

# Medicare Compliance & Regulation

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## TRANSMITTALS

### CMS Halts Bilateral Payment For Certain Procedures

► *Plus: Medicare debuts several new codes*

If you've become accustomed to collecting additional reimbursement when you report endometrial ablation bilaterally, you can wave goodbye to that extra money as of July 1.

Effective for dates of service starting July 1, Medicare has changed the bilateral indicator for 58353 (*Endometrial ablation*) and 58356 (*Endometrial cryoablation*) from "1," which indicates that bilateral payment is allowable, to "0," which means that "bilateral payment will not be allowed with these codes," says **Heather Corcoran** of **CGH Billing**.

CMS outlined the information in Transmittal 1528, which includes several changes that take effect in July.

In addition, Medicare will no longer recognize multiple-procedure payment with 51797 (*Intra-abdominal voiding pressure*) and +15847 (*Excess skin excision*).

Although these codes previously had multiple-procedure indicators of "2" (meaning that Medicare paid 100 percent for the highest-paying procedure and 50 percent for the others), CMS now assigns them indicator "0," allowing no payment adjustment.

#### CMS Introduces New Codes

Starting July 1, Medicare will recognize several new codes that CMS recently added to the Fee Schedule. CPT 2009 will include these codes.

You'll find several new Category III codes to report, such as 0190T (*Intraocular radiation applicator placement*) and 0191T-0192T (*Ant. segment insertion drainage without reservoir*), all of which will be carrier-priced.

*(Continued on following page)*

## TRANSMITTALS

(Continued from previous page)

**Critical care:** CMS debuts two new Category III codes to report videoconferenced critical care. You can submit 0188T for the first 30-74 minutes of critical care videoconferencing, and 0189T for each additional 30 minutes. “These codes could be helpful, but CMS currently

assigns them a status indicator of ‘N,’ meaning it’s currently noncovered,” says **Jay Neal**, a coding consultant in Atlanta.

You can read CMS’ Transmittal at [www.cms.hhs.gov/Transmittals/downloads/R1528CP.pdf](http://www.cms.hhs.gov/Transmittals/downloads/R1528CP.pdf). ■

## PUBLIC HEALTH

### HHS Handing Out Big Bucks For Medical Emergencies

#### ► \$1.1 billion will improve healthcare providers’ response to terrorism, pandemics

The **Department of Health and Human Services** has given a big boost to healthcare organizations’ efforts to respond to pandemic influenza, other naturally occurring emergencies, and terrorism.

In a June 3 press release, HHS Secretary **Mike Leavitt** says the department has \$1.1 billion for health departments, hospitals and healthcare delivery systems.

“States and local communities need to be supported because they are the front lines of response in a health emergency,” Leavitt says in the release. “These funds will continue to enhance community readiness by increasing the capabilities of health departments, hospitals and healthcare delivery systems to respond to any public-health emergency.”

Health departments in states, territories and the metro areas of New York City, Chicago, Los Angeles County and Washington, DC, will have access to \$704.8 million from the **Centers for Disease Control and Prevention’s** Public Health Emergency Preparedness cooperative agreement.

And \$398 million will be available from the Hospital Preparedness Program of the **HHS Assistant Secretary for Preparedness and Response**.

The release says that the Public Health Emergency Preparedness money will be used to meet goals that include:

- integrating public health and public and private medical capabilities with other first-responder systems;
- addressing the public health and medical needs of at-risk individuals (such as children, or people with chronic medical disorders) in a public-health emergency; and
- ensuring coordination among state, local, and tribal planning, preparedness and response activities.

#### Money Going For Development And Improvement

Funding from the Assistant Secretary for Preparedness and Response can go toward improving the readiness of hospitals and other healthcare organizations. The release says that recipients will use the money to finalize development of or improve:

- interoperable communication systems;
- systems to track available hospital beds;
- advance registration of volunteer health professionals;
- processes for hospital evacuations or sheltering-in-place;
- processes for fatality management; and
- strengthening healthcare partnerships at the community level. ■

## BUDGET

# Medicare Bill Takes Aim At Oxygen, Wheelchairs

## ► Home health agency and hospice payments are safe, for now

Politicians in Washington, DC are getting down to business in figuring out how to pay for Medicare's physician payment adjustment, and it could be oxygen and wheelchair suppliers who suffer.

