Every year on January 1, the CPT (Current Procedural Terminology) Codes are updated with new, revised and deleted codes. The CPT updates must be reviewed carefully to ensure the practice makes the necessary changes to their billing protocols. There are 700+ changes in CPT for 2017.

2017 CPT updates/additions/deletions click below to access individual specialty listings:

- Anesthesia
- Auditory
- Cardiovascular
- Digestive
- Evaluation & Management
- Eye & Ocular Adnexa
- Genitourinary
- Integumentary
- Maternity Care & Delivery
- Medicine
- Moderate Sedation Changes
- Musculoskeletal
- Nervous
- Pathology & Lab
- Radiology
- Respiratory
- Category II
- Category III


2017 ICD-10 CODE UPDATES
Refer to the 2016 Summer Newsletter (published 09/14/2016) for details regarding the ICD-10 code updates.

2017 PHYSICIAN FEE SCHEDULE (PFS) RULE
A single policy change has impacted the valuation and application of nearly 450 codes in CPT 2017. The change is that CPT no longer defines conscious sedation as an inherent part of any procedure.

See above Moderate Sedation Changes

The complete CMS-1654-F (final) rule is available via the Centers for Medicare & Medicaid Services website: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1654-f.html

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ANESTHESIA ~ MODERATE (CONSCIOUS) SEDATION

There are no new anesthesia codes for 2017, however moderate (conscious) sedation is no longer considered to be inherent in any CPT code. To report moderate (conscious) sedation when provided by the same physician or other qualified health care professional who performs the procedure, see new CPT 2017 codes 99151, 99152, or 99153. To report moderate (conscious) sedation services provided by a physician or other qualified health care professional other than the provider performing the procedure, see new CPT 2017 codes 99155, 99156, or 99157. For 2017, existing CPT codes for moderate sedation 99143-99150 have been deleted.

A new Moderate (Conscious) Sedation guideline section has been added to the Medicine section of the CPT book which includes a quick reference chart. (Source: AAPC CPT 2017 Professional book, page 678)

New HCPCS code for conscious sedation is available for Gastrointestinal (GI) Endoscopy procedures: G0500: Moderate sedation services provided by the same physician or other qualified health care professional performing a gastrointestinal endoscopic service that sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient’s level of consciousness and physiological status; initial 15 minutes of intra-service time, patient age 5 years or older (additional time may be reported if appropriate with +99153 (add-on code) each additional 15 minutes intraservice time.)

4 Levels of Sedation are:
1) Minimal sedation (anxiolysis, not billable)
2) Moderate sedation/analgesia (Conscious sedation)
3) Deep sedation (typically Monitored Anesthesia Care [MAC])
4) General Anesthesia

Modifier QS is limited solely to MAC. Remember if the case is medically directed, the proper modifiers are QX/QK.

<table>
<thead>
<tr>
<th>Total Intraservice Time for Moderate Sedation</th>
<th>Patient Age</th>
<th>Code(s)</th>
<th>Code(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 10 minutes</td>
<td>Any age</td>
<td>Not reported separately</td>
<td>Not reported separately</td>
</tr>
<tr>
<td>10-22 minutes</td>
<td>&lt; 5 years</td>
<td>99151</td>
<td>99155</td>
</tr>
<tr>
<td>10-22 minutes</td>
<td>5 years or older</td>
<td>99152</td>
<td>99156</td>
</tr>
<tr>
<td>23-37 minutes</td>
<td>&lt; 5 years</td>
<td>99151 + 99153 X 1</td>
<td>99155 + 99157 X 1</td>
</tr>
<tr>
<td>23-37 minutes</td>
<td>5 years or older</td>
<td>99152 + 99153 X 1</td>
<td>99156 + 99157 X 1</td>
</tr>
<tr>
<td>30-52 minutes</td>
<td>&lt; 5 years</td>
<td>99151 + 99153 X 2</td>
<td>99155 + 99157 X 2</td>
</tr>
<tr>
<td>30-52 minutes</td>
<td>5 years or older</td>
<td>99152 + 99153 X 2</td>
<td>99156 + 99157 X 2</td>
</tr>
<tr>
<td>53-67 minutes</td>
<td>&lt; 5 years</td>
<td>99151 + 99153 X 3</td>
<td>99155 + 99157 X 3</td>
</tr>
<tr>
<td>(5 min. - 1 hr. 7 min.)</td>
<td>5 years or older</td>
<td>99152 + 99153 X 3</td>
<td>99156 + 99157 X 3</td>
</tr>
<tr>
<td>53-67 minutes</td>
<td>(5 min. - 1 hr. 7 min.)</td>
<td>99151 + 99153 X 4</td>
<td>99155 + 99157 X 4</td>
</tr>
<tr>
<td>68-82 minutes</td>
<td>&lt; 5 years</td>
<td>99151 + 99153 X 4</td>
<td>99155 + 99157 X 4</td>
</tr>
<tr>
<td>(1 hr. 8 min. - 1 hr. 22 min.)</td>
<td>5 years or older</td>
<td>99152 + 99153 X 4</td>
<td>99156 + 99157 X 4</td>
</tr>
<tr>
<td>83 minutes or longer</td>
<td>&lt; 5 years</td>
<td>99153</td>
<td>Add 99157</td>
</tr>
<tr>
<td>(1 hr. 23 min. - etc.)</td>
<td>5 years or older</td>
<td>Add 99153</td>
<td>Add 99157</td>
</tr>
</tbody>
</table>

