DISCLAIMER

Disclaimer

This presentation was intended to be current at the time it was written. Remaining current with respect to updates and changes to any of the information provided is the responsibility of the provider.

Proper coding may require analysis of statues, regulations or carrier policies, and as a result, the proper code result may vary from one payer to another.

It is the provider's responsibility to determine and submit appropriate codes, modifiers and charges for the services that are rendered. This presentation is intended for personal use only. Re-sale of the content is prohibited.

AGENDA

Agenda:

- Ramifications of Incorrect Coding
- Data Mining & Predictive Modeling
- Common Coding Errors
- Getting it Right
- Utilization of Nationally Recognized Source Documents
- Learn More About it

Ramifications Of Incorrect Coding

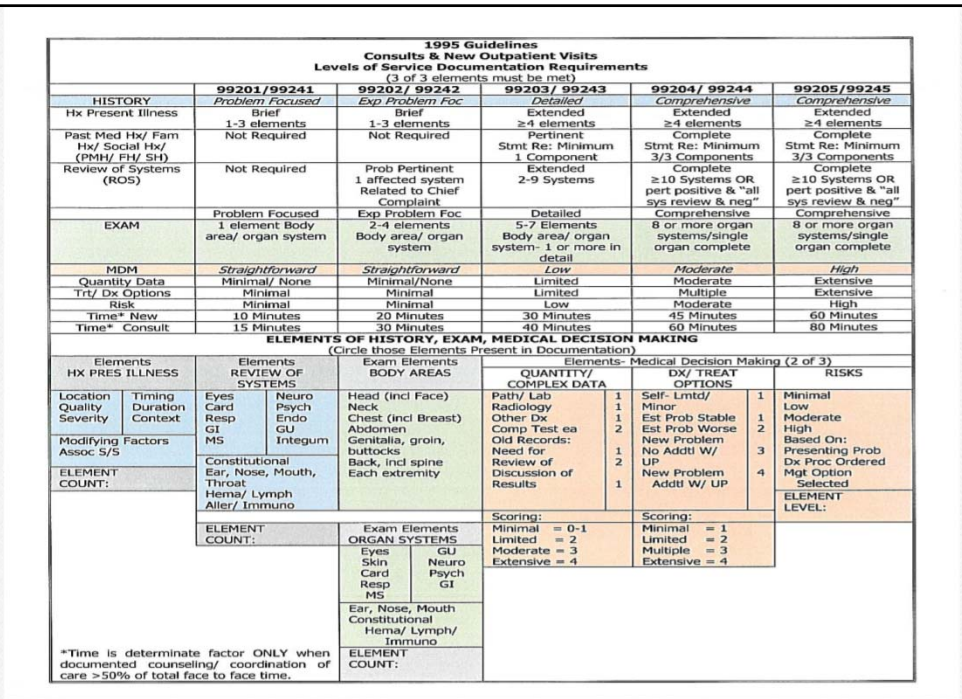
Ramifications of Incorrect Coding:

- Lost Revenue
- Insurance Carrier Overpayment Refund Demand
- Pre-Payment Review
- Suspension or Loss of License

Inadequate Coding

Inadequate coding:

- Evaluation & Management Services
  - **America's Most Audited!**
  - All new patients are Level 5
  - All hospital visits are always Level 3
  - I spent a lot of time with the patient, bill a Level 5
  - Each time a patient switches insurance bill a new patient



1995 Guidelines
Consults & New Outpatient Visits
Levels of Service Documentation Requirements
(3 of 3 elements must be met)

	99201/99241	99202/ 99242	99203/ 99243	99204/ 99244	99205/99245
HISTORY	*Problem Focused*	*Exp Problem Foc*	*Detailed*	*Comprehensive*	*Comprehensive*
Hx Present Illness	Brief 1-3 elements	Brief 1-3 elements	Extended ≥4 elements	Extended ≥4 elements	Extended ≥4 elements
Past Med Hx/ Fam Hx/ Social Hx/ (PMH/ FH/ SH)	Not Required	Not Required	Pertinent Stmt Re: Minimum 1 Component	Complete Stmt Re: Minimum 3/3 Components	Complete Stmt Re: Minimum 3/3 Components
Review of Systems (ROS)	Not Required	Prob Pertinent 1 affected system Related to Chief Complaint	Extended 2-9 Systems	Complete ≥10 Systems OR pert positive & "all sys review & neg"	Complete ≥10 Systems OR pert positive & "all sys review & neg"
	Problem Focused	Exp Problem Foc	Detailed	Comprehensive	Comprehensive
EXAM	1 element Body area/ organ system	2-4 elements Body area/ organ system	5-7 Elements Body area/ organ system- 1 or more in detail	8 or more organ systems/single organ complete	8 or more organ systems/single organ complete
MDM	*Straightforward*	*Straightforward*	*Low*	*Moderate*	*High*
Quantity Data	Minimal/ None	Minimal/None	Limited	Moderate	Extensive
Trt/ Dx Options	Minimal	Minimal	Limited	Multiple	Extensive
Risk	Minimal	Minimal	Low	Moderate	High
Time* New	10 Minutes	20 Minutes	30 Minutes	45 Minutes	60 Minutes
Time* Consult	15 Minutes	30 Minutes	40 Minutes	60 Minutes	80 Minutes

ELEMENTS OF HISTORY, EXAM, MEDICAL DECISION MAKING
(Circle those Elements Present in Documentation)

Elements HX PRES ILLNESS	Elements REVIEW OF SYSTEMS	Exam Elements BODY AREAS	Elements- Medical Decision Making (2 of 3) QUANTITY/ COMPLEX DATA	DX/ TREAT OPTIONS	RISKS
Location Timing Quality Duration Severity Context	Eyes Neuro Card Psych Resp Endo GI GU MS Integum	Head (incl Face) Neck Chest (incl Breast) Abdomen Genitalia, groin, buttocks Back, incl spine Each extremity	Path/ Lab 1 Radiology 1 Other Dx 1 Comp Test ea 2 Old Records: Need for 1 Review of 2 Discussion of Results 1	Self- Lmtd/ Minor 1 Est Prob Stable 1 Est Prob Worse 2 New Problem No Addtl W/ UP 3 New Problem Addtl W/ UP 4	Minimal Low Moderate High Based On: Presenting Prob Dx Proc Ordered Mgt Option Selected
Modifying Factors Assoc S/S	Constitutional Ear, Nose, Mouth, Throat Hema/ Lymph Aller/ Immuno				ELEMENT LEVEL:
ELEMENT COUNT:	ELEMENT COUNT:	Exam Elements ORGAN SYSTEMS Eyes GU Skin Neuro Card Psych Resp GI MS Ear, Nose, Mouth Constitutional Hema/ Lymph/ Immuno ELEMENT COUNT:	Scoring: Minimal = 0-1 Limited = 2 Moderate = 3 Extensive = 4	Scoring: Minimal = 1 Limited = 2 Multiple = 3 Extensive = 4	

*Time is determinate factor ONLY when documented counseling/ coordination of care >50% of total face to face time.

1995 Guidelines
Established Outpatient Visits
Levels of Service Documentation Requirements
(2 of 3 elements must be met)

	99211/Level 1	99212/ Level 2	99213/ Level 3	99214/ Level 4	99215/Level 5
HISTORY	*Straightforward*	*Problem Focused*	*Exp Problem Foc*	*Detailed*	*Comprehensive*
Hx Present Illness	May not require presence of physician	Brief 1-3 elements	Brief 1-3 elements	Extended ≥4 elements	Extended ≥4 elements
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Location Timing Quality Duration Severity Context Modifying Factors Assoc S/S ELEMENT COUNT:	Eyes Neuro Card Psych Resp Endo GI GU MS Integum Constitutional Ear, Nose, Mouth, Throat Hema/ Lymph Aller/ Immuno ELEMENT COUNT:	Head (incl Face) Neck Chest (incl Breast) Abdomen Genitalia, groin, buttocks Back, incl spine Each extremity Exam Elements ORGAN SYSTEMS Eyes GU Skin Neuro Card Psych Resp GI MS Ear, Nose, Mouth Constitutional Hema/ Lymph/ Immuno ELEMENT COUNT:	Path/ Lab 1 Radiology 1 Medicine 1 Discuss Test w/ Provider 1 **Old Records:** Need to obtain 1 Review/ summary/ Discussion of case/ Records 2 Independent visualization of image 2 Scoring: Minimal = 0-1 Limited = 2 Moderate = 3 Extensive = 4	Self- Lmtd/ 1 Minor Est Prob Stable 1 Est Prob Worse 2 New Problem No Addtl W/ UP 3 New Problem Addtl W/ UP 4 Scoring: Minimal = 1 Limited = 2 Multiple = 3 Extensive = 4	Minimal Low Moderate High Based On: Presenting Prob Dx Proc Ordered Mgt Option Selected ELEMENT LEVEL:

*Time is determinate factor ONLY when documented counseling/ coordination of care >50% of total face to face time.

