substantial public interest, does and should the law protect the information from disclosure?

New Signature Requirement for Clinical Lab Tests

ENFORCEMENT DATE DELAYED UNTIL APRIL FOOLS DAY

No joking here. Beginning April 1, 2011, CMS will begin to require a physician or NPP's signature on every clinical lab test that is paper-order. A simple stamp or sign off will not be accepted. This rule was originally set to go into effect on January 1, 2011, but CMS chose to push this date back to allow time to educate the stakeholders.

Once implemented, CMS indicates the consequence when clinics fulfill an order without a signature, will be denials and lack of payment. Providers must understand, labs will stop processing orders that do not have a signature. It would be a good idea to add signature collection to your office workflow.

Commonly, physicians document the chart, indicate test(s) and then leave the actual order and requisition completion process to the administrative staff, which then sends the information to the lab. In this same scenario, after April 1, before the administrative staff sends the information to the lab, they will have to first go back to the provider to complete the order – and obtain a signature!

Getting it signed after the fact will be costly. Not only monetarily, but the possibility of later testing could be harmful to the patients' outcome and also keep in mind, samples do not necessarily last if they sit around waiting for the doctor to be tracked down for a simple signature.

Here are examples of what CMS considers to be an acceptable signature:

- Legible full signature
- Legible first initial and last name
- Illegible signature over a typed or printed name
- Illegible signature where the letterhead, addressograph or other information on the page indicates the identity of the signator
- Illegible signature NOT over a typed/printed name and NOT on letterhead, but the submitted documentation is accompanied by a signature log, or attestation statement
- Initials over a typed or printed name
- Unsigned handwritten note where other entries on the same page in the same handwriting are signed

For now, MBJ says begin to prepare your game plan, but CMS still has many questions to answer.

New Way for Medicare to Monitor Quality of Care

CMS PROPOSES A RULE TO GIVE BENEFICIARIES AN AVENUE TO LODGE COMPLAINTS

A new rule is being proposed by the Centers for Medicare and Medicaid Services (CMS) that will require providers participating in Medicare to give beneficiaries written notice outlining how they can contact a Medicare Quality Improvement Organization (QIO) with their quality of care concerns.

Inpatient care settings are already required to provide such notice. This rule would extend the requirement to all providers and suppliers. The goal is to improve quality of care by providing beneficiaries with better access to QIOs.

CMS will accept comments on the proposed rule until April 3, 2011. To comment, go to www.regulations.gov and enter the keyword CMS-2011-0012-0001 then search.

RECs to receive another $12 million

FUNDS TO ADD EHR TECHNICAL SUPPORT TO RURAL AND CRITICAL ACCESS HOSPITALS

The National Coordinator for Health Information Technology, David Blumenthal, MD, announced an additional $12 million of funding to help rural and critical access hospitals to adopt Electronic Health Records (EHRs). The funds will be distributed to Regional Extension Centers (RECs), which are designed to provide technical support for these hospitals. The increased funding is intended to accelerate the adoption of EHRs.

Blumenthal is scheduled to step down in the spring and return to Harvard Medical School. He is leaving, as planned, after laying the foundation for EHR adoption.

Correction:

On page 6 of the February issue of the MBJ, CPT code 88305 was referenced for PSA (prostate specific antigen) which is the code for surgical pathology, not screening. PSA is actually reported via CPT 84153 for non-Medicare patients.

Thank you, Maya Kline for your expertise and valued feedback!

2011 Modifier Adjustments

MODIFICATIONS HELP CLEAR UP MODIFIERS

Historically, HCPCS modifiers have remained fairly stable throughout the years. Modifiers underwent their heftiest change back in 2008, and 2011 offers a few more adjustments to help clear things up just a bit more.

Keep in mind, some payers may have their own interpretations that could affect reimbursement or how they prefer you apply the modifier, so be sure to check with the payer.

Modifier 22

"Increased Procedural Services"

The documentation has to support a significant increase in time, complexity or effort. The documentation MUST include the reason(s) for additional work or time and not just a generic statement. In terms of documentation, the more detailed, the better justified for payer purposes. Remember, reporting services should mimic communication that clearly describes the services provided and the necessity of them. When there is a modification made, communicate that the best way possible to avoid any back-and-forth that undoubtedly delays the reimbursement process.

Guidelines/Instructions:

- Submit this modifier to indicate that the work done required the provider to provide a service substantially greater than what is typically required
- This modifier may only be reported with procedure codes that are specified as having a 0, 10 or 90 day global period
- This modifier may not be submitted with evaluation and management (E/M) procedures
- Documentation required with the claim:
    - A concise statement that explains the nature of the unusual service or other supporting documentation that the provider deems

relevant (i.e., an operative report) with relevant portions underlined

- The concise statement may be entered in the electronic documentation field or submitted with an electronic claim via the fax attachment process. Services that are submitted with CPT modifier 22 that do not meet these requirements will not be considered for additional reimbursement. Railroad Medicare does not have a fax attachment process.
- The concise statement may appear on the operative report, but it must be clearly identified. You may circle, underline, highlight or write the concise statement on the operative report. Failure to submit the appropriate information will result in a denial of the claim.

Modifiers 25 & Modifier 59

"Significant, separately identifiable E/M service by the same physician on the same day of the procedure or other service" & "Distinct Procedural Service"

Prior to 2008, there was a ton of confusion between these two modifiers. To avoid future confusion, both descriptors were changed to remove chiropractors, physician assistants, and physical or occupational therapists).