New HCPCS code for conscious sedation is available for Gastrointestinal (GI) Endoscopy procedures: G0500: Moderate sedation services provided by the same physician or other qualified health care professional performing a gastrointestinal endoscopic service that sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient’s level of consciousness and physiological status; initial 15 minutes of intra-service time, patient age 5 years or older (additional time may be reported if appropriate with +99153 (add-on code) each additional 15 minutes intraservice time.)

4 Levels of Sedation are:
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2) Moderate sedation/analgesia (Conscious sedation)
3) Deep sedation (typically Monitored Anesthesia Care [MAC])
4) General Anesthesia

Modifier QS is limited solely to MAC. Remember if the case is medically directed, the proper modifiers are QX/QK.

PROLONGED NON-FACE-TO-FACE E&M SERVICES:

CPTs:
99358 Prolonged evaluation and management service before and/or after direct patient care; first hour.
99359 + (add-on code) each additional 30 minutes.

The services regardless of place of service (POS) must be performed by the physician or NPP, not clinical staff, and cannot be items that are included in the clinical staff scope of services. Time does not have to be continuous. The date can be a different date from the E&M service, such as review of medical records; and can be billed in relation to any other face-to-face E&M code at any level.
INTERLAMINAR EPIDURAL CODES

For a complete list of CPT updates/deletions for the Nervous system, see page 1 of this newsletter.

CPT 2017 deletes the 4 epidural codes 62310, 62311, 62318 and 62319 and replaces them with 8 new epidural codes. The purpose of the exchange of the 4 old codes with the 8 new codes is to distinguish between interlaminar epidurals done with verses without fluoroscopy.

2017 CPT Code Book excerpt

New codes:

| Deleted codes: |
| 62310 has been deleted. To report, use 62320 |
| 62311 has been deleted. To report, use 62321 |
| 62318 has been deleted. To report, use 62324 |
| 62319 has been deleted. To report, use 62326 |

| New codes: |
| 62320 | Injection(s), of diagnostic or therapeutic substance(s) (e.g., anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, cervical or thoracic, without imaging guidance |
| 62321 | Injection(s), of diagnostic or therapeutic substance(s) (e.g., anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, cervical or thoracic, with imaging guidance (i.e., fluoroscopy or CT) |
| 62322 | Injection(s), of diagnostic or therapeutic substance(s) (e.g., anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, cervical or thoracic, with imaging guidance |
| 62323 | Injection(s), of diagnostic or therapeutic substance(s) (e.g., anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, cervical or thoracic, with imaging guidance |
| 62324 | Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (e.g., anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic, without imaging guidance |
| 62325 | with imaging guidance (i.e., fluoroscopy or CT) |
| 62326 | Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (e.g., anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, lumbar or sacral (caudal), without imaging guidance |
| 62327 | Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (e.g., anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, lumbar or sacral (caudal), with imaging guidance (i.e., fluoroscopy or CT) |

Remember to review Charge Tickets and EHR Templates for appropriate updates!

PHYSICAL/OCCUPATIONAL THERAPY (PT/OT)

*For a complete list of CPT updates/deletions and for full code descriptions and guidelines for the Medicine section, see page 1 of this newsletter.

New Physical Therapy (PT), Occupational Therapy (OT), and Athletic Training (AT) evaluation codes are the first significant changes to CPT physical medicine and rehabilitation codes in two decades. CPT codes 97001-97004 have been deleted.

Replacement Codes solve a long-time problem for practitioners who need a better way to document their assessment and plans for patient care; it is hoped that these new codes will improve future reimbursements as well. Guidelines have also been updated/revised to include several components*, “like E&M codes: History, Examination, Clinical decision making” and the development of plan of care. Providers should review the guidelines carefully to ensure documentation compliance.