Documentation Basics

Does the note include:

- The reason for the visit
- **Relevant** history, physical, any prior diagnostic test results
- Assessment, impression or diagnosis
- Plan of care
- Date and legible identity of the provider, valid electronic signature
- Patient's name
- Medical necessity for the ordering of diagnostic tests and/or ancillary services
- The patient's response to and changes to treatment and revision of diagnosis
- Physician signature/initials on laboratory, diagnostic and correspondence reviewed

CLICKITIS

Documentation Basics

Volume of Documentation vs. Medical Necessity:

- The Social Security Act, Section 1862 (a)(1)(A) states:
  - *"No payment will be made…for items or services…not reasonable and necessary for the diagnosis or treatment of an injury or illness or to improve the functioning of a malformed body member."*

THIS MEDICAL REASONABLENESS AND NECESSITY STANDARD IS THE OVERARCHING CRITERION FOR THE PAYMENT OF ALL SERVICES BILLED TO MEDICARE.

Word processing software, the electronic medical record and formatted note systems facilitate the "carry over" and repetitive "fill in" of stored information.

Documentation Basics

Volume of Documentation vs. Medical Necessity:

Even if a "complete" note is generates, only the medically reasonable and necessary services for the condition of the particular patient at the time of the encounter as documented can be considered when selecting the appropriate level of an E/M service.

Information that has no pertinence to the patient's situation at that specific time cannot be counted.

Cloned Documentation

Cloned Documentation:

Documentation is considered cloned when each entry in the medical record for a beneficiary is worded exactly like or similar to the previous entries or when medical documentation is exactly the same from beneficiary to beneficiary. All documentation in the medical record must be specific to the patient and his/her situation at the time of the encounter.

Cloning of documentation is considered a misrepresentation of the medical necessity requirement for coverage of services.

Cloned Documentation

Cloned Documentation:

- ***Identification of this type of documentation will lead to denial of services for lack of medical necessity and recoupment of all overpayments made.***

Cut & Paste

- Conflicting Information
  - Patient HPI complains of an itchy rash on the arm
  - The review of systems states Skin = denies,
  - Outdated Information
  - The patients medication record includes 3 pages of "active" medications
  - The medication list was never updated
  - Macros – patient comes in as a male and leaves as a female

Cut & Paste

- Carry over of patient's entire problem list
  - This usually includes problems which are not treated at the current encounter
- Carry over of another provider's old or undated documentation with slight alterations
  - You are adopting this as your own and are therefore responsible for the entire entry

Timeliness

Timeliness:

- Performed services must be documented at the outset
- Delayed written explanations will be considered
- They serve for clarification only
- **Cannot be used:**
  - To authenticate services billed and not documented at the time of service
  - Or to substantiate medical necessity

Timeliness

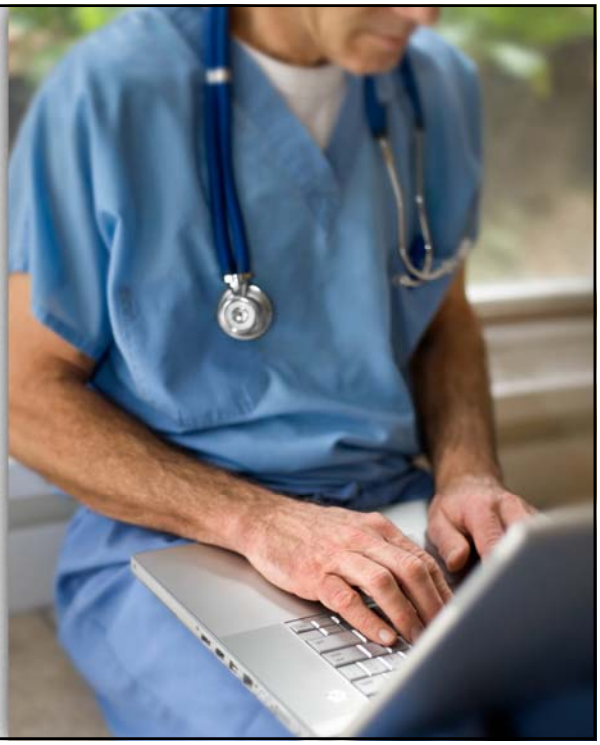
Timeliness:

- Documentation is expected to be generated at the time of service or shortly thereafter
- Delayed entries within a reasonable time frame (24-48) hours are acceptable for purposes of:
  - Clarification
  - Error correction
  - The addition of information not initially available
  - Unusual circumstances

Timeliness

Electronic notes should not be left open:

- If the author of the note did not authenticate the service, it is not billable
- Possibility of an altered record
- Someone else may have access to add to the open note

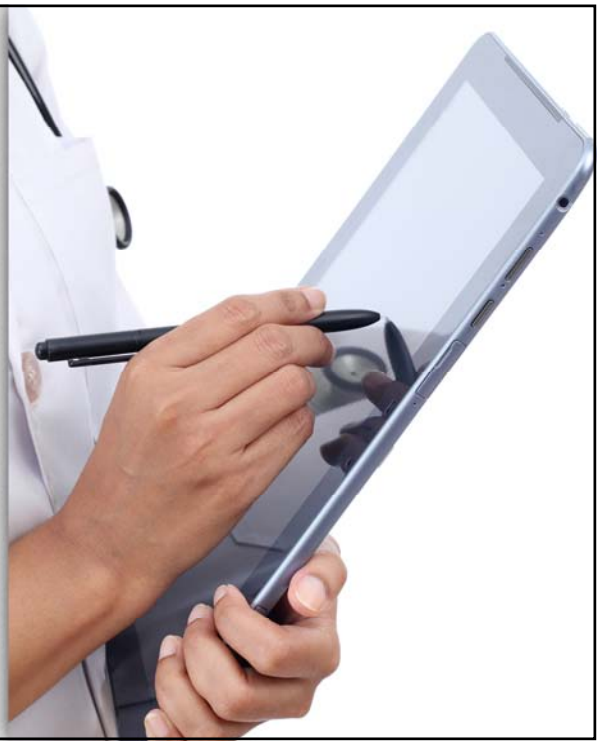


Electronic Signatures

Electronic Signatures:

An electronic health record should include a valid electronic signature. Such as:

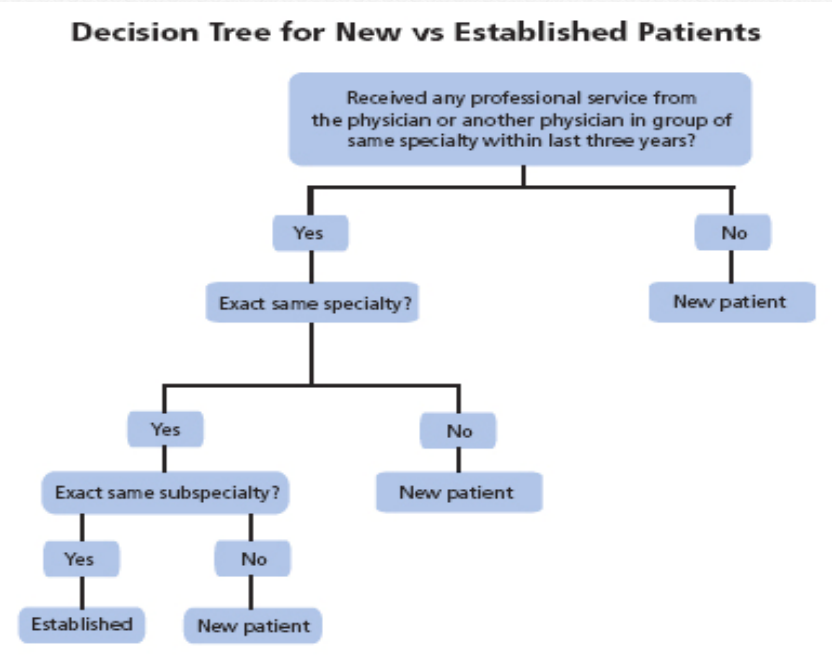
- Digitized signature – an electronic image of an individual's handwritten signature reproduced in its identical form using a pen tablet.



