MBJ
Medical Business Journal
Issue 8
Volume 2
August 2011

Coding Freeze Thaws New ICD 9 Codes!

ICD-9 See Page 10

National Immunization Month

Initial Preventative Physical Exam and Annual Wellness Visit FAQ

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Medical Business Journal

ISSUE 8, VOLUME 2, AUGUST 2011

Letter from the Editor

Dear Readers,

This month is chock full of the new ICD-9 codes. I know what you're thinking; you thought that there was going to be a coding freeze to prepare for the ICD-10. Well, you're right, these few hundred new and updated codes are only the most critically necessary revisions that CMS just couldn't wait to get out. So be sure to check out all the changes so you can keep on coding.

August is also Happiness Happens month, so be sure to share a smile with a friend or coworker. Check out the suggestions in the Happiness Happens article to find out ways to brighten your day.

There are a lot of changes coming up, between EHRs, eRxs, and new payment structures, so use this issue to keep abreast all the new rules and regulations. Major changes in the entire health care industry are right around the corner.

The password for August is **cyst***. When accessing the August issue on MBJonline.com type in* **cyst** *as the password to access the online issue.*

I hope you're having a nice summer,

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

If you haven't taken our online survey, we encourage you to do so. Again, the survey is available online at:
http://www.surveymonkey.com/s/5VYYJZL

Medical Business Journal

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Pharmacy Billing for Drugs Provided "Incident To" a Physician Service

UPDATE IN PAYMENT POLICY

Pharmacies, suppliers and providers may not bill Medicare Part B for drugs dispensed directly to a beneficiary for administration "incident to" a physician service, such as refilling an implanted drug pump. An E/M code is a common indicator that this is the situation, as a physician service was performed. In most cases, when the physician administers the drug it is not separately payable to the pharmacy, unless the physician bought the drug from the pharmacy.

Pharmacies billing Medicare Part B for certain classes of drugs must submit their requests to their Durable Medical Equipment Medicare Administrative Contractor (DME MAC) or they will be denied. If the DME MAC determines that the drugs are covered and necessary, they will make payment to the pharmacy.

The only time a payment request should be submitted to an A/B MAC is in the rare occasion where a pharmacy dispenses a drug that will be administered through implanted DME and a physician's service will not be utilized to fill the pump with the drug.

"Pharmacies, suppliers and providers may not bill Medicare Part B for drugs dispensed directly to a beneficiary for administration "incident to" a physician service"

"Medicare contractors will not search their files to either retract payment for claims already paid or to retroactively pay claims, but will adjust claims brought to their attention," according to CR transmittal R2251CP.

Initial Preventative Physical Exam and Annual Wellness Visit

FAQ

Due to the Affordable Care Act of 2010, the definition of "preventive services" has slightly changed. Preventive services now include two additional preventive physical examination services: the initial preventive physical examination (IPPE) and the annual wellness visit (AWV). In regards to Medicare, as with any new benefit, the IPPE and AWV have been sources of confusion for many health providers and support staff.

In light of the confusion, the Centers for Medicare & Medicaid Services (CMS) recently posted six new frequently asked questions (FAQs) regarding the IPPE.

Although this information is not new, it helps clear up common misperceptions providers have about this Medicare benefit.

Here are the IPPE questions and answers as recently posted:

Q: Are clinical laboratory tests part of the Initial Preventive Physical Examination (IPPE)?

A: No, the IPPE does not include any clinical laboratory tests, but the provider may want to make referrals for such tests as part of the IPPE.

Q: Is there a deductible or coinsurance/copayment for the Initial Preventive Physical Examination (IPPE)?

A: Coverage for the IPPE is provided as a Medicare Part B benefit. For dates of service prior to January 1, 2011, the annual Medicare Part B deductible is waived for the IPPE (HCPCS code G0402), but the coinsurance or copayment still applies. The deductible still applies to the optional screening EKG (HCPCS codes G0403, G0404, or G0405). For dates of service on or after January 1, 2011, both the Medicare Part B deductible and the coinsurance or copayment are waived for the IPPE only. Neither is waived for the screening EKG.

Q: If a beneficiary enrolled in Medicare in 2010, can he or she have the Initial Preventive Physical Examination (IPPE) in 2011 if it was not performed in 2010?

A: A beneficiary, who has not yet had an IPPE and whose initial enrollment in Medicare Part B began in 2010, will be able to have an IPPE in 2011, as long as it is done within 12 months of the beneficiary's initial Medicare Part B enrollment effective date.

Q: Is the Initial Preventive Physical Examination (IPPE) the same as a beneficiary's yearly physical?

A: No, this exam is a preventive physical exam and not a "routine physical checkup" that some seniors may receive every year or two from their physician or other qualified non-physician practitioner. For a newly enrolled beneficiary, the IPPE is an introduction to Medicare and covered benefits. Medicare does not provide coverage for routine physical exams.

Q: Can a separate E/M service be billed at the same visit as the IPPE?

A: Medicare payment can be made for a significant, separately identifiable medically necessary E/M service (Current Procedural Terminology [CPT] codes 99201-99215) billed at the same visit as the IPPE when billed with modifier 25. That portion of the visit must be medically necessary to treat the beneficiary's illness or injury, or to improve the functioning of a malformed body member.

Q: Who can perform the Initial Preventive Physical Examination (IPPE)?

A: The IPPE must be furnished by either a physician (a doctor of medicine or osteopathy) or a qualified non-physician practitioner (a physician assistant, nurse practitioner, or clinical nurse specialist).

You'll find other FAQs regarding all things Medicare on the CMS website, www.cms.gov.

Also note that the 2011 Medicare Physician Fee Schedule (MPFS) published a table of preventive services that was just recently added to Chapter 18 (Preventive and Screening Services) of the Medicare Claims Processing Manual, Pub. 100-04. Change Request (CR) 7423 is being implemented via the Recurring Update Notification form as CMS will update the preventive table as new services become available.

Celebrate National Immunization Awareness Month

GET OVER YOUR FEAR OF NEEDLES IN AUGUST

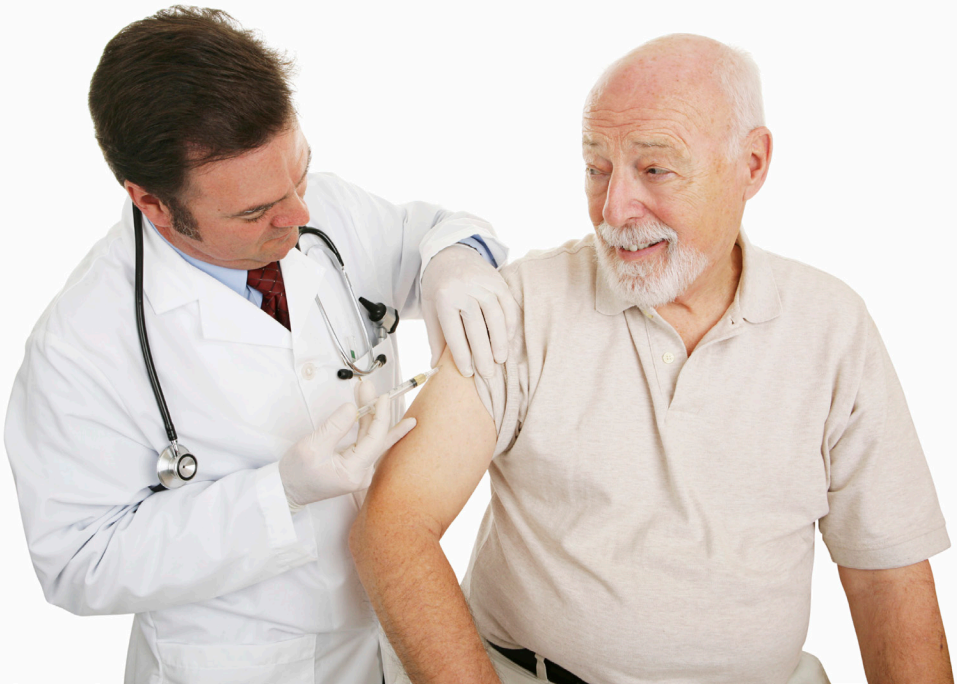
Though most vaccinations are administered by age 6, keeping up to date on vaccinations is a life long endeavor. That is why the Centers for Disease Control (CDC) reminds everyone to check their immunization status every August.