New Codes*:

97161 - Physical therapy evaluation: low complexity...Typically, 20 minutes are spent face-to-face...
97162 - Physical therapy evaluation: moderate complexity...Typically, 30 minutes are spent face-to-face...
97163 - Physical therapy evaluation: high complexity...Typically, 45 minutes are spent face-to-face...
97164 - Re-evaluation of physical therapy established plan of care...Typically, 20 minutes are spent face-to-face...
97165 - Occupational therapy evaluation: low complexity...Typically, 30 minutes are spent face-to-face..
97166 - Occupational therapy evaluation: moderate complexity...Typically, 45 minutes are spent face-to-face...
97167 - Occupational therapy evaluation: high complexity...Typically, 60 minutes are spent face-to-face...
97168 - Re-evaluation of occupational therapy established plan of care...Typically, 30 minutes are spent face-to-face...
New Modifier 95: Synchronous Telemedicine Service Rendered via a Real-Time Interactive Audio and Video Telecommunications System.

Requirements to bill Telehealth Services:
- Service furnished must be on the list of telehealth services (Appendix P)
- Service must be furnished via an interactive telecommunication system
- Service must be furnished by an authorized practitioner, i.e., physicians, Nurse Practitioners (NP), Physician Assistants (PA), Clinical Nurse Specialists (CNS), Clinical Psychologists (CP) and Clinical Social Workers (CSW)
- Patient must be at a telehealth originating site, i.e., physician office
- Patient must be an eligible telehealth patient
- Patient must be at a telehealth originating site, i.e., physician office, hospital, Skilled Nursing Facility (SNF), Critical Access Hospital (CAH), Community Mental Health Centers (CMHC), hospital based or CAH renal dialysis center
- Patient must be an eligible telehealth patient


CPT 99024 POST-OP VISITS WITHIN A GLOBAL PERIOD

CPT code 99024 will be used for reporting post-operative services rather than the proposed set of G codes. Reporting will not be required for pre-operative visits included in the global package or for services not related to the patient visit.

Providers are encouraged to begin reporting post-operative visits for procedures furnished on or after January 1, 2017, but the mandatory requirement to report will be effective for visits related to global procedures furnished on or after July 1, 2017.

Only practitioners who practice in groups with 10 or more practitioners, i.e., including non-physician practitioners (NPPs) in Louisiana, Florida and 7 other states, will be required to report post-operative visits on claims furnished during the global period of a specified procedure using CPT code 99024. Providers who only practice in smaller practices or in other geographic areas are encouraged to report data, if feasible.

A transcript of the CMS Town Hall meeting for Global Services is available via: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/CY2017-PFS-FR-Townhall.pdf

RADIOLOGY ~ NEW FX MODIFIER

The Consolidated Appropriations Act of 2016 (Section 502(a)(1)) is titled "Medicare Payment Incentive for the Transition from Traditional X-Ray Imaging to Digital Radiography and Other Medicare Imaging Payment Provision."

It amends the Social Security Act by reducing the payment amounts under the Physician Fee Schedule (PFS) by 20% for the technical component (and the technical component of the global fee) of imaging services that are X-rays taken using film.

To implement this provision, the Centers for Medicare & Medicaid Services (CMS) has created modifier FX (X-ray taken using film). Effective with dates of service on/after January 1, 2017, claims for X-rays using film must include modifier FX. This will result in the applicable payment reduction for which payment is made under the Medicare Physician Fee Schedule (MPFS).

RADIOLOGY ~ MULTIPLE PROCEDURE PAYMENT REDUCTION (MPPR) CUT TO 5%

The 25% Multiple Procedure Payment Reduction (MPPR) on the professional component (PC) of advanced imaging services after the first image, which has been in place since 2012, has now been revised to 5% effective January 1, 2017. This change was mandated in last year’s Congressional omnibus spending bill.

RADIOLOGY ~ MAMMOGRAPHY CODES

CPT codes 77051+, 77052+, 77055, 77056 and 77057 have been DELETED.  + = Add on code

NEW CPT CODES (listed below) were added in order to simplify reporting and bundle computer-aided detection (CAD) in with the mammography. (Also impacts overall WRVUs!)

The Medicare Fee Schedule for 2017 does not include the New CPT codes therefore the descriptors of the G0202, G0204 and G0206 HCPCS codes will be changing to include the CAD like the new CPT codes. Click “Medicare Fee Schedule” above for a link to the correspondence directly from a Novitas Representative.