Home health agencies, hospices and durable medical equipment suppliers have all feared receiving payment cuts in the bill that will avert the 10 percent cut to physician payment rates set to go into effect July 1. But in Democrats' first pass at a bill (S. 3101), just oxygen and wheelchair providers' fears are realized.

### Nearly \$10 Billion Could Delay Cuts

**The winners:** The bill that Senate Finance Committee Chair **Max Baucus** (D-MT) introduced June 6 calls for nearly \$10 billion to delay the doc rate cut for 18 months and increase rates 1 percent.

To pay for the change, the legislation mostly relies on Medicare Advantage cuts. But it also taps other unlucky providers, including some home care ones.

**The losers:** The bill calls for oxygen suppliers to retain the title of oxygen equipment when beneficiaries no longer need it, according to a summary of the legislation. And it "reforms the oxygen payment system to better reflect appropriate payment for medically necessary products and services," the Committee's summary says.

The bill would reduce payment rates for stationary concentrators to about \$144 a month from the current rate of \$198 a month, explains the **National Association for Home Care & Hospice**. But rates for portable equipment would increase from \$32 a month to \$77.

"Combined payment for stationary concentrators plus portable equipment would be \$222 a month, compared to the current rate of \$230 a month," NAHC concludes.

### Wheelchair Payments Could Drop 7.5 Percent

The bill also proposes to eliminate the first month purchase option for power wheelchairs, except for complex rehab chairs, the Committee says. The legislation would actually increase power wheelchair payments in the first

three months of the rental period from 10 to 15 percent, but payments in the remaining 10 months would drop up to 7.5 percent.

**Optimistic:** While budget bills are notorious for last-minute changes, things are looking promising for HHAs and hospices in this legislation, NAHC judges.

"Indications ... are good that the Medicare package, as it did last year, will preserve the home health and hospice inflation updates," the trade group cheers.

The bill contains other provisions that could affect home care, including a ban on deceptive Medicare Advantage marketing, an extension of the Part B therapy cap exceptions process, and a demonstration project to coordinate care including home care.

### Bill Faces Veto Challenge

**Horizon cloudy:** But the bill's path to law is far from clear. When Baucus broke off bipartisan negotiations on the bill a few weeks ago, the Bush Administration stated the President's intention to veto any bill that includes MA plan cuts.

The legislation "makes smart changes to stop overpayments to private plans that are getting more than their share of taxpayer dollars," Baucus says in a release.

### Republicans To Introduce Alternative

Senate Republicans will shortly introduce a similar bill averting the physician pay cut with different funding sources, according to press reports.

Negotiations among the lawmakers will have to proceed quickly to avoid the July 1 deadline, observers note. Until a Medicare bill is signed into law, all home care providers' payment rates are at risk.

**Bonus:** There's also a chance for positive changes. Sen. Baucus is seriously considering reinstating the 5 percent rural add-on for HHAs in the bill, NAHC reports.

**Note:** A summary of the bill is online at <http://finance.senate.gov/press/Bpress/2008press/prb060608a.pdf>. ■

## REVENUE BOOSTER

# Nail Down Acronyms To Code Charts Properly Every Time

## ► *Would you be able to count E/M bullets properly if the physician wrote ‘WBC/WNL’?*

If you can't differentiate such terms as PH and PI, your coding may suffer.

**Here's why:** When the physician documents a chart, he doesn't always have time to spell out phrases such as “past history” (PH) and “present illness” (PI), but knowing which is which can make a tremendous difference in the accuracy of your charts.

If you code a chart assuming that the patient currently suffers from every condition listed as “PH,” you'll be coding the wrong diagnoses for the current illness.

Because of the extended disease and procedure names in the healthcare world, physicians use a system of communication using acronyms and abbreviations to facilitate more efficient communication among other medical professionals.