August was chosen because it is right before children go back to school. This makes it a perfect time to prevent infectious disease, especially among children. From the mumps to the measles, there are many diseases that can be easily prevented with proper diligence and vaccination.

You can expect to administer a good deal of booster shots as school starts back up, so here are some helpful codes to remember. Vaccination codes are located in the Medicine section of the CPT (90281-90399). For patients 18 years of age or younger, CPT code 90460 should be used for physician administration of a vaccine. Remember, face-to-face counceling must be documented in order for the code to be applicable. For every additional vaccine administered during the visit, add on code 90461 should be attached.

Some vaccines are administered all at once, and some vaccines, such as Hepatitis B, are administered over several doses. Be sure to check the schedule attached to the vaccine code, for example CPT code 90649, Human Papilloma Virus (HPV) vaccine, types 6, 11, 16, 18 (quadrivalent), 3 dose schedule, for intramuscular use. This will prevent accidental billing of similar shots on different schedules. The greatest benefit to vaccination is that it decreases the risk of infection even for those who aren't vaccinated. The effect of having less people able to transmit the disease essentially reduces the probability of the disease being spread. Everyone wins.

Doctors often use combination vaccines (injections that contain many vaccinations at once) to reduce the amount of shots that have to be administered. The less shots the easier on the patient, although that probably also means less lollipops. CPT code 90720, Diphtheria, tetanus toxoids, and whole cell pertussis vaccine and Hemophilus influenza B vaccine (DTP-Hib), for intramuscular use is one such vaccine code. Be sure to check all of the ingredients of the vaccine before assigning the correct code.



There are sometimes instances when it is better to wait for vaccines. Ask the patients if they are sick, have severe allergies, have a weakened immune system or if they have had a blood transfusion lately.

The CDC also noted that this year, from January through June, the U.S. has had an abnormally high occurrence of measles, so make sure you get vaccinated for it if you aren't up to date.

There were 156 confirmed cases through June 17th; the highest reported number since 1996. The CDC attributes the outbreak primarily to people who traveled abroad and other unvaccinated people they came into contact with. So remember CPT code 90705, measles virus vaccine, live, for subcutaneous use.

The CDC offers many immunization educational resources for both the provider and patient's perspective. CDC.gov offers webcasts, studies and seminars on how to properly utilize all the benefits of vaccination. The Advisory Committee on Immunization Practices (ACIP) holds regular meetings where they recommend policies and discuss new vaccinations. The most recent meeting occurred June 22-23, 2011, and the minutes are available at CDC.gov. There are plenty of resources to refer patients to, so keep track of these helpful immunization schedules.

You can view the full birth to 6 years old immunization schedule here:
http://www.cdc.gov/vaccines/spec-grps/infants/downloads/parent-ver-sch-0-6yrs.pdf

You can view the full 7 to 18 years old immunization schedule here:
http://www.cdc.gov/vaccines/recs/schedules/child-schedule.htm#parentsteen

You can view the full adult immunization schedule here:
http://www.cdc.gov/vaccines/recs/schedules/adult-schedule.htm#everyone

IMMUNIZE YOURSELF AND YOUR STAFF

Historically, Medicare patients give every reason known to get out of their annual flu vaccination. The fact is, on average, that there are 36,000 flu-related deaths in the United States each year. Over 90% of these deaths occur in people 65 years of age and older. Please talk with your Medicare patients about the importance of getting their annual flu vaccination. Medicare does not only cover this preventive service but the vaccine will protect them for the entire flu season.

Don't forget to immunize yourself and your staff. Flu vaccination is just as important for health care workers too, who may spread the flu to high-risk patients. Protect your patients. Protect your family. Protect yourself. Get Your Flu Vaccine - Not the Flu.

Remember – Influenza vaccine plus its administration are covered Part B benefits. Note that influenza vaccine is NOT a Part D covered drug. For information about Medicare's coverage of the influenza vaccine and its administration, please visit http://www.cms.gov/MLNProducts/Downloads/Flu_Products.pdf and http://www.cms.gov/AdultImmunizations on the CMS Web site.

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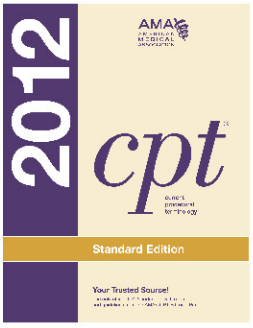

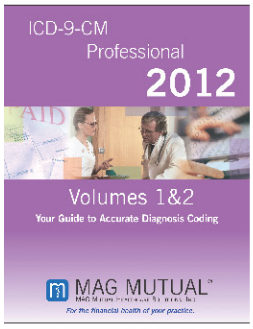

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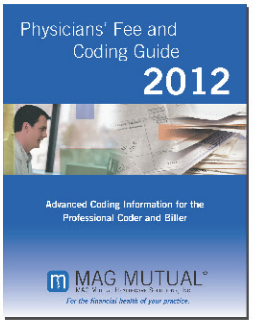

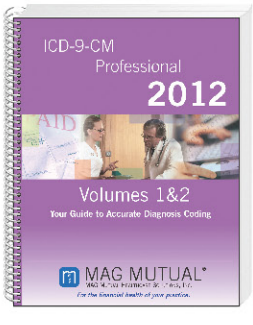

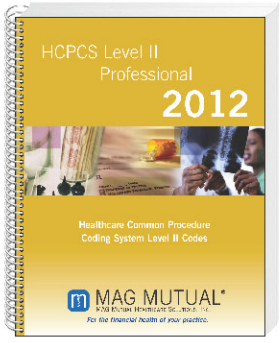

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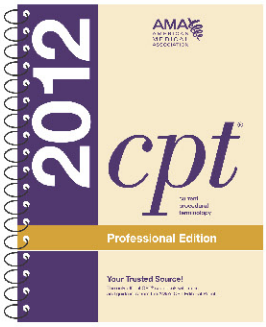

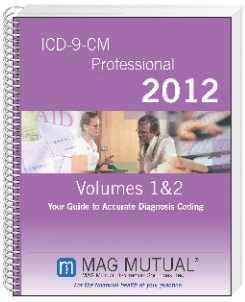

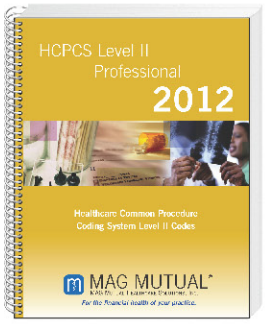

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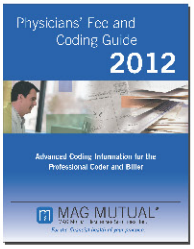

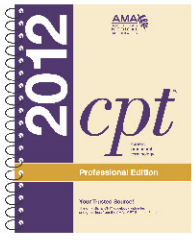

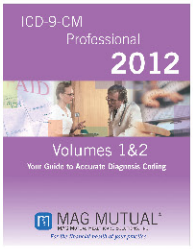

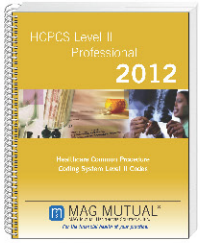

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Medicare Home Health Payment Changes

CMS PROPOSES 2012 PROVISIONS

The Centers for Medicare and Medicaid Services (CMS) has released a proposed rule to determine the 2012 payment rates for home health care. The rule was on display July 5th on the Federal Register.