77065 ~ Diagnostic mammography, including computer-aided detection (CAD) when performed; unilateral
77066 ~ Diagnostic mammography, including computer-aided detection (CAD) when performed; bilateral
77067 ~ Screening mammography, bilateral (2-view study of each breast), including computer-aided detection (CAD) when performed.

Diagnostic mammography is distinct from screening mammography; it is used when a tumor can be palpated or other abnormality is suspected.

HCPCS CODE UPDATES

There are a total of 272 new Healthcare Common Procedure Coding System (HCPCS) codes, 146 deletions and 127 revised codes for 2017.

A complete alpha-numeric listing of the HCPCS codes are available via the Centers for Medicare & Medicaid Services website: https://www.cms.gov/medicare/coding/hcpcsreleasecodesets/alpha-numeric-hcpcs.html


Excerpt:
URINE DRUG SCREEN (UDS)

For a complete list of CPT updates/deletions and for full code descriptions and guidelines for the Medicine section, see page 1 of this newsletter.

Effective January 1st 2017 there are new presumptive screening CPT Codes (80305 - 80307), these will replace the existing AMA CPT codes (80300 - 80304) and CMS HCPCS codes (G0477 - G0479) for presumptive drug testing.

New CPT Screening Codes:

80305 - Drug test(s), presumptive, any number of drug classes, qualitative; any number of devices or procedures, (e.g., immunoassay) capable of being read by direct optical observation only (e.g., dipstick, cups, cards, cartridges) includes sample validation when performed, per date of service (replaces: 80300 or G0477).

80306 - Drug test(s), presumptive, any number of drug classes, qualitative; any number of devices or procedures, (e.g., immunoassay) read by instrumented assisted direct optical observation (e.g., dipstick, cups, cards, cartridges) includes sample validation when performed, per date of service (replaces: 80300 or G0478).

80307 - Drug test(s), presumptive, any number of drug classes, qualitative; any number of devices or procedures, by instrument chemistry and analyzers (e.g., utilizing immunoassay [EIA, ELISA, EMIT, FPIA, IA, KIMS, RIA]), chromatography (e.g., GC, HPLC), and mass spectrometry either with or without chromatography, (DAT, DESI, GC-MS, GC-MS/MS, LC-MS, LC-MS/MS, LDTD, MALDI, TOF) includes sample validation when performed, per date of service (replaces: 80301, 80302, 80303, 80304 and G0479).

There are no planned changes to the AMA and CMS definitive drug testing CPT codes (80320 - 80377) and HCPCS codes (G0480 - G0483).

The Clinical Laboratory Fee Schedule (CLFS) Preliminary Determination reveals that beginning January 1st 2017 the national fee schedule, unadjusted by geographic location, is being increased for 4 UDS confirmation/definitive codes:

<table>
<thead>
<tr>
<th>Code</th>
<th>2016</th>
<th>2017</th>
<th>Positive Adjustment</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0480</td>
<td>$79.94</td>
<td>$117.65</td>
<td>$37.71</td>
</tr>
<tr>
<td>G0481</td>
<td>$122.99</td>
<td>$160.99</td>
<td>$38.00</td>
</tr>
<tr>
<td>G0482</td>
<td>$166.03</td>
<td>$204.34</td>
<td>$38.31</td>
</tr>
<tr>
<td>G0483</td>
<td>$215.23</td>
<td>$253.87</td>
<td>$38.64</td>
</tr>
</tbody>
</table>

The above table references the fee schedule for Louisiana.

The following requirement verbiage has been added to each of the 4 confirmation codes.

A confirmation test must utilize: "(2) stable isotope or other universally recognized internal standards in all sample (e.g., to control for matrix effects, interfaces and variations in signal strength), and (3) method or drug-specific calibration and matrix-matched quality control material (e.g., to control for instrument variations and mass spectral drift)."

Resources:

CMS Clinical Laboratory Fee Schedule:

Palmetto GBA, 2017 Controlled Substance Monitoring and Drugs of Abuse Coding and Billing Guidelines:

Remember to review Charge Tickets and EHR Templates for appropriate CPT updates
AND
Review the Practice’s CLIA level and expiration date!
**JW MODIFIER used on ALL J CODES for WASTAGE**

Per the CMS MedLearn Matters article MM9603 (transmittal # R3508CP), effective 01/01/2017, providers are **required** to use the JW modifier to bill for discarded/unused Part B drugs or biologicals from **single use vials** or **single use packages** that are appropriately discarded.


Remember to **document the discarded drug/biological** in the patient’s medical record!

