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Family Practice Coding Alert

The practical adviser for ethically optimizing coding, payment, and efficiency in family practices

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In this issue

Reader Questions

Code Changes

CPT® 2012 Includes Intradermal Flu Vaccine Option With 90654

Don't miss revisions to other vaccine, E/M codes.

CPT® 2012 goes into effect in a matter of weeks, so prepare now for new and revised choices related to vaccine administration and prolonged E/M service to ensure your claims stay accurate.

Look for Official Inclusion of 90654

CPT® 2012 adds another choice to your flu vaccine coding with the inclusion of 90654 (*Influenza virus vaccine, split virus, preservative-free, for intradermal use*). The addition expands on the code family 90655-90668 that already addressed influenza vaccines.

Two factors separate 90654 from many of the other flu vaccine codes:

» Code 90654 is not age specific, whereas codes 90655-90658 specify the patient's age (either 6 to 35 months of age, or age 3 years and older).
» Code 90654 represents an intradermal injection (administered to the dermal layer of skin), whereas other codes (e.g. 90655-90658 and 90662) describe intramuscular injections (administered to muscle tissue) and intranasal administration (e.g. 90660).

Tip: Code 90654 represents the vaccine product only. Include the appropriate administration code (90460-90474) on your claim. If your physician provides a significant, separately identifiable E/M service during the encounter for the vaccine, also report the appropriate E/M code (99201-99205 for a new patient or 99211-99215 for an established patient).

Although 2012 will be the first time 90654 is included in the CPT® book, the code has been in existence for more than a year. The American Medical Association released 90654 in July 2010 and implemented the code in January 2011. The code achieved FDA approval status in May 2011.

"The CPT® coding process allows for development of new codes and numbers, but they don't become active until FDA approval," explains **Richard L. Tuck, MD, FAAP,** a pediatrician at PrimeCare of Southeastern Ohio in Zanesville.

Heads up: "Most payers won't pay for vaccines until they're FDA approved," Tuck adds. "Even after approval, there can be a lag time from three to six months until payers pick up on the fully approved code."

Note Extra Specificity of 90460-90461

Several other vaccine and vaccine administration codes undergo revision for CPT® 2012. Revised codes include (underline indicates change):

» 90460 – *Immunization administration through 18 years of age via any route of administration, with counseling by a physician or other qualified health care professional; first or only component of each vaccine or toxoid administered*. "I believe that 'or only component of each' was added to clarify that you can still use this code if it's a single component vaccine," says **Kent J. Moore,** manager of healthcare delivery and financing systems for the American Academy of Family Physicians (AAFP) in Leawood, Kan. "The previous reference only to 'first' may have confused some people into thinking that 90460 could only be used in a situation where there was both a first and second component."
» +90461 – *... each additional vaccine or toxoid component administered (List separately in addition to code for primary procedure)*
» 90581 – *Anthrax vaccine, for subcutaneous or intramuscular use*. "I believe 'intramuscular' was added to reflect that alternative mode of administration, which was otherwise missing from the descriptor," Moore says.
» 90644 – *Meningococcal conjugate vaccine, serogroups C & Y and Hemophilus influenza B vaccine (Hib-MenCY), 4 dose schedule, when administered to children 2-15 months of age, for intramuscular use*. The descriptor previously included tetanus toxoid conjugate so the vaccine was abbreviated as Hib-MenCY-TT.

In addition, CPT® 2012 deletes vaccine codes 90470 (*H1N1 immunization administration [intramuscular, intranasal [including counseling when performed*) and 90663 (*Influenza virus vaccine, pandemic formulation, H1N1*). "These codes were probably considered no longer needed, especially with the addition of codes 90664-90668 in 2011," Moore says.

Learn Timeframes for Observation, Prolonged Care

E/M codes for observation services and prolonged care clarify timeframes and providers with CPT® 2012 revisions.

Observation times: Effective Jan. 1, 2012, each code for initial observation care (99218-99220) specifies the amount of time a physician typically spends at the patient's bedside or on the patient's hospital floor. Code 99218 (*Initial observation care, per day, for the evaluation and management of a patient which requires these 3 key components ...*) represents 30 minutes, code 99219 represents 50 minutes, and 99220 represents 70 minutes.

Prolonged service: Codes +99354-+99359 delete "physician" and "face-to-face" requirements from the descriptors, which opens the door for other providers in your practice to submit the codes when appropriate. For example,

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the new descriptor for +99354 will read: *Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service; first hour (List separately in addition to code for office or other outpatient Evaluation and Management service)*.