The new rule proposes a 3.35 percent decrease in Medicare payments to home health agencies in 2012. CMS estimates this to amount to a net decrease of $640 million in payments compared to 2011.

"The new rule proposes a 3.35 percent decrease in Medicare payments to home health agencies in 2012."

The proposed rule also removes two hypertension codes from the case-mix system. Home health agencies must submit quality-reporting data, or the home health market basket percentage will be reduced by 2 percentage points.

In a separate rule, CMS defined the conditions of a beneficiary being eligible for home health benefits. The beneficiary "must be under the care of a physician, have an intermittent need for skilled nursing care, or need physical or speech therapy, or continue to need occupational therapy," according to CMS' website.

HHS Tests New Medicare and Medicaid Financial Models

SEEKS TO IMPROVE PROCESS FOR DUAL ELIGIBLE BENEFICIARIES

The Department of Health and Human Services (HHS) is testing new financial models for Medicare-Medicaid dual eligible beneficiaries. The models seek to coordinate care while reducing costs to both the Federal and State governments.

Under one model, the Capitated Model, the State, the Centers for Medicare and Medicaid Services (CMS) and the health plan enter a three way contract. The provider would receive a prospective blended payment.

Under another model, the Managed Fee-for-Service model, the state and CMS enter into an agreement where the state can receive savings resulting from initiatives designed to improve quality and reduce costs for the Medicare and Medicaid programs.

Dual eligible beneficiaries have been a long standing problem for HHS, and often result in overpayments and disjointed care. These new financial models seek to align the payment structures of the two programs to better incentivize quality, low cost health care.

CMS is currently testing these models and determining which states may qualify for the new programs. Eligible states will be able to choose which model best suites their individual needs.

CMS

NEWS UPDATE

CMS Posts Final Full Update for 2012 ICD-9 Codes

The Centers for Medicare & Medicaid Services (CMS) has proposed revisions to the work relative value units (RVUs) for 290 CPT® codes to be enacted with adoption of the 2012 Medicare Physician Fee Schedule (Jan. 1, 2012). CMS posted the final-full version of new, revised, and invalid ICD-9-CM diagnosis codes for 2012 on its website back in June. The updated code set will be effective for dates of service on or after Oct. 1.

By law, CMS is obligated to review RVUs no less often than every five years. CMS' recommendations following the most recent five-year review are detailed in the proposed rule posted to the Federal Register on June 6.

Submitted through public comment and by Medicare contractor medical directors, as well as a number of potentially misvalued codes identified by CMS (for example, codes with site-of-service anomalies) were included in this five-year review. Of the 290 proposed code changes, the American Medical Association's (AMA's) Relative Value System Update Committee (RUC) provided opposing recommendations for 173 codes. Upon clinical review, CMS proposes to accept 89 of the AMA RUC recommendations for work RVUs.

Table 5 summarizes the proposed changes of the proposed rule and can be found on CMS' website.

In some cases, CMS refined physician times for codes as deemed appropriate to correspond with the proposed work RVUs (summarized in Table 6 of the proposed rule).

Per CMS, the proposed revisions "reflect changes in medical practice and coding that affect the relative amount of physician work required to perform each service …" As an additional consideration, RVU changes must be "budget neutral" under the law. Increases or decreases in RVUs "may not cause the amount of expenditures under Part B for the year to differ more than $20 million from what it would have been in the absence of these changes."

CMS will collect public comments on the proposed rule until July 25, with a final rule to follow. Until then, the proposed rule provides a full explanation of proposed changes for each code.

You can review the summary tables on the CMS website, or go to the National Center for Health Statistics' (NCHS') website to download the final addendum, posted June 30, providing complete information on tabular and index changes to ICD-9-CM procedure and diagnosis codes for 2012.

CMS Transmittal 2246, issued June 24, includes both summary tables and final addendum.

For your convenience, the changes are listed in this issue as well.

Coding Freeze Thaws

NEW ICD-9 CODES TO BE EFFECTIVE OCT. 1, 2011

New Diagnosis Codes

DIAGNOSIS CODE	DESCRIPTION
041.41	SHIGA TOXIN-PRODUCING ESCHERICHIA COLI [E. COLI] (STEC) O157
041.42	OTHER SPECIFIED SHIGA TOXIN-PRODUCING ESCHERICHIA COLI [E. COLI] (STEC)
041.43	SHIGA TOXIN-PRODUCING ESCHERICHIA COLI [E. COLI] (STEC), UNSPECIFIED
041.49	OTHER AND UNSPECIFIED ESCHERICHIA COLI [E. COLI]
173.00	UNSPECIFIED MALIGNANT NEOPLASM OF SKIN OF LIP
173.01	BASAL CELL CARCINOMA OF SKIN OF LIP
173.02	SQUAMOUS CELL CARCINOMA OF SKIN OF LIP
173.09	OTHER SPECIFIED MALIGNANT NEOPLASM OF SKIN OF LIP
173.10	UNSPECIFIED MALIGNANT NEOPLASM OF EYELID, INCLUDING CANTHUS
173.11	BASAL CELL CARCINOMA OF EYELID, INCLUDING CANTHUS
173.12	SQUAMOUS CELL CARCINOMA OF EYELID, INCLUDING CANTHUS
173.19	OTHER SPECIFIED MALIGNANT NEOPLASM OF EYELID, INCLUDING CANTHUS
173.20	UNSPECIFIED MALIGNANT NEOPLASM OF SKIN OF EAR AND EXTERNAL AUDITORY CANAL
173.21	BASAL CELL CARCINOMA OF SKIN OF EAR AND EXTERNAL AUDITORY CANAL
173.22	SQUAMOUS CELL CARCINOMA OF SKIN OF EAR AND EXTERNAL AUDITORY CANAL
173.29	OTHER SPECIFIED MALIGNANT NEOPLASM OF SKIN OF EAR AND EXTERNAL AUDITORY CANAL
173.30	UNSPECIFIED MALIGNANT NEOPLASM OF SKIN OF OTHER AND UNSPECIFIED PARTS OF FACE
173.31	BASAL CELL CARCINOMA OF SKIN OF OTHER AND UNSPECIFIED PARTS OF FACE
173.32	SQUAMOUS CELL CARCINOMA OF SKIN OF OTHER AND UNSPECIFIED PARTS OF FACE
173.39	OTHER SPECIFIED MALIGNANT NEOPLASM OF SKIN OF OTHER AND UNSPECIFIED PARTS OF FACE
173.40	UNSPECIFIED MALIGNANT NEOPLASM OF SCALP AND SKIN OF NECK
173.41	BASAL CELL CARCINOMA OF SCALP AND SKIN OF NECK
173.42	SQUAMOUS CELL CARCINOMA OF SCALP AND SKIN OF NECK
173.49	OTHER SPECIFIED MALIGNANT NEOPLASM OF SCALP AND SKIN OF NECK
173.50	UNSPECIFIED MALIGNANT NEOPLASM OF SKIN OF TRUNK, EXCEPT SCROTUM
173.51	BASAL CELL CARCINOMA OF SKIN OF TRUNK, EXCEPT SCROTUM
173.52	SQUAMOUS CELL CARCINOMA OF SKIN OF TRUNK, EXCEPT SCROTUM
173.59	OTHER SPECIFIED MALIGNANT NEOPLASM OF SKIN OF TRUNK, EXCEPT SCROTUM
173.60	UNSPECIFIED MALIGNANT NEOPLASM OF SKIN OF UPPER LIMB, INCLUDING SHOULDER
173.61	BASAL CELL CARCINOMA OF SKIN OF UPPER LIMB, INCLUDING SHOULDER
173.62	SQUAMOUS CELL CARCINOMA OF SKIN OF UPPER LIMB, INCLUDING SHOULDER
173.69	OTHER SPECIFIED MALIGNANT NEOPLASM OF SKIN OF UPPER LIMB, INCLUDING SHOULDER
173.70	UNSPECIFIED MALIGNANT NEOPLASM OF SKIN OF LOWER LIMB, INCLUDING HIP
173.71	BASAL CELL CARCINOMA OF SKIN OF LOWER LIMB, INCLUDING HIP
173.72	SQUAMOUS CELL CARCINOMA OF SKIN OF LOWER LIMB, INCLUDING HIP