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**MEDICINE ~ INFLUENZA VACCINE CODES**

*For a complete list of CPT updates/deletions and for full code descriptions and guidelines for the Medicine section, see page 1 of this newsletter.*

Influenza Vaccine CPT codes* 90655, 90656, 90657, 90658, 90685, 90686, 90687, and 90688 have been revised to change the patient age specific information in the descriptors to dosage information.

New CPT code **90674** Influenza virus vaccine, quadrivalent (cclV4) derived from cell cultures, subunit, preservative and antibiotic free, 0.5 mL dosage, for intramuscular use.

This code is for the supply of a vaccine that covers four strains of influenza, subtypes A and B.


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**RELATIVE VALUE UNIT (RVU) REDUCTIONS**

The Center for Medicare & Medicaid Services (CMS) is phasing in the first large Relative Value Unit (RVU) reductions based on the new final policy (see link on page 1 to the final rule). Mis-valued codes that had their RVUs cut by more than 20% will begin to have their new values phased in this year in 19% per year increments.

For example, if a code is revalued with a 50% reduction, providers will see a 19% reduction the first year, 19% the second year and the remaining 12% in the third year, i.e., 19% + 19% + 12% = 50% reduction.

The phased-in reduction applies only to mis-valued codes that are not new or revised.

There are roughly 47 effected codes for 2017, including diagnostic incision of larynx (31320), treatment of bladder lesion (51700), cystoscopy (52000), and laminectomy with spinal cord incision (63195, 63197)

Details for the Final Rule (CMS 1654-F) is available via the CMS Website: [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1654-F.html](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1654-F.html)

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**HEALTH AND BEHAVIOR ASSESSMENT/INTERVENTION**

Deleted CPT 99420 Administration and interpretation of health risk assessment instrument (eg. health hazard appraisal)

2 New codes:

**96160** Administration of patient-focused health risk assessment instrument (eg. health hazard appraisal) with scoring and documentation, per standardized instrument

**96161** Administration of caregiver-focused health risk assessment instrument (eg. depression inventory) for the benefit of the patient, with scoring and documentation per standardized instrument.

**Guidelines (per CPT book):**

Health and behavior assessment procedures are used to identify the psychological, behavioral, emotional, cognitive, and social factors important to the prevention, treatment, or management of physical health problems. The focus of the assessment is not on mental health but on the biopsychosocial factors important to physical health problems. The focus of the intervention is to improve the patient’s health and well being utilizing cognitive, behavioral, social and/or psychophysiological procedures designed to ameliorate specific disease-related problems.
CPT CODE 99070: SUPPLIES AND MATERIALS

When it comes to billing for supplies, most providers take one of three routes:

- Bill for every supply and let the insurer decide when it’s bundled.
- Bill for no supplies and assume they are all bundled.
- Report 99070 with everything and hope that insurers will universally apply it to the claims.

Improve your practices supply reimbursement by using a specific Healthcare Common Procedure Coding System (HCPCS) code whenever one is available and stay away from the generic CPT code 99070 (Supplies and materials [except spectacles], provided by the physician or other qualified healthcare professional over and above those usually included with the office visit or other services rendered [list drugs, trays, supplies, or materials provided]). Workers’ Comp carriers may be the exception.

HCPCS level II codes are some of the most overlooked and misreported items, but insurers often reimburse these supplies.

Insurance companies are more likely to pay for a HCPCS code rather than 99070, because 99070 is so general and there is an added burden of additional paperwork, i.e., noting the item’s description and attaching a copy of the invoice.

EXAMPLE: If the provider sees a patient for a sprained ankle and wraps it with an ACE bandage; the provider would report 99213 for the E&M visit AND HCPCS code S8431 (compression bandage, roll) as this supply is not included in the E&M visit code.

If the physician performs true “strapping” (CPT 29540), then the ACE bandage expense would be included in the strapping code.

Source: Part B Insider Vol 18, No 1

NATIONAL CORRECT CODING INITIATIVE (NCCI/CCI)

Watch for our Quarterly News Blast!

There are multiple policy updates that will be effective January 1, 2017. Visit the CMS website for the CCI Policy Manual: https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html?redirect=/nationalcorrectcodinitiated/

Cerumen-removal policy: “Removal of cerumen by an audiologist prior to audiologic function testing is not separately reportable”. Audiologists are not permitted to report CPTs:

- 69209 (Removal impacted cerumen using irrigation/lavage, unilateral)
- 69210 (Removal impacted cerumen requiring instrumentation, unilateral)

on the same date of service as audiologic function testing.