Track Tobacco Cessation With Revised 4004F

CPT® 2011 introduced a new Category II code for patients who are screened for tobacco use and counseled about tobacco cessation. You'll have a revised version of the code to report when Jan. 1, 2012 rolls around: 4004F (*Patient screened for tobacco use AND received tobacco cessation intervention [counseling, pharmacotherapy, or both], if identified as a tobacco user [PV, CAD]*).

Background: Category II codes are a set of tracking codes that are intended to be used for performance measurement, according to **Denae M. Merrill, CPC,** a coder for Covenant MSO in Saginaw, Mich. As such, Category II codes are the "common denominator" for PQRS reporting, so it's in your best interest to report them when appropriate. ❑

Rural Care

Protect Your Bottom Line: Implement These Revalidation Letter Requirements

Here's the lowdown on how these CMS changes apply to your practice.

If you're a rural healthcare provider, you'll want to know the latest news CMS officials discussed during an Open Door Forum call on October 18. Read on for a few highlights about revalidation letters that your practice might need to know.

Watch for Your Revalidation Letter From CMS

As part of the Patient Care and Affordable Care Act (section 6401(a)), all new and existing Medicare providers must be reevaluated under new screening criteria that went into effect March 25, 2011. All enrolled providers and suppliers must revalidate their enrollment information every five years, to ensure that Medicare has the most current information on file.

"If your physician is newly enrolled on or after March 25, 2011, you're not affected by this effort," **Sabeen Chong, CPI,** said during the call.

Revalidation letters will be sent on a regular basis over the next year or more. "Phase one is in effect, and the first group of providers and suppliers have received their letters," Chong said.

Consequence: Failure to submit complete enrollment application(s) and supporting documentation within 60 calendar days of receiving your revalidation letter could result in Medicare billing privileges being deactivated. Physicians shouldn't be so anxious to comply that they jump the gun, however.

"Don't try to revalidate until you hear from your contractor," Chong warned. "If you respond in a timely manner once you hear from the contractor, it shouldn't interrupt your payment cycle."

Providers and suppliers can enroll in the Medicare program by paper application or by using the

(Continued on next page)

Internet-based Provider Enrollment, Chain, and Ownership System (PECOS).

Follow up: CMS will be posting a list of providers who should have received their notices on the CMS website. "You can check the list to be sure you're acting on things appropriately," Chong said. A listing of providers who have been sent a letter as part of Phase I is currently available in the "Downloads" section of the following web page: http://www.cms.gov/MedicareProviderSupEnroll/11_Revalidations.asp#TopOfPage The list includes provider names, NPIs, and dates the letters were mailed.

So, while you are waiting for your letter, check the list periodically (once a month or so) to see if it's been mailed and keep your eyes open for such a letter from your MAC. When you do receive your letter, respond promptly (i.e., within 60 days) by completing the necessary enrollment application, either virtually in PECOS or on paper, if necessary. If you're on the list and have not received your letter, then contact your MAC immediately for more information on what you should do and ask them to possibly fax or e-mail you a copy of the letter in this regard.

Cost: Prepare now for a bottom-line hit when your practice goes through the Medicare revalidation process. "It will cost about $500 per provider," says **Barbara Berg,** clinic administrator for Lake Chelan Clinic in Chelan, Wash. ❑

Version 5010

The Countdown's On for Electronic Transaction Changes Jan. 1

Compliance, payment, and ICD-10 hang in the balances

Are you ready to say goodbye to version 4010/4010A1 for electronic transactions? You'll need to be, starting Jan. 1, 2012, when your practice should be fully functional with version 5010 to comply with the Health Insurance Portability & Accountability Act of 1996 (HIPAA) electronic transaction standards.

Consequence: If you don't have your 5010 glitches worked out by January, you won't be able to submit electronic transactions to Medicare and potentially other payers, as well.

Prepping for ICD-10

Version 5010 lays out the technical electronic standards mandated for HIPAA transactions: claims, eligibility inquiries, remittance advice, and payment data using ICD-10.

The current version -- 4010/4010A1 -- does not accommodate the ICD-10 code set. That's why CMS will require version 5010 for use by all HIPAA-covered entities (providers, health plans, clearinghouses, and their business associates, including billing agents) as of Jan. 1, 2012. Implementing the 5010 form in 2012 gives time for testing and implementation before ICD-10 takes effect on Oct. 1, 2013.

Beware of 5010 Glitches

Experts familiar with the 5010 conversion say you should prepare for several common pitfalls before implementation.

Fix the P.O. box: Under the new 5010 standards, the place of service address (the doctor's practice office location) cannot be a P.O. box. It must be a street address, says **Robert B. Burleigh, CHBME,** president of Brandywine Healthcare Services in West Chester, Penn. If it isn't a street address, the claim will reject. Fixing the problem is up to you. "The vendor doesn't have control of the provider master list – the practice

or billing company has to make sure that address is a street address," Burleigh says. Your "pay to" address can continue to be a P.O. box, however.