173.79	OTHER SPECIFIED MALIGNANT NEOPLASM OF SKIN OF LOWER LIMB, INCLUDING HIP
173.80	UNSPECIFIED MALIGNANT NEOPLASM OF OTHER SPECIFIED SITES OF SKIN
173.81	BASAL CELL CARCINOMA OF OTHER SPECIFIED SITES OF SKIN
173.82	SQUAMOUS CELL CARCINOMA OF OTHER SPECIFIED SITES OF SKIN
173.89	OTHER SPECIFIED MALIGNANT NEOPLASM OF OTHER SPECIFIED SITES OF SKIN
173.90	UNSPECIFIED MALIGNANT NEOPLASM OF SKIN, SITE UNSPECIFIED
173.91	BASAL CELL CARCINOMA OF SKIN, SITE UNSPECIFIED
173.92	SQUAMOUS CELL CARCINOMA OF SKIN, SITE UNSPECIFIED
173.99	OTHER SPECIFIED MALIGNANT NEOPLASM OF SKIN, SITE UNSPECIFIED
282.40*	THALASSEMIA, UNSPECIFIED
282.43*	ALPHA THALASSEMIA
282.44*	BETA THALASSEMIA
282.45*	DELTA-BETA THALASSEMIA
282.46*	THALASSEMIA MINOR
282.47*	HEMOGLOBIN E-BETA THALASSEMIA
284.11*	ANTINEOPLASTIC CHEMOTHERAPY INDUCED PANCYTOPENIA
284.12*	OTHER DRUG INDUCED PANCYTOPENIA
284.19*	OTHER PANCYTOPENIA
286.52	ACQUIRED HEMOPHILIA
286.53	ANTIPHOSPHOLIPID ANTIBODY WITH HEMORRHAGIC DISORDER
286.59	OTHER HEMORRHAGIC DISORDER DUE TO INTRINSIC CIRCULATING ANTICOAGULANTS, ANTIBODIES, OR INHIBITORS
294.20	DEMENTIA, UNSPECIFIED, WITHOUT BEHAVIORAL DISTURBANCE
294.21	DEMENTIA, UNSPECIFIED, WITH BEHAVIORAL DISTURBANCE
310.81	PSEUDOBULBAR AFFECT
310.89	OTHER SPECIFIED NONPSYCHOTIC MENTAL DISORDERS FOLLOWING ORGANIC BRAIN DAMAGE
331.6	CORTICOBASAL DEGENERATION
348.82	BRAIN DEATH
358.30	LAMBERT-EATON SYNDROME, UNSPECIFIED
358.31	LAMBERT-EATON SYNDROME IN NEOPLASTIC DISEASE
358.39	LAMBERT-EATON SYNDROME IN OTHER DISEASES CLASSIFIED ELSEWHERE
365.05	OPEN ANGLE WITH BORDERLINE FINDINGS, HIGH RISK
365.06	PRIMARY ANGLE CLOSURE WITHOUT GLAUCOMA DAMAGE
365.70	GLAUCOMA STAGE, UNSPECIFIED
365.71	MILD STAGE GLAUCOMA
365.72	MODERATE STAGE GLAUCOMA
365.73	SEVERE STAGE GLAUCOMA
365.74	INDETERMINATE STAGE GLAUCOMA
379.27*	VITREOMACULAR ADHESION
414.4*	CORONARY ATHEROSCLEROSIS DUE TO CALCIFIED CORONARY LESION
415.13	SADDLE EMBOLUS OF PULMONARY ARTERY
425.11*	HYPERTROPHIC OBSTRUCTIVE CARDIOMYOPATHY
425.18*	OTHER HYPERTROPHIC CARDIOMYOPATHY
444.01	SADDLE EMBOLUS OF ABDOMINAL AORTA
444.09	OTHER ARTERIAL EMBOLISM AND THROMBOSIS OF ABDOMINAL AORTA
488.81*	INFLUENZA DUE TO IDENTIFIED NOVEL INFLUENZA A VIRUS WITH PNEUMONIA

488.82*	INFLUENZA DUE TO IDENTIFIED NOVEL INFLUENZA A VIRUS WITH OTHER RESPIRATORY MANIFESTATIONS
488.89*	INFLUENZA DUE TO IDENTIFIED NOVEL INFLUENZA A VIRUS WITH OTHER MANIFESTATIONS
508.2*	RESPIRATORY CONDITIONS DUE TO SMOKE INHALATION
512.2*	POSTOPERATIVE AIR LEAK
512.81*	PRIMARY SPONTANEOUS PNEUMOTHORAX
512.82*	SECONDARY SPONTANEOUS PNEUMOTHORAX
512.83*	CHRONIC PNEUMOTHORAX
512.84*	OTHER AIR LEAK
512.89*	OTHER PNEUMOTHORAX
516.30	IDIOPATHIC INTERSTITIAL PNEUMONIA, NOT OTHERWISE SPECIFIED
516.31	IDIOPATHIC PULMONARY FIBROSIS
516.32	IDIOPATHIC NON-SPECIFIC INTERSTITIAL PNEUMONITIS
516.33*	ACUTE INTERSTITIAL PNEUMONITIS
516.34	RESPIRATORY BRONCHIOLITIS INTERSTITIAL LUNG DISEASE
516.35	IDIOPATHIC LYMPHOID INTERSTITIAL PNEUMONIA
516.36	CRYPTOGENIC ORGANIZING PNEUMONIA
516.37	DESQUAMATIVE INTERSTITIAL PNEUMONIA
516.4	LYMPHANGIOLEIOMYOMATOSIS
516.5	ADULT PULMONARY LANGERHANS CELL HISTIOCYTOSIS
516.61	NEUROENDOCRINE CELL HYPERPLASIA OF INFANCY
516.62	PULMONARY INTERSTITIAL GLYCOGENOSIS
516.63	SURFACTANT MUTATIONS OF THE LUNG
516.64	ALVEOLAR CAPILLARY DYSPLASIA WITH VEIN MISALIGNMENT
516.69	OTHER INTERSTITIAL LUNG DISEASES OF CHILDHOOD
518.51*	ACUTE RESPIRATORY FAILURE FOLLOWING TRAUMA AND SURGERY
518.52*	OTHER PULMONARY INSUFFICIENCY, NOT ELSEWHERE CLASSIFIED, FOLLOWING TRAUMA AND SURGERY
518.53*	ACUTE AND CHRONIC RESPIRATORY FAILURE FOLLOWING TRAUMA AND SURGERY
539.01	INFECTION DUE TO GASTRIC BAND PROCEDURE
539.09	OTHER COMPLICATIONS OF GASTRIC BAND PROCEDURE
539.81	INFECTION DUE TO OTHER BARIATRIC PROCEDURE
539.89	OTHER COMPLICATIONS OF OTHER BARIATRIC PROCEDURE
573.5*	HEPATOPULMONARY SYNDROME
596.81	INFECTION OF CYSTOSTOMY
596.82	MECHANICAL COMPLICATION OF CYSTOSTOMY
596.83	OTHER COMPLICATION OF CYSTOSTOMY
596.89	OTHER SPECIFIED DISORDERS OF BLADDER
629.31	EROSION OF IMPLANTED VAGINAL MESH AND OTHER PROSTHETIC MATERIALS TO SURROUNDING ORGAN OR TISSUE
629.32	EXPOSURE OF IMPLANTED VAGINAL MESH AND OTHER PROSTHETIC MATERIALS INTO VAGINA
631.0	INAPPROPRIATE CHANGE IN QUANTITATIVE HUMAN CHORIONIC GONADOTROPIN (HCG) IN EARLY PREGNANCY
631.8	OTHER ABNORMAL PRODUCTS OF CONCEPTION