If the audiologist refers the ear-wax removal to another provider, the provider who performs the service should report code G0268 (Removal of impacted cerumen (one or both ears) by physician on same date of service as audiologic function testing).

See prior updates via the MEDTRON 122016 News Blast: NCCI Versions 22.1, 22.2, 22.3

Episode of care clarification: “An episode of care begins when a patient arrives at a facility for treatment and terminates when the patient leaves the facility.”

MULTIPLE ENDOSCOPY RULE

CPT® and the Centers for Medicare & Medicaid Services (CMS) classify endoscopic procedure codes by “family,” where each family is comprised of related services. Each family has a “parent” code—called the endoscopic base code—that represents the most basic version of that endoscopic service.

Usually, the base code is the first-listed code within a sequence of codes in CPT®. A no fail way to find the endoscopic base code within each family is to consult the Medicare Physician Fee Schedule Relative Value File. The Relative Value File is updated at least annually (and often several times per year).

The file is available via the CMS website: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html

The column labeled “ENDO BASE” identifies the parent code for every endoscopic procedure. If there is no code in the “ENDO BASE” column, the code in column “A” is the base code. Confirm the multiple—scope rule applies to a given code if you find indicator “3” in the “MULTI PROC” column.
TIPS for SEAMLESS CONSULTATION CODING for NON GOVERNMENT PAYERS

When Medicare stopped paying consultation codes in 2010, and LA Medicaid followed in 2015, many providers thought that was the end of their consult coding days. However CPT did not do away with the consult codes, and consequently many private payers still reimburse for the service.

Ensure you are reporting consultations correctly with the below tips.

Know the Ropes of Consults:
The definitions for CPT® consultation codes 99241-99245 state that they are for new or established patients. The applicable codes are as follows:

99241 – Office consultation for a new or established patient, which requires these 3 key components: a problem focused history; a problem focused examination; and straightforward medical decision making ...

99242 – Office consultation for a new or established patient, which requires these 3 key components: an expanded problem focused history; an expanded problem focused examination; and straightforward medical decision making ...

99243 – Office consultation for a new or established patient, which requires these 3 key components: a detailed history; a detailed examination; and medical decision making of low complexity ...

99244 – Office consultation for a new or established patient, which requires these 3 key components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity ...

99245 – Office consultation for a new or established patient, which requires these 3 key components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity ...

The key to consult reimbursement is that the documentation has to meet the three key components and include a:

- Request for the provider’s opinion, which includes…
- Reason for the requested service in order to develop an opinion (the consult visit)
- Report back to the requesting provider with the rendering provider’s opinion

After the rendering provider creates an opinion and potentially treats the condition, correspondence should be sent back to the requesting provider stating the rendering provider’s opinion and that the patient is being returned. Include details of the plan of care that is stated in the original correspondence, provide an update as to how it worked out, inform of any modifications that were made to the plan of care and provide the status of the patient.

Invite the requesting provider to not hesitate in sending the patient back if they have any further problems. If the consulting provider feels that the condition he/she consulted for and treated needs regular monitoring, relay to the requesting provider when the patient should check in with the office so the consulting provider can monitor how the patient is doing (for example, return once per year).

CAUTION: Use of the words “referring physician” indicates that the patient is being sent to the consulting provider to take over the care of the patient.

Ask for the consultant to render his/her opinion in their area of specialty!

Source: Part B Insider Vol 17 no. 38
TEST YOUR CODING SKILLS

Evaluation & Management (E&M):
Scenario: The provider did not perform a physical exam after an E&M encounter for a follow-up patient but did obtain a complete history and vitals. A detailed treatment plan was prepared for the patient. Can an E&M service be reported?

Answer: Notice the descriptors for “established” E&M codes (99212-99215) (Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components...) state that only two of the three key components: history, examination and medical decision-making are required for an “established” E&M visit.

Since the patient’s history was documented and a treatment plan was drawn up, and because the patient is an “established” patient, two of the three components were met, in this case the physical examination is not needed to report the E&M code for the established visit. However, since the case states the provider recorded the vitals, the vitals (an element of the exam component) this would qualify as a problem focused examination that satisfies the third of the three components if this was a new patient visit where all three key components are required.

Pediatrics:
Scenario: A six year old male patient comes to the office and his mother says he makes a grunting sound every few minutes. The mother asks the provider to determine whether the boy has Tourette’s disorder, but the provider doesn’t find anything wrong with the child other than the vocal tick, what ICD-10 code should be used?