New Patients

In a physician private practice setting, the definition of a new patients is:

A new patient is one who has not received any professional services from the physician/qualified healthcare professional or another physician/qualified healthcare professional of the exact same specialty or subspecialty who belongs to the same group practice within the past three years.



Inadequate Documentation

Spending 40 minutes with a patient means providers can code a Level 5 visit.

TIME EXCEPTION

Time Exception

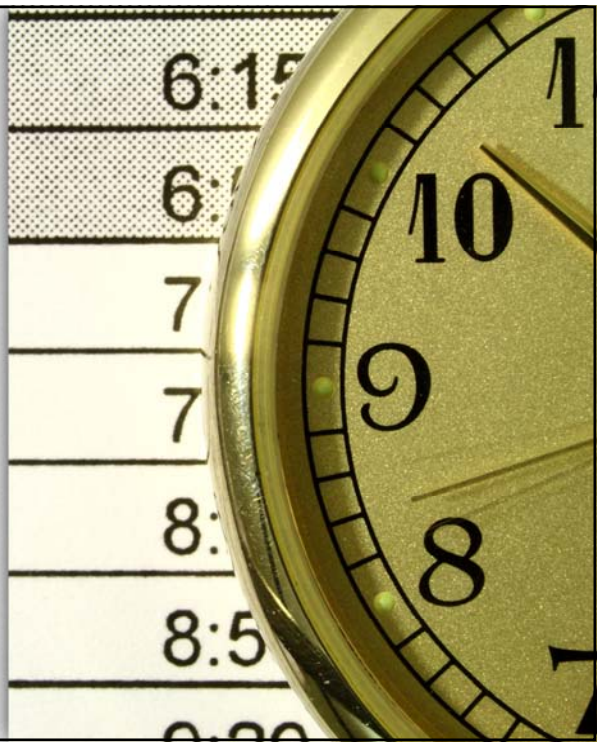
Time Exception:

- When counseling and/or coordination of care dominate the encounter (50% or more of the total visit time)
- Time ***may*** determine the level of service
- Physician face- to- face time with the patient in the office or outpatient setting, or floor/unit time in hospital

Documenting Time

Documenting Time:

- Length of time counseling/coordinating care
- Total visit time
- Summary of issues and items discussed
- Who was present



Documenting Counseling

Documenting Counseling:

- Discussion of significant medical problems
- Treatment options
- Potential risks & benefits
- Long term impact and arrangements
- Involvement of family members/care givers
- Amount of time & discussion to include other providers

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Case Study Extrapolation

Case Study Extrapolation:

- A simple review of 50 claims or 10 patient's can result in costly overpayments due to extrapolation.
- Check the Laws for the look back period
- New York State has a 2 year look back unless
  - The carrier can prove an abusive billing pattern or fraud

Insurance Carrier Refund Demands

Insurance Carrier Refund Demands:

- Carrier review of records
  - Requests 50 records
  - Inadequate documentation to support 25 of the records
  - Results in a 50% error rate
- Carrier will extrapolate based upon error rate

Patient Name	DOS	CPT Billed	Req Amt	Co-pay	Pay Amt	PaySum	New CPT	feeregion	Max Fee	Pay Difference	Count
	2/28/2007	99213	$200.00	$15.00	$43.00	$58.00	99999	03ALL	$0.00	$58.00	1
	3/6/2007	99213	$200.00	$15.00	$43.00	$58.00	99213	03ALL	$58.00	$0.00	1
	6/1/2007	99213	$200.00	$15.00	$41.58	$56.58	99999	UNY73149	$0.00	$56.58	1
	8/7/2007	99213	$200.00	$15.00	$41.58	$56.58	99213	UNY73149	$56.58	$0.00	1
	9/26/2007	99214	$350.00	$15.00	$52.33	$67.33	99213	UNY73149	$56.58	$10.75	1
	12/5/2007	99213	$200.00	$15.00	$41.58	$56.58	99213	UNY73149	$56.58	$0.00	1
	3/25/2008	99213	$300.00	$15.00	$41.58	$56.58	99213	UNY73149	$56.58	$0.00	1
	5/23/2008	99213	$300.00	$15.00	$41.58	$56.58	99213	UNY73149	$56.58	$0.00	1
	1/29/2008	99213	$200.00	$15.00	$41.58	$56.58	99213	UNY73149	$56.58	$0.00	1
	2/5/2008	99245	$350.00	$15.00	$191.77	$206.77	99202	UNY73149	$60.91	$145.86	1
	12/3/2007	99214	$350.00	$15.00	$52.33	$67.33	99214	UNY73149	$67.33	$0.00	1
	4/22/2008	99213	$300.00	$20.00	$36.58	$56.58	99213	UNY73149	$56.58	$0.00	1
								Pay Difference Sum:		$857.52	55

Monday, October 11, 2010 Page 4 of 4

Established Visit Extrapolation

Avg overpayment per established visit claim:	$9.52
Count of established visit claims in universe	7713
Final Collection Extrapolation for established visit claims:	$73,396.61

Consultation Extrapolation

Avg overpayment per Consultation claim:	$120.90
Count of Consultation claims in universe	172
Final Collection Extrapolation for Consultation claim	$20,794.23

New Visit Extrapolation

Avg overpayment per new visit claim:	
Count of new visit claims in universe	417
Final Collection Extrapolation for new visit claims:	

Collection

Consultation Amt	Established Visit Amt	New Visit Amt	TOTAL COLLECTION
$20,794.23	$73,396.61		
			$94,190.84

Prepayment Review

Prepayment Review:

- The Carrier will require the physician/provider to submit documentation with each claim
  - Administratively burdensome
  - Delay reimbursement up to 3-6 months
  - Appeal denials
  - Brings Cash Flow to a halt
  - Time consuming process to get off of pre-pay review

Data Mining & Predictive Modeling

Data Mining:

The process of analyzing data from different perspectives and summarizing it into useful information that can be used to:

- Increase Revenue,
- Cuts Costs
- or Both.

Data Mining & Predictive Modeling

Data Mining:

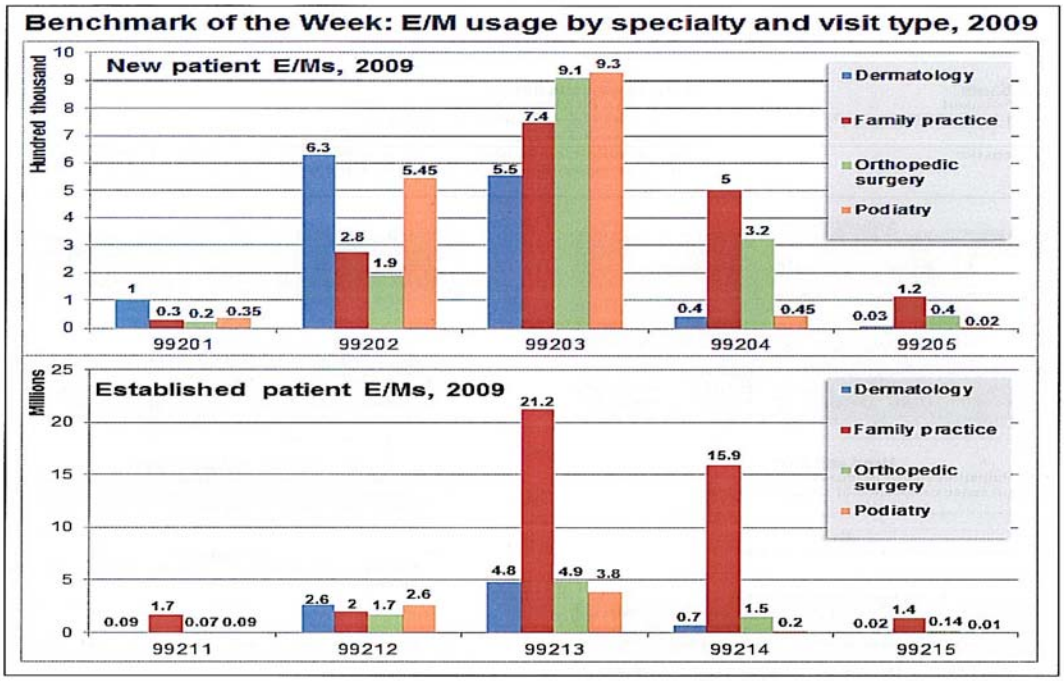
Data mining software is one of a number of analytical tools for analyzing data. It allows users to analyze data from many different dimensions or angles, categorize it, and summarize the relationships identified.