649.81	ONSET (SPONTANEOUS) OF LABOR AFTER 37 COMPLETED WEEKS OF GESTATION BUT BEFORE 39 COMPLETED WEEKS GESTATION, WITH DELIVERY BY (PLANNED) CESAREAN SECTION, DELIVERED, WITH OR WITHOUT MENTION OF ANTEPARTUM CONDITION
649.82	ONSET (SPONTANEOUS) OF LABOR AFTER 37 COMPLETED WEEKS OF GESTATION BUT BEFORE 39 COMPLETED WEEKS GESTATION, WITH DELIVERY BY (PLANNED) CESAREAN SECTION, DELIVERED, WITH MENTION OF POSTPARTUM COMPLICATION
704.41	PILAR CYST
704.42	TRICHILEMMAL CYST
726.13*	PARTIAL TEAR OF ROTATOR CUFF
747.31	PULMONARY ARTERY COARCTATION AND ATRESIA
747.32	PULMONARY ARTERIOVENOUS MALFORMATION
747.39	OTHER ANOMALIES OF PULMONARY ARTERY AND PULMONARY CIRCULATION
793.11*	SOLITARY PULMONARY NODULE
793.19*	OTHER NONSPECIFIC ABNORMAL FINDING OF LUNG FIELD
795.51*	NONSPECIFIC REACTION TO TUBERCULIN SKIN TEST WITHOUT ACTIVE TUBERCULOSIS
795.52*	NONSPECIFIC REACTION TO CELL MEDIATED IMMUNITY MEASUREMENT OF GAMMA INTERFERON ANTIGEN
808.44	MULTIPLE CLOSED PELVIC FRACTURES WITHOUT DISRUPTION OF PELVIC CIRCLE
808.54	MULTIPLE OPEN PELVIC FRACTURES WITHOUT DISRUPTION OF PELVIC CIRCLE
996.88	COMPLICATIONS OF TRANSPLANTED ORGAN, STEM CELL
997.32	POSTPROCEDURAL ASPIRATION PNEUMONIA
997.41	RETAINED CHOLELITHIASIS FOLLOWING CHOLECYSTECTOMY
997.49	OTHER DIGESTIVE SYSTEM COMPLICATIONS
998.00*	POSTOPERATIVE SHOCK, UNSPECIFIED
998.01*	POSTOPERATIVE SHOCK, CARDIOGENIC
998.02*	POSTOPERATIVE SHOCK, SEPTIC
998.09*	POSTOPERATIVE SHOCK, OTHER
999.32*	BLOODSTREAM INFECTION DUE TO CENTRAL VENOUS CATHETER
999.33*	LOCAL INFECTION DUE TO CENTRAL VENOUS CATHETER
999.34*	ACUTE INFECTION FOLLOWING TRANSFUSION, INFUSION, OR INJECTION OF BLOOD AND BLOOD PRODUCTS
999.41	ANAPHYLACTIC REACTION DUE TO ADMINISTRATION OF BLOOD AND BLOOD PRODUCTS
999.42	ANAPHYLACTIC REACTION DUE TO VACCINATION
999.49	ANAPHYLACTIC REACTION DUE TO OTHER SERUM
999.51	OTHER SERUM REACTION DUE TO ADMINISTRATION OF BLOOD AND BLOOD PRODUCTS
999.52	OTHER SERUM REACTION DUE TO VACCINATION
999.59	OTHER SERUM REACTION
V12.21	PERSONAL HISTORY OF GESTATIONAL DIABETES
V12.29	PERSONAL HISTORY OF OTHER ENDOCRINE, METABOLIC, AND IMMUNITY DISORDERS
V12.55	PERSONAL HISTORY OF PULMONARY EMBOLISM
V13.81	PERSONAL HISTORY OF ANAPHYLAXIS
V13.89	PERSONAL HISTORY OF OTHER SPECIFIED DISEASES

V19.11	FAMILY HISTORY OF GLAUCOMA
V19.19	FAMILY HISTORY OF OTHER SPECIFIED EYE DISORDER
V23.42	PREGNANCY WITH HISTORY OF ECTOPIC PREGNANCY
V23.87	PREGNANCY WITH INCONCLUSIVE FETAL VIABILITY
V40.31*	WANDERING IN DISEASES CLASSIFIED ELSEWHERE
V40.39*	OTHER SPECIFIED BEHAVIORAL PROBLEM
V54.82	AFTERCARE FOLLOWING EXPLANTATION OF JOINT PROSTHESIS
V58.68*	LONG TERM (CURRENT) USE OF BISPHOSPHONATES
V87.02	CONTACT WITH AND (SUSPECTED) EXPOSURE TO URANIUM
V88.21	ACQUIRED ABSENCE OF HIP JOINT
V88.22	ACQUIRED ABSENCE OF KNEE JOINT
V88.29	ACQUIRED ABSENCE OF OTHER JOINT

Notes:

** These diagnosis codes were discussed at the March 9–10, 2011 ICD-9-CM Coordination and Maintenance Committee meeting and were not finalized in time to include in the FY 2012 IPPS/LTCH PPS proposed rule. They will be implemented on October 1, 2011.*

New Procedure Codes:

PROCEDURE CODE	DESCRIPTION
02.21*	INSERTION OR REPLACEMENT OF EXTERNAL VENTRICULAR DRAIN [EVD]
02.22*	INTRACRANIAL VENTRICULAR SHUNT OR ANASTOMOSIS
12.67*	INSERTION OF AQUEOUS DRAINAGE DEVICE
17.53*	PERCUTANEOUS ATHERECTOMY OF EXTRACRANIAL VESSEL(S)
17.54*	PERCUTANEOUS ATHERECTOMY OF INTRACRANIAL VESSEL(S)
17.55*	TRANSLUMINAL CORONARY ATHERECTOMY
17.56*	ATHERECTOMY OF OTHER NON-CORONARY VESSEL(S)
17.81*	INSERTION OF ANTIMICROBIAL ENVELOPE
35.05*	ENDOVASCULAR REPLACEMENT OF AORTIC VALVE
35.06*	TRANSAPICAL REPLACEMENT OF AORTIC VALVE
35.07*	ENDOVASCULAR REPLACEMENT OF PULMONARY VALVE
35.08*	TRANSAPICAL REPLACEMENT OF PULMONARY VALVE
35.09*	ENDOVASCULAR REPLACEMENT OF UNSPECIFIED HEART VALVE
38.26	INSERTION OF IMPLANTABLE PRESSURE SENSOR WITHOUT LEAD FOR INTRACARDIAC OR GREAT VESSEL HEMODYNAMIC MONITORING
39.77*	TEMPORARY (PARTIAL) THERAPEUTIC ENDOVASCULAR OCCLUSION OF VESSEL
39.78*	ENDOVASCULAR IMPLANTATION OF BRANCHING OR FENESTRATED GRAFT(S) IN AORTA
43.82*	LAPAROSCOPIC VERTICAL (SLEEVE) GASTRECTOMY
68.24*	UTERINE ARTERY EMBOLIZATION [UAE] WITH COILS
68.25*	UTERINE ARTERY EMBOLIZATION [UAE] WITHOUT COILS