Answer: If the provider diagnoses the child with a chronic vocal tick disorder, the appropriate code is F95.1 (Chronic motor or vocal tick disorder). Some providers/coders may overlook this code if the patient doesn’t have a motor tic, but keep in mind the use of the word “or” in the descriptor, meaning it can be used for either a vocal tic or a motor tic.

Avoid reporting the Tourette’s disorder diagnosis (F95.2) because the provider did not diagnose the patient with the disorder. If the provider determines that the patient’s vocal tick is from a different tic disorder that isn’t listed in the ICD-10 manual, report F95.8 (Other tic disorders).

Obstetrics/Gynecology (OB-GYN):
Scenario: A patient comes back in for a Pap smear due to abnormal results, what ICD-10 code(s) should be used and why?

Answer: ICD-10 code R87.61 (Abnormal cytological findings in specimens from cervix uteri...) should be reported if the OB-GYN repeats the Pap smear due to abnormal results. This code requires a sixth character.

Otolaryngology:
Scenario: A patient comes into the office with a post-tonsillectomy hemorrhage. Does the tonsillitis diagnosis apply to the visit? Or is there an aftercare code that fits more appropriately?

Answer: In this situation, since tonsillitis is coded to the respiratory system, the correct code choice is J95.830 (Postprocedural hemorrhage of a respiratory system organ or structure following a respiratory system procedure). This is a more accurate ICD code than using a tonsillitis code, since the patient no longer has tonsillitis.

BILL for PREVENTATIVE and SICK VISITS on the SAME DATE of SERVICE
Carriers, including Medicare* and Medicaid, are aggressively promoting preventative visits. Providers CAN bill for a preventative E&M service AND a problem oriented (sick) E&M service on the same day (when appropriate) and be reimbursed for both by adding modifier 25 to the E&M code for the problem oriented (sick) visit. Medical records must have documentation to justify both services independent of each other.

* Medicare continues to not pay CPT 99381-99397, see the Preventive Services/Screenings section of the Novitas Solutions website.

CPT guidelines state: “The abnormality (Z00.121) or pre-existing problem found during the preventative exam must be significant enough to require additional work to perform all the components of the problem oriented (sick) E&M service.”

Modifier 25 must be added to the problem oriented (sick) E&M code with a sick ICD. Blue Cross/Blue Shield Clear Claim example:

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Procedure Code</th>
<th>Date of Service</th>
<th>Description</th>
<th>ICD Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allow</td>
<td>90391</td>
<td>01/03/2017</td>
<td>PER PM REVAL EST PAT INFANT</td>
<td>Z00.121</td>
</tr>
<tr>
<td>Allow</td>
<td>99212</td>
<td>01/03/2017</td>
<td>OFFICE/OUTPATIENT VISIT EST</td>
<td>J95.830</td>
</tr>
</tbody>
</table>

See MEDTRON’S 111616 News Blast: Educational Series—Modifier 25 for more detailed information!
MODIFIER AND ICD-10 BILLING REMINDER

Remember when billing CPT Modifiers LT/RT/50 the appropriate ICD-10 codes with the ‘left’ and/or ‘right’ and/or ‘bilateral’ designations must be used. Failure to follow these laterality guidelines will result in a denial of the claim.

ICD-10 FIRST-LISTED DIAGNOSIS - ‘CODE FIRST’

Since the implementation of ICD-10-CM, there has been some confusion and incorrect information disseminated about how the first-listed diagnosis code should be determined. Below are some of the biggest issues associated with coding signs and symptoms, sequencing, and episode of care (see definition on page 8 of this newsletter). If an incorrect diagnosis is placed in the first diagnosis pointer position when the ‘Code First’ rule applies, the claim will result in a denial. Any special coding guidelines can be found in the Official Coding Guidelines Section for ICD-10-CM.

Rule 1: (Section I.C.18.a.)
"Codes that describe symptoms and signs are acceptable for reporting purposes when a related definitive diagnosis has not been established (confirmed) by the provider."

For example, if the provider is unsure if there is an intervertebral disc disorder caused by the accident until the MRI results get back, go ahead and code the symptoms. Never report a diagnosis code for a condition or injury that the provider has not yet confirmed to be present in the documentation.

Rule 2: (Section I.C.18.b.)
"Codes for signs and symptoms may be reported in addition to a related, definitive diagnosis when the sign or symptom is not routinely associated with that diagnosis, such as the various signs and symptoms associated with complex syndromes. The definitive diagnosis code should be sequenced before non routine associated symptom codes. Signs or symptoms that are associated routinely with a disease process should not be assigned as additional codes, unless otherwise instructed by the classification."