Technically, data mining is the process of finfinding correlations or patterns among dozens of fields in large relational databases.

Data Mining & Predictive Modeling

Data Mining:

- E/M – do you have a bell curve?
- Do you bill the same level of service for every patient, every new patient?
- Frequent use of modifiers
- Over use of diagnostic testing
- Coding outside of the scope of your specialty
- All claims are billed under one provider



Data Mining & Predictive Modeling

Predictive Modeling:

- A combination of advanced analytic techniques, including predictive analytics, linkage analysis, outlier analysis, network analysis and other statistical techniques

- Frequently used by banks, credit card companies and insurance to identify fraud before it occurs

Data Mining & Predictive Modeling

Predictive Modeling:

Identifies potential fraudulent providers based upon:

- Historical billing patterns
- Information about the individual or company

Data Mining & Predictive Modeling

Beginning July 1, 2011 CMS will utilize predictive modeling:

- For a national pre-payment, electronic 'audit' or screen of your fee-for-service claims
- The initiative will identify claims that hit target red flag areas before CMS pays you for the service.
- Your flagged claims will be assigned risk scores which will determine whether they require further audit or investigation.

This will replace the old "pay and chase"

Common Coding Errors

Common Coding Errors

"I am always entitled to bill an office visit each and every time the patient comes in."

- Billing an office visit and a surgical procedure on the same day is OK as, long as I have a different diagnosis and use modifier 25!
- I can bill 99211 when patients present for vaccines and blood drawings

Common Coding Errors

99211:

Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.

- Requires medical necessity
- If the reason for the visit is the blood drawing or for a vaccination
  - Report only the blood drawing OR
  - Vaccine administration and vaccine administered

COMMON CODING ERRORS

Common Coding Errors:

- Appendix C of the CPT Manual includes Clinical examples of when to use 99211
  - Specialty specific examples
- When billing 99211 the patient is responsible for their copayment and/or co-insurance

Inadequate Documentation

- 36410 Venipuncture, age 3 years or older, necessitating physician's skill (separate procedure), for diagnostic or therapeutic purposes (***not to be used for routine venipuncture***)
  - As per the CPT Assistant, May 2001 - Code 36410 **would be reported if a routine venipuncture, usually performed, for example, by a nurse or phlebotomist, is unsuccessful and the skill of the physician is required to perform the procedure. In this case, it is no longer a routine venipuncture.** It would not be appropriate to report code 36410 if the physician performs the venipuncture merely because the nurse, phlebotomist, or other health professional is unavailable to perform the service.

Testing & Therapeutic Services

Blood Drawing:

- ✓ 36415 Collection of venous blood by venipuncture
- ✓ 36416 Collection of capillary blood specimen (e.g., finger, heel, ear stick)

Testing & Therapeutic Services

Nebulizer Treatment:

- ✓ 94640 Pressurized or nonpressurized inhalation treatment for acute airway obstruction or for sputum induction for diagnostic purposes (e.g., with an aerosol generator, nebulizer, metered dose inhaler or intermittent positive pressure breathing [IPPB] device) For more than one treatment performed on the same date, append modifier 76
  - ✓ Modifier 76: Repeat procedure or service by the Same Physician or other Qualified Health Care Professional

Demonstration of Nebulizer

CPT Code 94664

- ✓ 94664 Demonstration and/or evaluation of patient utilization of an aerosol generator, nebulizer, metered dose inhaler or IPPB device
- ✓ As per the National Correct Coding Initiative (NCCI Edits) CPT code 94664 is bundled into the CPT code for the nebulizer treatment (94640)
- ✓ Modifier 59 is overtimes inappropriately appended.
  - ✓ When used in this scenario modifier 59 would indicate the two services were provided at separate encounters
- ✓ 94664 is reported for the "initial" demonstration and/or evaluation.

Demonstration of Nebulizer

CPT Code 94664

- ✓ Codes 94664 has several facets and may be reported to describe:
  - ✓ demonstration of a metered-dose inhaler or a nebulizer
  - ✓ bronchodilator administration for the purpose of long-term management of bronchospasm
  - ✓ bronchodilator administration to mobilize sputum for therapeutic purposes (i.e., movement of thick secretions)
  - ✓ bronchodilator administration to mobilize sputum for sputum induction for diagnostic studies (e.g., culture, gram stain)

Allergy Testing

Allergy Testing:

- ✓ 95004 Percutaneous tests (scratch, puncture, prick) with allergenic extracts, immediate type reaction, **including test interpretation and report**, specify number of tests
- ✓ 95012 Nitric oxide expired gas determination
- ✓ 95024 Intracutaneous (intradermal) tests with allergenic extracts, immediate type reaction, **including test interpretation and report**, specify number of tests

Allergy Testing

Documentation Requirements:

- ✓ **Consent**
- ✓ **Patient information**
  - ✓ Patient name, date of birth and identifying number (if applicable)
  - ✓ Ordering physician name, address and telephone number
  - ✓ Testing date
  - ✓ Last administration of medications that can interfere with skin test results or reactions
- ✓ **Allergy skin test methods**
  - ✓ Skin test technician
  - ✓ Location of test (e.g. back, arm)
  - ✓ Type of test (e.g., intradermal, prick, puncture)
  - ✓ Instrument used (e.g., testing device, needle size, commercial kit)
  - ✓ Time elapsed between application of tests and reading of tests
  - ✓ Amount injected with intradermal technique

Allergy Testing

Documenting Medical Necessity

- ✓ Immunotherapy should be considered for patients with moderate or severe persistent allergic rhinitis that is not responsive to usual treatment.
- ✓ Document the following:
  - ✓ Conservative therapy has been attempted prior to testing
  - ✓ The allergy testing has been performed
  - ✓ The administration of antigens has been provided

Allergy Testing

Documentation Requirements:

- ✓ **Testing Materials**
  - ✓ Positive and negative controls
  - ✓ Manufacturing company or source of reagent
  - ✓ Common name (scientific name optional)
  - ✓ Concentration used in testing
  - ✓ Dilution and diluent if applicable
  - ✓ Contents, concentrations, diluents of any mixtures
- ✓ **Reporting of results**
  - ✓ Quantitative or semi-quantitative reporting based on wheal size, erythema/flare and pseudopodia.
  - ✓ Scoring reported as either measurement of wheal in millimeters, including presence or size of flare, or scoring as 0 through 4+ (key to scoring must be including, and must be based on measurement of wheal and flare)

Balloon Sinuplasty

Documentation Prerequisite Requirements:

- ✓ All of the following must be met:
- ✓ Presence of **two or more of the following signs/symptoms for more than 3 months**
  - Nasal obstruction
  - Anterior or posterior mucopurulent (foul) drainage
  - Facial pain, pressure and/or fullness over the affected sinus
  - Decreased sense of smell
- ✓ Evidence of chronic rhinosinusitis on CT scan in each of the sinuses being considered for treatment including **ANY** of the following:
  - Mucosal thickening >3 millimeters
  - Air fluid levels opacification
  - Nasal polyposis
  - Bony remodeling,
  - Bony thickening
  - Obstruction of the ostiomeatal complex

Balloon Sinuplasty

Documentation Prerequisite Requirements:

1. Failure of medical management for at least eight weeks including **ALL** of the following:
   a. At least two different full course of antibiotics
   b. Steroid nasal spray antihistamine nasal spray and/or decongestant
   c. Nasal saline irrigation

Inadequate Documentation

Inadequate documentation of a minor surgical procedure:

Merely stating the procedure in the documentation is insufficient documentation to support the service billed

Inadequate Documentation

Common Coding Errors:

- Your reimbursement for the office visit is included in the Relative Value Unit (RVU) for the surgical procedure
- If treating a separate diagnosis the medical record needs to include separate documentation to support the E/M components for the level of E/M selected

Minor Surgical Procedures

Global Surgical Package:

The global surgical package concept includes the pre-operative, intra-operative and post-operative services, and are considered included in the specific CPT code.