Update patient info: Dig into your claim forms now to ensure that the beneficiary's information is accurate to the letter, or you'll face scores of denied claims with the new HIPAA version 5010. That's because CMS will deny claims with a beneficiary's name that doesn't perfectly match how it's listed on the Medicare I.D. card. Along with the patient's last name, you need to be sure you include suffixes, such as Jr. or Sr.. Additionally, the date of birth you put on the claim form must match exactly what the Social Security Administration has on file.

New remark codes: CMS will use several new error codes on claims once the 5010 version goes into effect. If you use a clearinghouse, you should discuss with them how they'll communicate these errors to you, and how these changes will impact your practice.

Check your ZIP codes: You must include 9-digit zip codes with billing and service facility locations. Five-digit zip codes will not be sufficient.

Think 5010 Even for Non-Medicare Patients

Even practices that don't treat many Medicare patients should know about the transition to 5010.

"Either directly or indirectly, HIPAA Version 5010 will impact nearly everyone involved in healthcare transactions – providers, clearinghouses, and payers, as well as vendors who provide practice management (PM) systems and other transaction-related software(s)," says **Kim Dues, CPC,** owner of Mass Medical Billing Services in Dickinson, Tex. "It is mostly a complex technical issue for those on the business and administrative side. Although, if the implementation doesn't go smoothly, it will affect all." ❑

ICD-10

Train Physicians Now for Extra Osteoarthritis Documentation in 2013

Unspecified location? Look to the M19 codes.

When ICD-9 becomes ICD-10 in October 2013, physicians will need to be more conscious of documentation when noting a patient has osteoarthritis. Current diagnosis choices (e.g., 715.xx) specify the arthritis location and whether it is primary or secondary to other conditions.

ICD-10 difference: Under ICD-10, you'll have several code families to search for the best diagnosis:

» M15 (*Polyosteoarthritis*)
» M16 (*Osteoarthritis of hip*)
» M17 (*Osteoarthritis of knee*)
» M18 (*Osteoarthritis of first carpometacarpal joint*)
» M19 (*Other and unspecified osteoarthritis*).

Each code is broken down into location, primary, and secondary like your ICD-9 codes, but they also sometimes specify unilateral, bilateral, and posttraumatic indications. For example, the most accurate diagnosis for a patient with primary OA of the right knee would be M17.11 (*Unilateral primary osteoarthritis, right knee*). The code would change to M17.12 for left knee or M17.0 for bilateral primary OA of the knee.

Documentation: To submit the most detailed diagnosis, the physician will need to expand documentation to include notes regarding unilateral, bilateral, and/or post-traumatic conditions. Some key terms to watch for include "osteoarthritis," "arthritis," "arthrosis," "DJD," "arthropathy," "post traumatic arthritis," and "traumatic arthritis."

Coding tips: You often find "unspecified" diagnoses in ICD-9 with codes representing more specific diagnoses for the same condition (as in, the .x9 choice in most

(Continued on next page)

You Be the Coder

Choose the Correct Code for Kenalog Injections

Question:
How should I report an intra-epididymal injection of Kenalog?

South Carolina Subscriber

Answer: See page 86. ❑

ICD-9 categories). ICD-10 changes that by listing all "unspecified" diagnoses at the end of the condition category. For example, codes M19.90--M19.93 represent unspecified locations of osteoarthritis.

In addition, traumatic osteoarthritis is now more appropriately indexed and described as post-traumatic osteoarthritis, the true condition. ❑

Reader Questions

Turn to 99214 to Give Credit for Extra Time

Question:
Our family physician spends a lot of time discussing treatment options, imaging results, and other issues with patients. How should she document these activities to support coding E/M based on time?

Arizona Subscriber

Answer:
When counseling and/or coordination of care take up more than 50 percent of the encounter, and you choose to code based on time, CPT®'s E/M guidelines state, "the extent of counseling and/or coordination of care must be documented in the medical record." Medicare's 1995 and 1997 E/M documentation guidelines add that the physician should document the total length of the encounter and "describe the counseling and/or activities to coordinate care."

In the office or outpatient setting, you should count face-to-face time. In the hospital or in a nursing facility, you can count floor/unit time, according to both CPT® guidelines and Medicare's documentation guidelines. CPT® guidelines describe the encounter as a "physician/patient and/or family encounter."

Example: The physician might document spending 20 minutes of a 25-minute encounter with an established patient discussing test results and going over the likely outcome of a procedure (she should be specific when documenting the test results). The physician fills in the remaining details of the visit, as appropriate. In this case, based on the 25-minute session, you could report 99214 because the code specifies the visit usually lasts 25 minutes. The full descriptor reads: *Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.* ❑

For E/M, 3 'Vitals' Equals 1 Exam Bullet

Question:
Would you please explain how taking the vital signs contributes to determining the E/M service's physical exam?