Invalid Diagnosis Codes

DIAGNOSIS CODE	DESCRIPTION
041.4	ESCHERICHIA COLI [E. COLI] INFECTION IN CONDITIONS CLASSIFIED ELSEWHERE AND OF UNSPECIFIED SITE
173.0	OTHER MALIGNANT NEOPLASM OF SKIN OF LIP

173.1	OTHER MALIGNANT NEOPLASM OF SKIN OF EYELID, INCLUDING CANTHUS
173.2	OTHER MALIGNANT NEOPLASM OF SKIN OF EAR AND EXTERNAL AUDITORY CANAL
173.3	OTHER MALIGNANT NEOPLASM OF SKIN OF OTHER AND UNSPECIFIED PARTS OF FACE
173.4	OTHER MALIGNANT NEOPLASM OF SCALP AND SKIN OF NECK
173.5	OTHER MALIGNANT NEOPLASM OF SKIN OF TRUNK, EXCEPT SCROTUM
173.6	OTHER MALIGNANT NEOPLASM OF SKIN OF UPPER LIMB, INCLUDING SHOULDER
173.7	OTHER MALIGNANT NEOPLASM OF SKIN OF LOWER LIMB, INCLUDING HIP
173.8	OTHER MALIGNANT NEOPLASM OF OTHER SPECIFIED SITES OF SKIN
173.9	OTHER MALIGNANT NEOPLASM OF SKIN, SITE UNSPECIFIED
284.1*	PANCYTOPENIA
286.5	HEMORRHAGIC DISORDER DUE TO INTRINSIC CIRCULATING ANTICOAGULANTS
310.8	OTHER SPECIFIED NONPSYCHOTIC MENTAL DISORDERS FOLLOWING ORGANIC BRAIN DAMAGE
425.1*	HYPERTROPHIC OBSTRUCTIVE CARDIOMYOPATHY
444.0	EMBOLISM AND THROMBOSIS OF ABDOMINAL AORTA
512.8*	OTHER SPONTANEOUS PNEUMOTHORAX
516.3	IDIOPATHIC FIBROSING ALVEOLITIS
518.5*	PULMONARY INSUFFICIENCY FOLLOWING TRAUMA AND SURGERY
596.8	OTHER SPECIFIED DISORDERS OF BLADDER
631	OTHER ABNORMAL PRODUCT OF CONCEPTION
718.60*	UNSPECIFIED INTRAPELVIC PROTRUSION OF ACETABULUM, SITE UNSPECIFIED
747.3	ANOMALIES OF PULMONARY ARTERY
793.1*	NONSPECIFIC (ABNORMAL) FINDINGS ON RADIOLOGICAL AND OTHER EXAMINATION OF LUNG FIELD
795.5*	NONSPECIFIC REACTION TO TUBERCULIN SKIN TEST WITHOUT ACTIVE TUBERCULOSIS
997.4**	DIGESTIVE SYSTEM COMPLICATIONS
998.0*	POSTOPERATIVE SHOCK, NOT ELSEWHERE CLASSIFIED
999.4	ANAPHYLACTIC SHOCK DUE TO SERUM
999.5**	OTHER SERUM REACTION
V12.2	PERSONAL HISTORY OF ENDOCRINE, METABOLIC, AND IMMUNITY DISORDERS
V13.8	PERSONAL HISTORY OF OTHER SPECIFIED DISEASES
V19.1	FAMILY HISTORY OF OTHER EYE DISORDERS
V40.3*	OTHER BEHAVIORAL PROBLEMS

Notes:

** These diagnosis codes were discussed at the March 9-10, 2011 ICD-9-CM Coordination and Maintenance Committee meeting and were not finalized in time to include in the FY 2012 IPPS/LTCH PPS proposed rule. They will be deleted on October 1, 2011.*

*** The code title has changed from the proposed rule.*

Invalid Procedure Codes

PROCEDURE CODE	DESCRIPTION
02.2*	VENTRICULOSTOMY

Notes:

** This procedure code was discussed at the March 9-10, 2011 ICD-9-CM Coordination and Maintenance Committee meeting and was not finalized in time to include in the FY 2012 IPPS/LTCH PPS proposed rule. It will be deleted on October 1, 2011.*

Medicare Covers Test that helps Diagnose Metastatic and Other Difficult to Diagnose Cancers

Palmetto GBA, Medicare administrator for California, Nevada, Hawaii, Virginia, West Virginia, North & South Carolina, will now allow coverage for the Pathwork® Diagnostics Tissue of Origin Test. Pathwork® Diagnostics, a molecular diagnostic company focused on oncology, announced the coverage. The reason being, all tissue of origin tests are processed in the Pathwork® Diagnostics Laboratory in California, the Palmetto decision merely means that the test will now be covered for patients nationwide.

Through gene expression, the tissue-of-origin test is used to identify the primary tumor in metastatic disease, or those with a complex clinical history. A tumor's site of origin may be difficult to determine because the original tumor may be small, and due to this would thereby avoid detection by imaging and other techniques. Tumor cells also may change appearance and no longer resemble tumors from the originating site. In other words, an accurate diagnosis of the primary tumor site helps the physician choose the best course of treatment for the patient.

According to www.patchworkdx.com, "up to 10 percent are tumor types are not readily classifiable in the course of the initial diagnostic workup. These tumors, which may be metastatic, undifferentiated, or poorly differentiated, are among the most frustrating for physicians, and place a disproportionate burden on patients, health care professionals, and the health care system."

Pathwork® Diagnostics' Tissue of Origin Test was approved by the Food and Drug Administration (FDA) in 2010, and currently is the only FDA-cleared molecular diagnostic test for tissue of origin. Although FDA-cleared, Pathwork® claims they are committed to expanding insurance covered for the origin test and vows to continue to work with all major plans across the United States. In the interim, they have developed a reimbursement assistance program (RAP) to perform benefits investigations, which provide patients with information about their specific coverage and potential financial responsibility.

CMS Expands Multiple Procedure Payment Reduction to Advanced Imaging Services

In a recent proposed rule, the Centers for Medicare and Medicaid Services (CMS) extended the multiple procedure payment reduction (MPPR) policy to the professional component (PC) of advanced imaging services. The specific procedures affected are computed tomography (CT) scans, magnetic resonance imaging (MRI) and ultrasound.

Under the proposed rule procedures with the highest PC payment would be paid in full and all other payments for subsequent procedures furnished to the same patient, on the same day, in the same setting would be reduced by 50 percent.

CMS estimates that this will reduce payments by $200 million. It will affect over 100 types of services.