- **The pre-operative stage includes:**
  - Local infiltration
  - Metacarpal/metatarsal/digital block
  - Topical anesthesia
  - Subsequent to the decision for surgery, **one related E/M encounter on the date immediately prior or on the date of the procedure (history and physical)**

Minor Surgical Procedures

Global Surgical Package:

- **Intra-operative service:**
  - Actual performance of the surgical procedure
- **Post-operative services:**
  - Immediate postoperative care, including dictation, post-operative notes, talking with the family and other physicians
  - Writing orders
  - Evaluating the patient in the post-anesthesia recovery area
  - Typical uncomplicated post-operative care
- **Certain minor surgical procedures should have a consent form (e.g. foreign body removal etc.)**

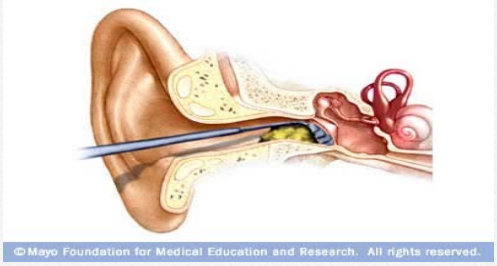
Minor Surgical Procedures

- You may only bill an office visit when supported by documentation in the patient's medical record.
  - Meets the requirements on an E/M code
  - Goes above and beyond the work included in the global surgical package
  - Evaluation and management of an additional diagnosis

Removal of Impacted Cerumen

CPT Code 69210

- ✓ 69210 Removal impacted cerumen requiring instrumentation, **unilateral**
- ✓ For bilateral procedure report 69210 with modifier 50
- ✓ OR 69210 –RT, 69210-LT



Removal of Impacted Cerumen

Documentation Requirements

- ✓ Documentation of impacted cerumen:
  - ✓ cerumen impairs the examination of clinically significant portions of the external auditory canal, tympanic membrane, or middle ear condition;
  - ✓ extremely hard, dry, irritative cerumen causes symptoms such as pain, itching, hearing loss, etc.;
  - ✓ cerumen is associated with foul odor, infection, or dermatitis; or
  - ✓ obstructive, copious cerumen cannot be removed without magnification and multiple instrumentations requiring physician skills.

Removal of Impacted Cerumen

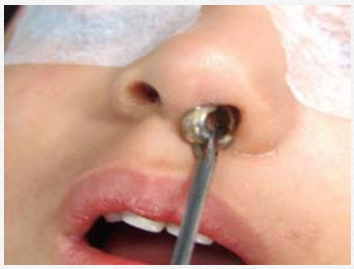
Documentation Requirements

- ✓ Documentation of instrumentation utilized:
  - ✓ instrumentation is defined as the use of an otoscope and other instruments such as wax curettes and wire loops, or an operating microscope and suction plus specific ear instruments (e.g., cup forceps, right angle forceps).
  - ✓ Accompanying documentation should indicate the time, effort, and equipment required to provide the service.
- ✓ **Cerumen removal by means of an ear lavage or irrigation would NOT be reported with CPT code 69210**
  - ✓ In this case it would be part of the E/M visit

Foreign Body Removal

Different Types:

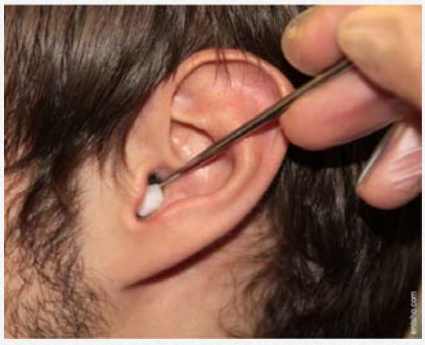
- ✓ 10120 Incision and removal of foreign body, subcutaneous tissues; simple
- ✓ 30300 Removal foreign body, intranasal; office type procedure
- ✓ 65205 Removal of foreign body, external eye; conjunctival superficial



Foreign Body Removal

Documentation Requirements:

- ✓ Obtain written consent
- ✓ Instruments utilized for the procedure
- ✓ Document the foreign body removed (e.g. splinter, Q-tip, etc..)
- ✓ Follow up instructions and after care as applicable



Foreign Body Removal – Global Days

Proposed Rule for 2017:

- ✓ CPT codes with Global Days of 10 or 90 will have 8 new unpaid "G codes" to report in 2017
  - ✓ For visits and services provided during the global period
  - ✓ Proposed as mandatory staring on January 1, 2017
  - ✓ CMS is considering a withhold of 5% of payments for non-compliance
  - ✓ Codes GXXX1-GXXX8 are time based (one unit equals 10 minutes)
  - ✓ Selected by the site of service and level of complexity
  - ✓ Six codes are for face-to-face care
  - ✓ Two codes are patient interactions via electronic means (think telehealth)
  - ✓ Two codes for clinical staff work during the global period (both face-to-face and electronic)

Special Service Codes

CPT Code 99050

- ✓ 99050 - Services provided in the office at times **other than regularly scheduled office hours, or days when the office is normally closed** (e.g., holidays, Saturday or Sunday), in addition to basic service
- ✓ 99051 - Service(s) provided in the office **during regularly scheduled evening, weekend, or holiday office hours,** in addition to basic service

Special Service Codes

CPT Code 99050

- ✓ As per the CPT Assistant : Code 99050 is intended to describe circumstances under which patient requested care is **outside of the usual timeframe of the routine scheduling.**
- ✓ An example of when this code might be used is when an office has regularly posted office hours of Monday-Friday from 8:30 AM to 5 PM, and a patient is seen by the physician at 7 PM or during the weekend outside of the usual time.
- ✓ The physician would report the appropriate Evaluation and Management Service (E/M), and any other therapeutic (e.g., wound repair), and/or diagnostic (e.g., X-ray) service(s) provided, in addition to code 99050, to indicate that the service was requested and performed outside of the posted office hours.

Inadequate Documentation

99058:

Service(s) provided on an emergency basis in the office, which disrupts other scheduled office services, in addition to basic service

Inadequate Documentation

Required Documentation:

- CPT code 99058 reports office services provided on an emergency basis ***that disrupt other scheduled office services.*** This code is reported for those office patients whose condition, in the clinical judgment of the physician, ***warrants the physician's interrupting his or her care of another patient to deal with the emergency.*** **This code is not reported when the physician's usual practice is to have time slots available in the schedule and patients are fit into that schedule.**

Misrepresenting The CPT Code

Platelet Rich Plasma (PRP):

- I was told by the representative to report CPT code 20926 Tissue grafts, other (e.g., paratenon, fat, dermis)

- As per CPT Guidelines: Report with CPT Category III Code - 0232T Injection(s), **platelet rich plasma, any site,** including image guidance, harvesting and preparation when performed

Misrepresenting The CPT Code

What is a Category III Code?

- Temporary codes used for emerging technology, services, and procedures that cannot be described by a nonspecific Category I unlisted code.
- If a Category III code is available, this code must be reported instead of a Category I unlisted code.
- Category III codes are usually considered "investigational" by many insurance carriers and as such are non-reimbursable.

Medical Necessity

- As per CMS, "It is not enough to link the procedure code to a correct payable ICD-9-CM code. The Diagnosis or clinical signs/symptoms must be present for the procedure to be paid".
- Remember there are **NO Rule Out Diagnosis codes** is the outpatient setting

Modifiers

Modifier 59

Modifier 59 – Distinct Procedural Service:

Under certain circumstances, the physician may need to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services that are not normally reported together, but are appropriate under the circumstances.

Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion or separate injury not ordinarily encountered or performed on the same day by the same individual.

Modifier 59

Modifier 59 – Distinct Procedural Service:

However, when another already established modifier is appropriate it should be used rather than, modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances should modifier 59 be used. **Note:** modifier 59 should not be appended to an E/M service with a non-E/M service performed on the same date, see modifier -25.

Modifier 59

Modifier 59:

Is used:

- A different session or patient encounter
- A different procedure or surgery
- A different site or organ system
- A separate incision or excision
- A separate lesion
- A separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same physician

Modifier 59

Modifier 59:

- Should be used with caution
- The documentation should be clear as to the separate and distinct procedure
- Effects reimbursement as it unbundles services/procedures
- Is only used if another modifier does not describe the situation more accurately

Modifier 59 - Example

CPT Codes:

93503 Insert & placement of flow directed catheter

36010-59 Introduction of catheter, superior or inferior vena cava

Different site and a different service on the same day.

Modifier 59 - Example

Modifier 59 - Example:

Pressure sores that were 20 sq. cm on a patient's right ankle and right hip were debrided in the morning, but because of the patient's condition, selective debridement of a 17-sq cm sacral pressure sore was performed at a separate session in the afternoon on the same day by the same provider.