Georgia Subscriber

Answer:
Checking any three of seven vital signs will count as one bullet in the physical exam, based on the current (1997) documentation guidelines for E/M services, which you can find at (www.cms.gov/MLNEdWebGuide/25_EMDOC.asp).

Here's how it works: Under the 1997 documentation guidelines for E/M services, performing (and documenting) any three of the following seven vital signs will count as one bullet in the constitutional system/body area of the general multisystem examination:

1. Sitting or standing blood pressure
2. Supine blood pressure
3. Pulse rate and regularity
4. Respiration
5. Temperature
6. Height
7. Weight.

You Be the Coder

Choose the Correct Code for Kenalog Injections

(Question on page 85)

Answer:
Report 96372 (*Therapeutic, prophylactic, or diagnostic injection [specify substance or drug]; subcutaneous or intramuscular*) for the injection. Then, choose between J3300 (*Injection, triamcinolone acetonide, preservative free, 1 mg*) or J3301 (*...not otherwise specified, 10 mg*) for the Kenalog itself, based on your physician's documentation. ❑

The current 1995 documentation guidelines do not specify the type or number of vital signs that count toward "taking vital signs," so you need document only one vital sign from the list above to count as documenting a physical examination of the "Constitutional" organ system under the 1995 guidelines.

Bonus: Ancillary staff (such as a nurse) may measure and record the vitals. ❑

Forget Modifier 55 for Suture Removal

Question:
An 11-year-old established patient went to the emergency room in another state over the weekend because of a laceration to his arm. The ER staff sutured the cut and told his parents to follow up with his physician at home. At the office visit, the family physician removed the stitches, cleaned and re-bandaged the area, and spoke with the parent about wound care. We reported an E/M code with modifier 55, but insurance only paid $15. What did we do wrong?
New Mexico Subscriber

Answer:
The problem could lie in your use of modifier 55 (*Postoperative management only*). You should use modifier 55 when another physician performs surgery and your physician provides postoperative management/care. In that instance, modifier 55 is appended to the surgical procedure code, not an E/M code for the post-procedure visit.

Most suture removal as you described isn't extensive enough to rise to the level of "postoperative management" that would justify reporting modifier 55 with the corresponding laceration repair code.

In the case you describe, you should report an E/M code (such as 99213) without a modifier. This should be linked to V58.32 (*Encounter for removal of sutures*) for suture removal. Appendix C of CPT® supports this approach; one of the clinical examples of 99213 which it lists is "Office visit for a 20-year old male, established patient, for removal of sutures in hand." ❑

Submit 95250, Then 95251 for Glucose Monitoring

Question:
What is the best way to bill for continuous glucose monitoring? Do we bill for the initial visit and when the patient returns to the office after five days of monitoring, or report only one visit?
Nevada Subscriber

Answer:
You can bill for both dates of service related to continuous glucose monitoring (CGM). The codes are:

- 95250 – *Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; sensor placement, hook-up, calibration of monitor, patient training, removal of sensor, and printout of recording*
- 95251 – *Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; interpretation and report*.

Initial day: Report 95250 for the initial placement of the CGM and related patient training. If a significant, separately identifiable E/M service is provided at the same encounter, you may also submit the appropriate E/M code, such as 99211 (*Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician ...*).

Follow up: When the patient returns, report 95251 for the interpretation and report. Do not report 95250 again, because the removal and printout are already covered by your previous reporting of this code. As with the initial visit, include the appropriate office visit E/M code from 99211-99215 (*Office or other outpatient visit for the evaluation and management of an established patient ...*) if there is a significant, separately identifiable E/M service (such as, for the time your provider takes to explain the results to the patient). ❑

Choose 10120 for Punch Biopsy FBR

Question:
The physician used a punch biopsy to remove a thickly embedded tick from a patient's back. Do we code differently because of the punch biopsy?
Michigan Subscriber

Answer:
Disregard the tool your physician used, and simply report the service – a foreign body removal. In this case, submit 10120 (*Incision and removal of foreign body, subcutaneous tissues; simple*), which includes closure for repair. ❑

Information for and answers to You Be the Coder *and* Reader Questions *reviewed by* ***Kent Moore,*** *manager of health care financing and delivery systems for the American Academy of Family Physicians in Leawood, Kan.*

Family Practice CODING ALERT

We would love to hear from you. Please send your comments, questions, tips, cases, and suggestions for articles related to Family Practice coding and reimbursement to the Editor indicated below.

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