New K-Codes Added to HCPCS

Effective for claims with dates of service on, or after, July 1, 2011, these new codes have been added to the HCPCS manual:

- K0743 - SUCTION PUMP, HOME MODEL, PORTABLE, FOR USE ON WOUNDS
- K0744 - ABSORPTIVE WOUND DRESSING FOR USE WITH SUCTION PUMP, HOME MODEL, PORTABLE, PAD SIZE 16 SQUARE INCHES OR LESS
- K0745 - ABSORPTIVE WOUND DRESSING FOR USE WITH SUCTION PUMP, HOME MODEL, PORTABLE, PAD SIZE MORE THAN 16 SQUARE INCHES BUT LESS THAN OR EQUAL TO 48 SQUARE INCHES
- K0746 - ABSORPTIVE WOUND DRESSING FOR USE WITH SUCTION PUMP, HOME MODEL, PORTABLE, PAD SIZE GREATER THAN 48 SQUARE INCHES

Wound suction systems are classified as containing all of the following components:

- Code K0743 describes a suction pump for wounds, which provides controlled subatmospheric pressure that is designed for use with dressings (K0744 – K0746) without a canister.
- Codes K0744 - K0746 describe an allowance for dressing sets that are used in conjunction with a stationary or portable suction pump (K0743) but not used with a canister. Each of these codes (K0744 – K0746) is used for a single, complete dressing change, and contains all necessary components, including but not limited to non-adherent porous dressing, drainage tubing, and an occlusive dressing which creates a seal around the wound site for maintaining subatmospheric pressure at the wound. These dressing sets are selected based upon wound size using the smallest size necessary to cover the wound. For multiple wounds located close together, a single large dressing must be used rather than multiple smaller dressing sets if it is possible to fit the wounds under a single larger dressing set.
- Disposable wound suction system pumps must be coded A9270 (Noncovered item or service).
- Supplies, including dressings, used with disposable wound suction systems must be coded as A9270 (Noncovered item or service).
- Only products reviewed by the PDAC and placed on the product category list may use the NPWT codes E2402 and A6550.

Proposed Changes and Payment Updates for Dialysis Facilities

CMS PROPOSES NEW RULE TO IMPROVE ESRD TREATMENT FOR 2012

The Centers for Medicare and Medicaid Services (CMS) have proposed the 2012 rates for dialysis treatment facilities that see End Stage Renal Disease patients with Medicare. The rule will affect services provided on or after January 1, 2012

CMS estimates that payments to these facilities will increase by 1.8 percent, or roughly $8.3 billion in 2012. In addition to the new payment structure, the Quality Incentive Program (QIP) is also being updated.

CMS is removing the quality measure requiring keeping hemoglobin levels above 10 g/dL based on new findings by the Food and Drug Administration (FDA). New medical evidence questions the safety of a common treatment of anemia, administration of erythropoiesis-stimulating agents (ESAs). CMS is currently looking for new ways to incentivize anemia treatment for dialysis patients, without compromising the patients' safety.

For Payment Year 2014, CMS is proposing adding the following measures:

- Dialysis adequacy, as measured through the Kt/V method, which is widely recognized as a more accurate measure of whether dialysis cleanses blood effectively
- Anemia management, as measured by the rate of patients with a hemoglobin level greater than 12 grams per deciliter;
- Percent of patients receiving treatment through an arteriovenous fistula – a type of vascular access used to connect patients' bloodstreams to dialysis equipment for cleansing;
- Rates of infection of the vascular access sites;
- Ratios of hospitalization rates among dialysis clinic patients;
- Whether the facility reports certain dialysis-related infections to the Centers for Disease Control & Prevention;
- Whether the facility administers a patient experience of care survey; and
- Whether the facility monitors phosphorus and calcium levels on a monthly basis.

More information can be found at: http://www.ofr.gov/inspection.aspx?AspxAutoDetectCookieSupport=1

Electronic Prescription Incentive Program Update

THERE'S STILL TIME

There is still time to qualify for incentive payments under the Electronic Prescription (eRx) incentive program for 2011. Eligible providers (EPs) can receive a 1.0 percent increase in their Physician Fee Schedule (PFS) payments in 2012. Starting in 2012, there will be reductions in PFS payments for not meeting the eRx requirements. The Centers for Medicare and Medicaid Services (CMS) remind physicians on how to qualify for payments.

In order to qualify for incentive payments EPs must generate an eRx for at least 25 unique patient visits per year. Electronically generated refills without a face-to-face encounter do not qualify. In order to be eligible a professional's Medicare Part B PFS allowed charges with an applicable eRx code should comprise at least 10 percent of the professional's total 2011 estimated allowed charges.

The following codes have applicable eRx G-codes:
90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 90862, 92002, 92004, 92012, 92014, 96150, 96151, 96152, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99345, 99347, 99348, 99349, 99350, G0101, G0108, G0109

EPs must use a qualified reporting system when reporting their eRx program compliance. There are two types of systems: a stand-alone eRx program or an Electronic Health Record (EHR) system with eRx functionality. In order for the system to be considered qualified, it must generate a complete active medication list incorporating electronic data received from applicable pharmacies, select medications, print prescriptions, electronically transmit prescriptions, conduct alerts, provide information on lower cost alternatives (if applicable) and provide information on formulary or tiered formulary medications, patient eligibility, and authorization requirements received electronically from the patient's drug plan.

There are three ways to report participation in the eRx program.

1. Claims-based reporting using G-code G8553 when billing Medicare Part B.
2. Registry-based reporting using a qualified registry to assist in collecting eRx measure data and submitting 2011 data to CMS during the first quarter of 2012.
3. EHR-based reporting using a qualified EHR product submitting 2011 data during the first quarter of 2012.

In order to avoid a payment reduction in 2012, EPs must take the following actions:

- Become a successful electronic prescriber via claims before June 30, 2011.
- Be exempt because you are not a physician, Nurse Practitioner, or Physician Assistant as of June 30, 2011.
- Be exempt because you do not have prescribing privileges and report G-code G8644 at least once on an eligible claim prior to June 30, 2011.
- Claim a hardship exemption using G-code G8642 or G8643, meaning that the EP practices in a rural area without sufficient access to high speed internet or the EP practices in an area without sufficient available pharmacies for electronic prescribing, respectively.

HHS Gives Up To $500 Mil. for Partnership for Patients Program

PROGRAM SEEKS TO REDUCE HARM IN HOSPITALS AND READMISSIONS

A new program mandated by the Affordable Care Act (ACA) will provide up to $500 million to "Hospital Engagement Contractors." These federal contractors will compete to receive the funds from the Department of Health and Human Services (HHS).

"Hospital Engagement Contractors" will take steps to reduce patient harm in hospitals and readmissions. They will be responsible for designing intensive programs to teach and support hospitals in making care safer, training hospitals and care providers, providing technical assistance and establishing and implementing a system to track hospital progress in meeting quality improvement goals.

To apply for an opportunity to get one of these contracts, visit:
https://owa.hhs.gov/owa/redir.aspx?C=f698fd1bdf864392ab1770d8b5d21de6&URL=http%3a%2f%2fwww.fbo.gov

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CMS Proposes Standards for Non-Profit Health Plans

QUALIFYING CO-OPS MAY BE ELIGIBLE FOR GOVERNMENT LOANS

Another type of health insurance plan is on the horizon, so it's time to prepare for another new type of payment structure. The Centers for Medicare and Medicaid Services (CMS) proposed a new rule that would set the ground rules for establishing Consumer Operated and Oriented Plans (CO-OPs).

CO-OPs would be private non-profit entities that have to abide by regulations released by CMS. They also may be eligible for loans from CMS to get started, but the loans would have to be repaid in full plus interest. Any entity receiving a loan would be subject to strict oversight for the repayment period plus 10 years, including audits, reporting requirements, site visits and quarterly financial statements.

Here are some of the proposed regulations:

- "CO-OP members elect the board of directors, a majority of whom must also be enrolled in the CO-OP health plan."
- "CO-OPs are required to use their profits to lower premiums, improve health benefits, improve the quality of health care, expand enrollment or otherwise contribute to the stability of coverage for members."
- "Because a CO-OP relies on its enrollees to help decide the direction of the plan, communication about key features of the plan will be a high priority."