MODIFIER
59 REVISIONS

Modifier 59 Update

- CMS developed four new modifiers to be utilized as a subset to modifier 59
  - XE -Separate Encounter: A Service That Is Distinct Because It Occurred During A Separate Encounter
  - XS - Separate Structure: A Service That Is Distinct Because It Was Performed On A Separate Organ/Structure
  - XP - Separate Practitioner: A Service That Is Distinct Because It Was Performed By A Different Practitioner
  - XU - Unusual Non-Overlapping: Service: The Use Of A Service That Is Distinct Because It Does Not Overlap Usual Components Of The Main Service.

Modifier 59 Update

Key Tips to remember About the Subsets:

- The subsets were developed to provide more detail to the payer regarding separate payment for multiple codes on the same day
- CMS will continue to recognize the use of modifier 59
- Individual providers will be contacted by their MAC (Medicare Administrator Contractor) regarding use of the "X" modifiers.
- **Therefore providers should continue to report modifier 59 unless you have been contacted by your MAC to report the "X" modifiers.**
- Check with your third party payer for their requirements regarding modifier 59

Modifier 59 Update

X modifiers in more detail:

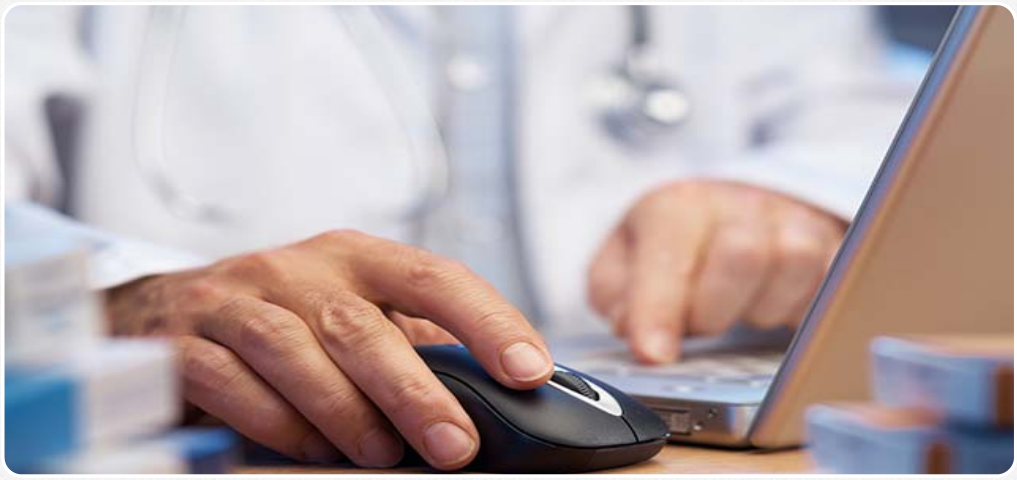
- XS – Separate structure – this refers to a separate organ/structure (e.g. different organ or different anatomical site)
    - For example: separate and distinct lesions
- XE – Separate encounter – This represents scenarios when bundled services are performed at separate encounters on the same day.
    - For example: a patient who has an ECG in the morning and returns for a stress test later that same day. Since the ECG is bundled into the stress test when performed at the same encounter, modifier XE would identify the services were provided at separate encounters

Modifier 59 Update

X modifiers in more detail:

- XP – this represents a bundled service performed by a different provider.
    - For example: bundled anesthesia/surgical procedures that may be performed by separate providers
- XU – Unusual non-overlapping services – At this time CMS has not provided clear guidance on the usage of this modifier

Nationally Recognized Source Documents



Coding Manuals

Coding Manuals:

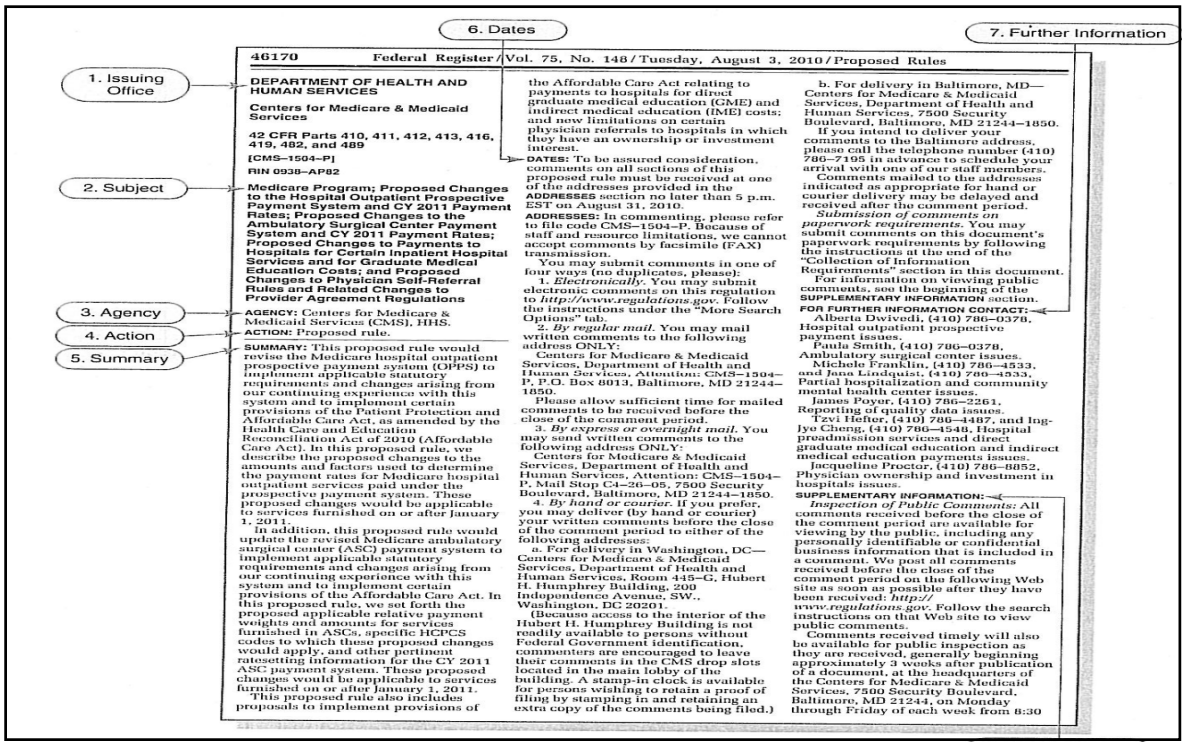
- CPT - Current Procedural Terminology (Describes Procedure Codes)
- ICD-9 CM - International Classification Of Diseases 9th Revision Clinical Modification Describes diagnosis codes, medical necessity or the reason for the visit.
- HCPCS - Health Care Financing Administration Common Procedure Coding System (Describes DME, Drugs, Supplies, etc.)
- **Save Older Versions!**

Federal Register

Federal Register:

- Addresses reimbursement
- Proposed changes
  - Allows for comments and suggestions to the proposed changes
  - Final rule is published in the fall and implemented the following calendar year

https://www.federalregister.gov/



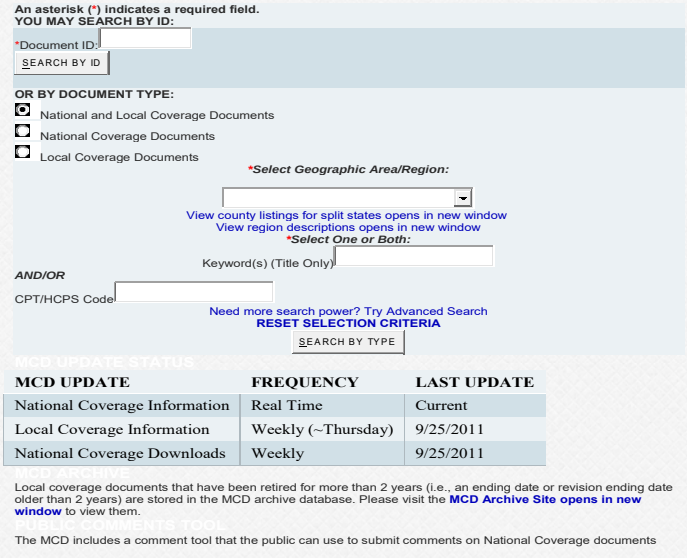
Local Coverage Determinations

Local Coverage Determinations:

- Effective date, revision date
- Indications & Limitations
- Qualified Professionals
- Medical Necessity
- Required Documentation
- Frequency

- Change Frequently and should be checked routinely for updated/revisions
- http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx

Local Coverage Determinations



MCD UPDATE	FREQUENCY	LAST UPDATE
National Coverage Information	Real Time	Current
Local Coverage Information	Weekly (~Thursday)	9/25/2011
National Coverage Downloads	Weekly	9/25/2011

CMS Internet Only Manual

CMS Internet Only Manual:

- Internet Only Manual (IOM)
- http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html
- Medicare Benefit Policy Manual
- Medicare National Coverage Determinations (NCD) Manual
- Medicare Claims Processing Manual
- Medicare Secondary Payer Manual
- Medicare Contractor Beneficiary and Provider Communications Manual

Care furnished to an individual who has elected the hospice care option is custodial only if it is not reasonable and necessary for the palliation or management of the terminal illness or related conditions. (See the Medicare Benefit Policy Manual, Chapter 9, "Coverage of Hospice Services Under Hospital Insurance," §40.)