Knowing the commonly associated signs and symptoms of a particular condition/injury is key for this rule. Many injuries are commonly associated with redness, pain, swelling, effusion, inflammation, and stiffness; but if the normal timeframe for seeing these symptoms has passed, their presence may indicate another problem. Providers should clearly identify signs and symptoms that should be coded, compared to those inherent to the injury or condition, in the documentation.

The ICD-10 book should be referenced often as ‘Code First’ notes present under the applicable codes, see page 10 of MEDTRON’s 2016 Summer Newsletter (available via https://www.medtronsoftware.com/pdf/2016/2016_SUMMER_NEWSLETTER.pdf). The Remittance Advice Remark Code (RARC) typically used for ‘Code First’ denials is M76: “Missing/incomplete/invalid diagnosis or condition.”

Upon receipt of the denial, correct the claim with the appropriate diagnosis code in the ‘A’ pointer position.

**REMINDER:** Category Z3A ‘Weeks of Gestation’ ICD-10 codes CANNOT be used as a primary diagnosis code under ANY conditions; the result will be a M76 denial from the carrier.

Example:
D63.1 cannot be keyed in the 1st position.
A diagnosis from the N18 section must be keyed in the 1st position.
ICD-10 7th CHARACTER ASSIGNMENT ~ REVISITED

Episode of Care (see definition on page 8 of this newsletter)
Most injury codes require a 7th character to identify the episode of care being provided:
- "A" is for initial encounter (active care),
- "D" is subsequent encounter (during the healing phase), and
- "S" is for sequela (after effects of an injury that show up after the patient has healed).
Whether you code for a physical therapist or other specialty, the rules apply the same to all.
Any special coding guidelines will be found in the Official Coding Guidelines Section for ICD-10-CM.

Claims submitted with the wrong code will be denied, causing delays in payments and additional costs in appeals. To avoid such issues, as they relate to ICD-10-CM code reporting, keep in mind the following guidelines taken directly from Chapter 19 of the Official Coding Guidelines - 2017 ICD-10-CM:

Initial Encounter (Section I.C.19.1.c)
"Traumatic fractures are coded using the appropriate 7th character for initial encounter for each encounter where the patient is receiving active treatment for the fracture. The appropriate 7th character for initial encounter should also be assigned for a patient who delayed seeking treatment for the fracture or nonunion."

If you are part of the active care for the injury, then report the 7th character "A." An example of this might be for a patient who sustained a lumbar strain, whose primary care ruled out any intervertebral disc disorders and referred him to physical therapy to increase strength and range of motion and reduce stiffness and pain. If active care is provided, the documentation should also state, "Therapy is for active care."

Subsequent Encounter (Section I.C.19.1.c)
"Fractures are coded using the appropriate 7th character for subsequent care for encounters after the patient has completed active treatment of the fracture and is receiving routine care for the fracture during the healing or recovery phase."

If the patient is receiving treatment, after the active phase of care is completed, this is considered "subsequent care" or care given during the healing phase of the injury. Good examples of this include improving function of a body part after an injury that required surgery. The surgery was the active care and the therapy is the subsequent or healing phase. Once again, be sure the documentation reflects the episode of care properly to support code selection by stating "Subsequent care provided."

Application of 7th Character (Section I.C.19.1.a)
"While the patient may be seen by a new or different provider over the course of treatment for an injury, assignment of the 7th character is based on whether the patient is undergoing active treatment and not whether the provider is seeing the patient for the first time."

AFTERCARE Z CODES
"The aftercare Z codes should not be used for aftercare for conditions such as injuries or poisonings, where 7th characters are provided to identify subsequent care. For example, for aftercare of an injury, assign the acute injury code with the 7th character "D" for "subsequent encounter."

A patient who undergoes joint replacement surgery for an osteoarthritic knee would report aftercare using a Z code, while a patient who underwent repair of an ACL tear injury would use the injury code originally used to report the injury along with the 7th character (A, D, or S) to report the aftercare.
Everyone follows the same rules, unless the rules contain something individual to the specialty or location, i.e., Z51.0 Encounter for antineoplastic radiation therapy and Z51.1 Encounter for antineoplastic chemotherapy and immunotherapy.

Denials received include Claim Adjustment Reason Codes (CARC): 4, 11 146; Remark Adjustment Reason Codes (RARC): M64, M76, MA63, N46 & N657 ~ see the Washington Publishing Company's website for code descriptions.
Auditing will begin to focus more and more on accuracy, following the guidelines, and proving medical necessity through proper ICD-10-CM code reporting.