CO-OPs must also participate in the Small Business Health Option Program (SHOP), which would be part of the new state insurance exchanges and give health insurance options to small businesses.

The full proposed rule can be found in .pdf form at:
http://www.ofr.gov/OFRUpload/OFRData/2011-18342_PI.pdf

The Ways of Water

Water makes up 70-75% of the Earth's surface. Roughly 70% of an adult's body is made up of water. Water dissolves more substances than any other liquid. By the time a person feels thirsty, their body has lost over 1% of its total water amount. The weight a person loses directly after intense physical activity is weight from water, not fat.

As you can see, water is essential. However, there are many opinions out there on the topic. Water has its advantages depending on the amount, and time it's consumed. Here are a few expert tips to consider in your daily life:

Challenges of the Month

HOW MUCH?

"Drink 8 glasses of water a day". Though not an official recommendation, it is a good start.

Truth: There is no actual recommended daily allowance (RDA). The 8-glass myth is not exactly a research-based determination, but more so a good estimation. Just like protein, carbs, calories and fat, a person's water needs can be extremely variable. The daily amount of water a person needs depends on factors such as height, weight, level of physical activity, the climate in which they reside, and their age and health status.

New Rule: Drink half of your body weight, in ounces, to help transport nutrients and flush out toxins and waste from your body. Example: You weigh 160 lbs – drink 80oz of water a day or 10 glasses.

Challenge: Drink this amount for two weeks. You may just be pleasantly surprised to see improvements in your skin, hydration of your lips, and the chemical reactions involved with weight loss

WHEN TO DRINK WATER

According to a survey by AllAboutWater.org, the majority of water drinkers do so because of convenience. The most popular reasons for water drinking are post-workout, heat and attempted weight loss.

Truth: For the sake of your kidneys, drink what you want, but "drink a glass of water first," says Dr. David Lee of Wellness Revolution Clinics. For people who rarely drink water, by suddenly doing so, this kicks the kidneys into high gear and detoxifies the body to reduce bloating and swelling. The detoxifying and hydration alone, puts the body in an increased state to be receptive to weight loss. Replacing carbonated beverages with water is highly recommended.

Challenge: Drink water before drinking anything else. This will give your kidneys what they need first. Throughout the day, drink half of your weight in ounces for brighter skin, moist lips and cuticles.

Lastly, take meal times for drinking what you want.

Truth: Drinking water during meals can dilute your stomach acid while it breaks down the foods you eat causing the food to improperly digest.

New Rule: Take mealtime as an opportunity to treat your taste buds.

Challenge: Take your mealtimes to give your body the calcium it needs through milk or some dinner-time antioxidants with a glass of red wine...your taste buds need some attention too.

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Signature Logs and Attestation Statements

CGS RELEASES TIPS ON DOCUMENTATION

A letter released by Jurisdiction C Durable Medical Equipment Medicare Audit Contractor (DME MAC) CGS gives tips on how to avoid denied claims by identifying the author of medical records. Signature logs and attestation statements are two approved methods of ensuring proper documentation.

Signature logs are a single page which attributes the author(s) of a multipage medical record. Each author is paired with their initials or "illegible" signatures which appear throughout the medical record. The signature log must be signed and dated by the author(s) on it.

Attestation statements must be signed and dated by the author of the medical record and contain sufficient information to identify the beneficiary. Here is a sample attestation statement:
"I, _____[print full name of the physician/practitioner]___, hereby attest that the medical record entry for _____[date of service]___ accurately reflects signatures/notations that I made in my capacity as _____[insert provider credentials, e.g., M.D.]___ when I treated/diagnosed the above listed Medicare beneficiary. I do hereby attest that this information is true, accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to administrative, civil, or criminal liability."

New Interest Rate for Medicare Over and Under-Payments

JULY 18, 2011 IS THE EFFECTIVE DATE

The Centers for Medicare and Medicaid Services (CMS) has released the new interest rate for overpayment and underpayments. As of July 18, the new interest rate is 11.50 percent.
The full transmittal 190 can be viewed in .pdf form at:
http://www.cms.gov/transmittals/downloads/R190FM.pdf

Happiness Happens Month

SHARE YOUR SMILE AND SEE IT SPREAD

Since 1998, the Secret Society of Happy People (SOHP) has plagued the United States of America. Through their "Happiness Happens Day" on August 8th, they have spread misery and woe throughout all 50 states. Their evil empire has even managed to take over the entire month of August with their fascist agenda.

All joking aside, this group really exists, and they just want to spread happiness. The three purposes of "Happiness Happens Day & Month" are recognizing and expressing happiness, listening to others talking about their happiness, and not raining on other people's parades.

Mental health problems are a growing concern in the US. According to the National Mental Health Association (NMHA), serious medical depression affects 21 million Americans annually, or 6.7%. Depression also affects 14% of 13 to 18 year olds. Even those not affected by depression could use a smile every once in a while, and the SOHP believes that the best way to do it is as a community. The sunny month of August just so happens to be the perfect time to look on the bright side. For more helpful ways to stay happy, visit: www.sohp.com

CODING CORNER

Q: My pulmonologist has started supervising a pulmonary rehabilitation program for our local hospital. The only code that I could find is G0424. Is that correct, and are there any other codes we could bill for this? He is only supervising and not actually performing any tests.

A: As long as the Dr. is on site/in the suite ready to assist, code G0424 should be just fine, since it does state (includes monitoring).

Q: Do you know where I can find any written documentation stating the physician is responsible for the ICD-9 and CPT codes selected for the patient at the time of visit. We are having a debate with a new physician. Although, we have EMR and an electronic superbill, he believes his NA should enter the codes, both CPT and ICD-9, for the visit. Yesterday, we had a charge for a 99213 for a patent with bilateral first-degree burns of the hands coded as "burns to the trunk NOS" and no documentation of date or place of injury.

A: Please see the E/M service guide (found on CMS' website) by CMS, MLN and AMA. On page 5, it outlines the documentation needed for the medical record, which is more than what you stated your new doc is doing.

Suggestion: Depending on whether the billing office is part of the physician practice, or is separate -
If separate, you may want to look at your contract with the practice and revise it to state the need for ample documentation.
If you are one in the same, you may want to include the process/ requirement for documentation in your office's compliance plan so its part of your practice's process.

Reply from reader: The billing office is part of the practice. As a matter of fact, we are in the process of updating the compliance plan and we will be adding that per your suggestion. Great idea!

Q: When assigning an E/M level, if the patient has a CC [chief complaint], for example cold- respiratory symptoms- and you indicate the recognized elements- in the HPI, do you also include the respiratory system in the review of systems or because it is addressed as part of the chief complaint, it would not be counted as an ROS? I have received conflicting information on this.
On one hand, I was told if a system is part of the CC/HPI, the same system cannot be counted as part of the ROS, but on another I was told you could still count it in both.

A: The ROS, whether problem-pertinent, extended or complete, inquires about the system directly related to the problem identified in the HPI, plus all additional systems (when applicable).

Q: If in the course of a preventive Gynecologic exam a provider detects an abnormality (e.g. an Endo cervical polyp) and refers the patient to a specialist with no additional work up noted, would this justify billing a separate e/m service?
In another situation, if a provider lists an established diagnosis such as autism along with a well-child check – but the patient is followed for that diagnosis by a different practice; the provider doing the preventive exam notes the patient is stable and should continue follow up with other provider, again would this qualify to bill a separate e/m?
In both of these instances, I am thinking no, but am wondering if I am being too strict.

A: An encounter prompts another e/m when the condition is identifiably separate, and treated, not just addressed.
Another way to look at this: take all the components of one encounter and after that, see if there is still enough documentation left to support another encounter.

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