Since 2008, there has still been a lot of confusion on the appropriate use of modifier 25. It is a popular belief that modifier 25 can only be used when the diagnosis for the E/M is different than that of the procedure. However, per the CPT, different diagnoses are not required to report modifier 25.

Modifier 59 continues to be used to report services that are distinct from each other.

This modifier serves as an aid to communicate to the payer that both services, though normally considered part of each other, should be paid. Be careful; this is still the most overly misused modifier– inappropriate use of this modifier can be interpreted as fraudulent behavior. It is key to ensure the documentation clearly supports the use of modifier 59, and that no other modifier is more appropriate.

Modifier 58 & Modifier 78

"Staged or related procedure or service by the same physician during the postoperative period" & "Unplanned return to the operating/ procedure room by the same physician or other qualified health care professional following initial procedure for a related procedure during the postoperative period"

At first, these two modifiers appeared to be interchangeable. To alleviate this confusion, both definitions were changed to distinguish their proper use.

Modifier 58's language was revised to expand its application to other billing providers and not just physicians as the previous descriptor stated. Additionally, the phrase "planned prospectively" was altered to read "planned or anticipated" to allow for a wider application in instances where the subsequent procedure is dependent on the outcome of the surgery. This no longer limits this modifier only to procedures that were planned ahead of time. Whereas modifier 78 is to be reserved for those unplanned returns to the operating or procedure room.

Another notable revision for 2011 modifiers, is the phrase "or other qualified health care professional" which added to the descriptor of Modifiers 76, 77 & 78 to expand the use of these modifiers to more than just physicians.

Screening Mammography

WHAT'S COVERED IN 2011

Over the years there has been quite a bit of confusion regarding the billing, reimbursement and frequency of a covered screening mammography. For 2011, the MBJ offer some clarity on the subject.

Medicare covers one screening mammogram for women aged 40 years or older, once every 12 months. To report this, use CPT code 77057 if a standard screening mammogram is performed. This code descriptor reads "Screening mammography, bilateral" meaning a two-view film study of each breast.

Medicare also covers computer aided detection (CAD) technology when performed in addition to the screening mammography. This service is reported using CPT add-on code +77052 for computer-aided detection (computer algorithm analysis of digital image data for lesion detection); screening mammography. This is in addition to code 77057. The Medicare deductible is waived for this service but the patient is responsible for 20% of the Medicare approved amount.

For the use of digital technology for screening and diagnostic mammography studies, Medicare covers and provides additional payment (since 2001). To report this full-field digital mammogram, HCPCS II code G0202 was developed which indicates "Screening mammography, producing direct digital image, bilateral, all views". Diagnosis code(s) V76.11 (screening mammogram for high-risk patient) or V76.12 (other screening mammogram) should be linked to the appropriate CPT-4 mammography code reported. The Medicare deductible is waived for this service, but the patient is responsible for 20% of the Medicare approved amount.

A diagnostic mammogram is rightfully covered whenever it is medically necessary (e.g. when the patient has an illness disease or symptoms indicating the need for a mammogram).

CODING CORNER

Q: Can you tell me what the difference is between the 1995 & 1997 E&M coding guidelines? And, in an organization, does the entire organization have to use the same guidelines, or can different providers use the 1995 guidelines while others use the 1997 guidelines?

A: *The 1995 documentation guidelines are sometimes viewed as more straightforward by providing a general description of a multi-systems exam. Many prefer these documentation guidelines (DG) for Primary Care Physicians (PCP). Whereas, the 1997 documentation guidelines give a more comprehensive description of a general multi-system exam AND also defines the components of a 10 single-organ system exams.*
Medicare added the single multi-system exam guidelines in 1997 to allow specialists to reach the highest level of service - as specialists normally focus an exam on a single organ system. Therefore, many specialists find these DGs more suitable for their encounters
When selecting a level of E/M to code and report, physicians have the option of using either the 1995 or 1997 guidelines, whichever is most advantageous to the provider, and this can be on a case-by-case basis.

Q: A patient received 1500 mg of Vitamin B12. Normally he receives 1000mg, which we bill with J3420. For a short time the dose was increased to 1500 mg. How do we bill this? Medicare won't recognize billing the units as 1.5.

A: *Report J3420 twice; the second append modifier JW to indicate the excess was discarded.*

Q: I am reading the definitions for CPT 99315 & 99316. It is not clear if the doctor needs to be present with patient or not.

A: *For Nursing Facility discharge services, the doctor does not necessarily need to see the patient on the date they leave. However, the doctor does need to have a face-to-face visit with them prior to making the decision for discharge; even if that is days later.*

Q: Dr. orders a 3T MRI of pelvis- what CPT code do we use for that? 3T MRI is the newest. I checked CPT I Codes and CPT III codes and I can't find it. I was just curious if you ever heard of a code for this?

A: *With all the new changes in Radiology this year, we consulted with radiology experts as well as a 3T MRI vendor - For 3T MRI of the pelvis, you would use a code from 72195-72197, depending on the contrast material.*

Q: I need some clarification regarding a patient coming into the office to leave a urine specimen, which is dipped by a MA. What is required for the MA to document to be able to bill this as a 99211?

A: *99211 would not be appropriate in this case since an E/M visit was not performed. For the specimen handling and conveyance, report 99000 (Handling and/or conveyance of specimen for transfer from the physician's office to a laboratory).*

If the MA performed the actual urinalysis, you'll want to take a look at codes 81000-81099.

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