120 - Cosmetic Surgery
(Rev. 1, 10-01-03)
A3-3160, HO-260.11, B3-2329

Cosmetic surgery or expenses incurred in connection with such surgery is not covered. Cosmetic surgery includes any surgical procedure directed at improving appearance, except when required for the prompt (i.e., as soon as medically feasible) repair of accidental injury or for the improvement of the functioning of a malformed body member. For example, this exclusion does not apply to surgery in connection with treatment of severe burns or repair of the face following a serious automobile accident, or to surgery for therapeutic purposes which coincidentally also serves some cosmetic purpose.

130 - Charges Imposed by Immediate Relatives of the Patient or Members of the Patient's Household
(Rev. 1, 10-01-03)
A3-3161, HO-260.12, B3-2332

A. General
These are expenses that constitute charges by immediate relatives of the beneficiary or by members of their household. The intent of this exclusion is to bar Medicare payment for items and services that would ordinarily be furnished gratuitously because of the relationship of the beneficiary to the person imposing the charge. This exclusion applies to items and services rendered by providers to immediate relatives of the owner(s) of the provider. It also applies to services rendered by physicians to their immediate relatives and items furnished by suppliers to immediate relatives of the owner(s) of the supplier.

B. Immediate Relative

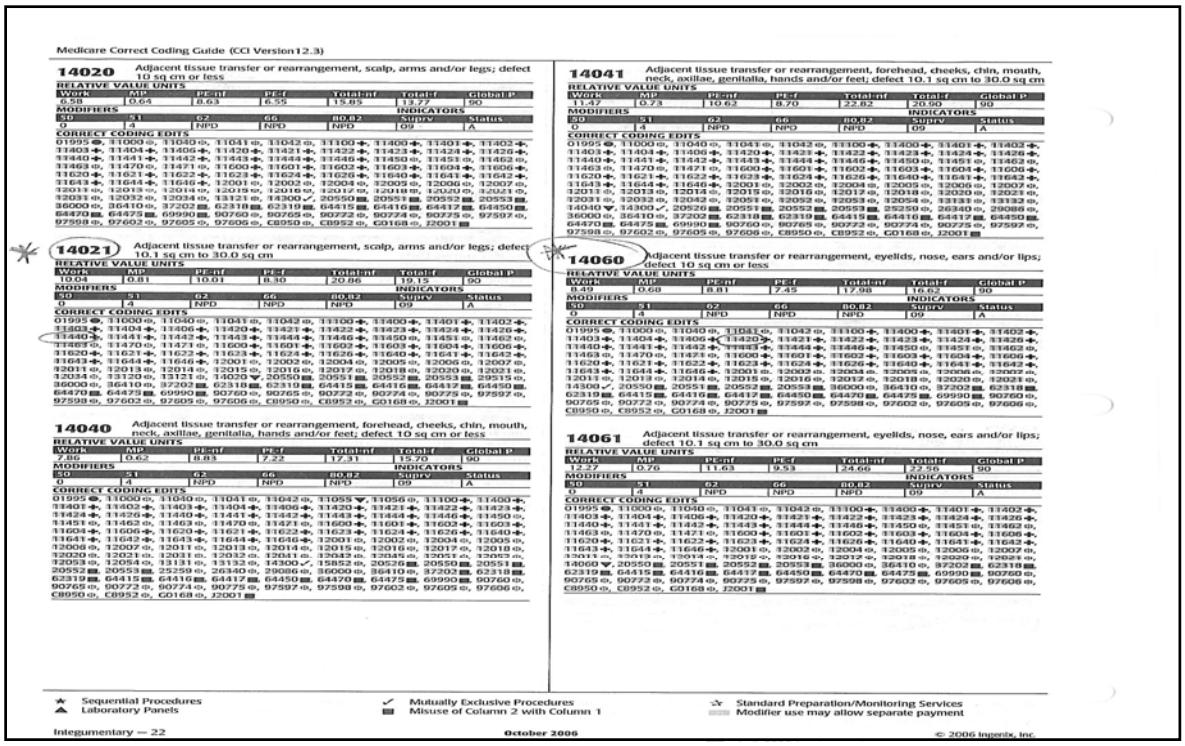
The following degrees of relationship are included within the definition of immediate relative.

- Husband and wife;
- Natural or adoptive parent, child, and sibling;
- Stepparent, stepchild, stepbrother, and stepsister;
- Father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, and sister-in-law;

NCCI Edits

NCCI Edits:

- National Correct Coding Initiative (NCCI) edits
- https://www.cms.gov/nationalcorrectcodinited/
- The purpose of the NCCI edits is to prevent improper payment when incorrect code combinations are reported.
- The NCCI contains two tables of edits. The Column One/Column Two Correct Coding Edits table
- Mutually Exclusive Edits table
- Include code pairs that should not be reported together for a number of reasons explained in the Coding Policy Manual.



Medicare Correct Coding Guide (CCI Version12.3)

14020 Adjacent tissue transfer or rearrangement, scalp, arms and/or legs; defect 10 sq cm or less

14021 Adjacent tissue transfer or rearrangement, scalp, arms and/or legs; defect 10.1 sq cm to 30.0 sq cm

14040 Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less

14041 Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10.1 sq cm to 30.0 sq cm

14060 Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less

14061 Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10.1 sq cm to 30.0 sq cm

★ Sequential Procedures ▲ Laboratory Panels ✓ Mutually Exclusive Procedures ■ Misuse of Column 2 with Column 1 ☆ Standard Preparation/Monitoring Services Modifier use may allow separate payment

Integumentary — 22 October 2006 © 2006 Ingenix, Inc.

NCCI EDITS

INTRODUCTION_final10312012.doc
Revision Date: 1/1/2013

INTRODUCTION
FOR
NATIONAL CORRECT CODING INITIATIVE POLICY MANUAL
FOR MEDICARE SERVICES

G. **Medically Unlikely Edits (MUEs)**

1. MUEs are described in Chapter I, Section V.

2. Providers/suppliers should be cautious about reporting services on multiple lines of a claim utilizing modifiers to bypass MUEs. MUEs were set so that such occurrences should be uncommon. If a provider/supplier does this frequently for any HCPCS/CPT code, the provider/supplier may be coding units of

3. CPT codes 76942, 77002, 77003, 77012, and 77021 describe radiologic guidance for needle placement by different modalities. CMS payment policy allows one unit of service for any of these codes at a single patient encounter regardless of the number of needle placements performed. The unit of service for these codes is the patient encounter, not number of lesions, number of aspirations, number of biopsies, number of injections, or number of localizations.

CPT Assistant

CPT Assistant:

- Coding Communication to keep you informed - discover the most timely, up-to-date information on codes
- Clinical Vignettes that offer insight into confusing codes
- Coding Consultation that covers your most frequently asked questions
- Anatomical illustrations, charts and graphs for quick reference Information

July 2008 page 5

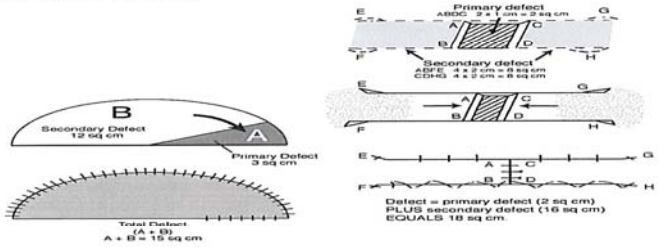
Coding Communication: Adjacent Tissue Transfer or Rearrangement

Adjacent tissue transfer or rearrangement procedures (local flaps) are described by CPT codes 14000-14350 and represent local flaps, including rotation, transposition, and advancement. To perform adjacent tissue transfers, a tissue flap is created by surgically freeing the skin and underlying subcutaneous tissue and/or fascia. The base of the tissue flap remains connected to one or more borders of the donor site, thus maintaining the blood supply to the surgically created flap.

The following table describes types of local or adjacent flaps.

Type of flap	Characteristics	Examples
Rotation	Curvilinear flap that closes a defect by rotation of skin around a pivot point	
Transposition	A flap that is cut, lifted, and transferred over intervening tissue into the defect	Rhombic, bilobed, nasolabial fold
Advancement	Tissue is moved in a straight line and stretched over the defect	V-Y

As with many of the codes in the Integumentary System section, codes 14000-14300 are reported on the basis of the anatomic area and defect size. The term *defect* includes the primary and secondary defects. The primary defect, which results from the excision, and the secondary defect, which results from flap design to perform the reconstruction, are measured together to determine the square centimeter area (in sq cm) in order to choose the correct code.



The excision of a benign lesion (codes 11400-11446) or a malignant lesion (codes 11600-11646) is not reported separately with codes 14000-14300. When an adjacent tissue transfer or rearrangement is performed after the excision of lesions, the excision of the lesion is included with codes 14000-14350 and is not reported separately.

When it is applied to the repair of lacerations, an adjacent tissue transfer or rearrangement must be purposely performed by the surgeon to accomplish the repair. For example, if direct closure or rearrangement of traumatic wounds results in the incidental configuration of a "Z", it is not appropriate to report these codes.

The following table is provided to assist in selection of the appropriate code.

Anatomic area	10 sq cm or less	10.1 sq cm to 30 sq cm	Over 30 sq cm

Example 1

A physician excises a 1.5 cm lesion on the cheek with an excised diameter of 1.8 cm (primary defect, approximately 3.2 sq cm) and performs an adjacent tissue transfer (flap dimension of 1.4 3 3.0 cm) which equals a 4.2 sq cm secondary defect). In this instance, only code *14040, Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less*, would be reported, because the excision of the lesion is included in the adjacent tissue transfer codes. The primary defect (3.2 sq cm) plus the secondary defect (4.2 sq cm) equals 7.4 sq cm for dimensions of the total defect.

Sometimes a tissue transfer or rearrangement procedure creates an additional defect that must be repaired. If a skin graft or another flap is necessary to close a secondary defect, this should be reported separately, as indicated in Example 2.

Example 2

A 6 cm malignant lesion with 0.5 cm margins and a 7 cm excised diameter is excised from the neck. A transposition flap is used to close the 50 sq cm defect. The flap donor site is partially closed, but there is a remaining 10 sq cm defect, which requires a split-thickness skin graft:

14300 Adjacent tissue transfer

15120 Split-thickness autograft
51

The lesion excision is included in the adjacent tissue transfer code and is not coded separately. The skin graft necessary to close the flap donor site is coded in addition to the flap.

Note that modifier *51, Multiple Procedures*, is appended to CPT code 15120 to indicate that multiple procedures were performed at the same session by the same physician. However, reporting practices related to these services may vary, and third-party payers should be consulted for their preferred method of reporting multiple procedures. Some payers may require the use of modifier 59.

Example 3

A patient's nostril is retracted secondary to a scar. The scar is excised, and an 11 sq cm dorsal nasal flap used to repair the 2 sq cm defect resulting from the scar excision.

14061 Adjacent tissue transfer

When a scar is excised and the defect repaired with a flap, report only the appropriate adjacent tissue transfer code, which includes the scar excision.

Example 4

A lesion is removed from the forehead, resulting in a 5.2 sq cm defect, and another lesion is removed from the neck, resulting in a 7.3 sq cm defect; both lesions require rotational and advancement flaps of 10.2 sq cm and 12.2 sq cm, respectively, to provide closure.

14041 Adjacent tissue transfer, forehead lesion

14041 Adjacent tissue transfer, neck lesion
51

If two lesions from the same anatomical classification are removed, with both of the resulting defects requiring adjacent tissue transfer closure, the appropriate code from the 14000-14300 series may be reported for each tissue transfer (eg, flap advancement) performed, provided the defects have distinct margins and are not contiguous. For the forehead and neck excisions in this example, CPT code 14041 is reported twice, with modifier 51 appended to the second code. Although both anatomic sites fall into the same anatomic classification, as defined by the code descriptor for code 14041, the defects do not have contiguous margins and represent separate and distinct defects. Some payers may require the use of modifier 59.

Example 5

Excision of nasal basal cell carcinoma (BCC), cheek scar, BCC of the forehead, and nevus of the chin.

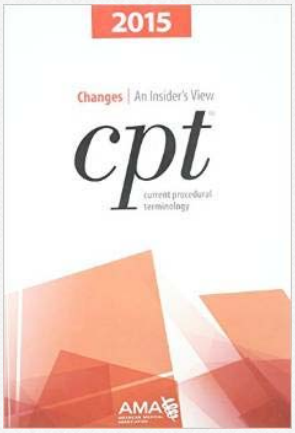
14060 Adjacent tissue transfer (excision of nasal BCC and nasal flap)

14040 Adjacent tissue transfer (excision of cheek scar and two Z-plasties)
51

CPT Changes An Insider's View

CPT Changes an Insiders View:

- Organized by CPT code section and code number, just like the CPT code book
- Detailed rationales provide an explanation as to why the code change occurred
- "At-a-glance" tabular review of 2013 code, text and guideline changes
- Useful clinical examples, procedural descriptions and illustrations throughout



Abdomen

EXCISION

▲ 22900
Excision, tumor, soft tissue of abdominal wall, subfascial (eg, intramuscular); less than 5 cm

● 22901
5 cm or greater

● 22902
Excision, tumor, soft tissue of abdominal wall, subcutaneous; less than 3 cm

● 22903
3 cm or greater

● 22904
Radical resection of tumor (eg, malignant neoplasm), soft tissue of abdominal wall; less than 5 cm

● 22905
5 cm or greater

Rationale

In the Abdomen section, code 22901 has been established to report excision of a subfascial soft tissue tumor of the abdominal wall, greater than 5 cm. Code 22900 has been revised for standardization of the nomenclature to describe excision of a subfascial soft tissue tumor of the abdominal wall, less than 5 cm.

Codes 22902 and 22903 have been established to report excision of a subcutaneous soft tissue tumor of the abdominal wall, less than and greater than 3 cm. Codes 22904 and 22905 have been established to report radical resection of a soft tissue tumor of the abdominal wall, less than and greater than 5 cm.

Clinical Example (22900)

A 40-year-old male undergoes excision of a 4-cm lipoma of the external oblique muscle.

Description of Procedure (22900)

An incision is made through the skin and subcutaneous tissue over the lesion. Subcutaneous flaps are raised with electrocautery. The external oblique muscle is exposed around the tumor. The tumor is excised along with surrounding muscle using electrocautery and dissection. As the tumor is lifted out of the wound, small lymphatics and feeding blood vessels are ligated. Hemostasis is secured with electrocautery and sutures where needed. The wound is inspected and irrigated. The devitalized muscle is debrided. Where possible, the muscle fascial defect is approximated. A Penrose drain is placed in the cavitary defect. The wound is closed in layers with interrupted sutures.

OIG Work Plan

OIG Work Plan:

- http://oig.hhs.gov/publications/workplan.asp
- Published yearly in October/November
- A good guide to provide an annual check up for your practice
- 2016 Some Targeted Areas
  - Medical Necessity
  - Overutilization (e.g. KX Modifier)
  - Physical Therapy
  - Chiropractic Services
  - EMR Incentives

Documentation Guidelines

Documentation Guidelines:

- 1995 & 1997 Documentation guidelines
- Rules and Regulations regarding Evaluation & Management coding
- Utilized by all insurance carriers including Medicare

MED Learn

Medicare Learning Network:

- https://www.cms.gov/mlnmattersarticles/
- Articles
- Newsletters
- Webinars

Being Prepared

Being Prepared & Staying Compliant

Compliance Plan:

- OIG has a compliance plan posted on their website
- http://oig.hhs.gov/fraud/complianceguidance.asp
- It is not mandatory, however, it should be considered preventive medicine for your practice

Office Policy and Procedure Manual:

- Include a section about proper medical record documentation
- Ensure that staff is trained
- Develop a policy for internal and external auditing

Being Prepared & Staying Compliant

OMIG – Office of Medicaid Inspector General:

- Mandatory Compliance Plan for providers doing $500,000.00 or more in Medicaid & Medicaid HMO Business
- http://www.omig.ny.gov/compliance

QUESTIONS & COMMENTS

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MEDCO
CONSULTANTS, INC.

THANK YOU

Presented by: Jacqueline Thelian, CPC. CPC-I, CHCA