**What is it?** An acronym is a word formed from the initial letter (or letters) of words in a phrase or multi-word description.

Unfortunately, in addition to being more efficient, the onslaught of acronyms has increased the possibility of error because of misunderstandings of the acronym or abbreviation.

For instance, you may see a radiology report that refers to “FS,” which could indicate a “fracture, simple” or may just mean that the film was shot while the patient's forearm was supinated.

**Best bet:** Get to know the most frequent acronyms for your practice.

“I memorize them,” says **Kay Brown, CPC**, of **Bayou Anesthesia and Pain** in Spring, TX. “When I come across one I have not seen before, I have a coders' dictionary that I use, and I also look on Web MD.”

And when all else fails, you can ask the physician who documented the acronym for a definition.

**Example 1:** The physician documents the following note: “35 y.o. new pt. requires treatment for UTI determined by abn. C&S.”

In this case, a 35-year-old new patient required treatment for a urinary tract infection (UTI) that the urologist diagnosed via an abnormal (abn.) culture and sensitivity test (C&S).

**Example 2:** Suppose the doctor documents that the WBC is WNL.

In this example, the patient's white blood count is within normal limits, says **Randall Karpf** of **East Billing** in East Hartford, CT. ■

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## HEALTH IT

### Communities Join Electronic Health Record Demo Project

#### ► Selected practices to get cash rewards up to \$290,000

##### Department of Health and Human Services

Secretary **Mike Leavitt** applauded more than 30 communities for registering for a new demonstration project that will improve efficiency in healthcare, says a press release from the HHS. The project provides incentive payments to primary-care physician practices that use certified electronic health records to improve the quality of patient care.

“This is an outstanding response from communities and, in some cases, entire states,” Leavitt says.

The project aims to reduce medical errors and improve the quality of care for an estimated 3.6 million Americans. The performance of the small and medium physician practices would be measured against specific clinical measures

over a five-year period. Out of these, 1,200 physician practices in 12 communities that use certified EHRs to improve quality would be provided financial incentives, and bonus payments would be awarded after CMS has assessed the number of EHR functionalities a physician group has incorporated into its practice.

Under the demonstration, total payments for all five years may be up to \$58,000 per physician or \$290,000 per practice.

The 12 EHR community partners will be announced in June. CMS will then begin working with community partners to recruit small- and medium-size primary-care physician practices to take part in the demonstration. ■

## READER QUESTION

### Check These Rules Before Billing For Stitch Removal

#### ► You must differentiate between simple post-op removal and more complex procedures

**Question:** *Our physician saw a patient for the sole purpose of removing the patient's stitches. Which code should we report for the suture removal?*

**Answer:** You may be able to report suture removal separately, but only in relatively rare circumstances. If the same physician who placed the sutures removes them during the original procedure's global period, you cannot report the removal separately.

**For example:** A patient returns to the office for suture removal during the global period of the surgery that warranted the stitches. In this case, you cannot report the removal separately because carriers consider it to be part of the standard follow-up care.

**Tip:** Payers associate a zero charge with 99024 (*Postoperative follow-up visit, normally included in the surgical package, to indicate that an evaluation and management service was performed during a postoperative period for a reason[s] related to the original procedure*), but you can use it to keep track of visits for risk management purposes to show that the patient did present for a follow-up visit within the surgical period.

If you must place a patient under general anesthesia for suture removal, you may be able to report the service separately using 15850 (*Removal of sutures under anesthesia [other than local], same surgeon*) or 15851 (*Removal of sutures under anesthesia [other than local], other surgeon*) — but cases that call for coding of this kind are unusual.

**Example:** A patient received sutures for a serious wound, and skin has grown over the sutures, requiring a complex suture removal. The same surgeon who placed the sutures returns the patient to the OR and places her under general anesthesia to remove the sutures. In this case, you may report 15850.

**Avoid this mistake:** You should not append 15850 or 15851 with modifier 52 (*Reduced services*) to get paid for suture removal without anesthesia. ■

## CODING COACH

### Vascular Family Matters For Catheter Coding

#### ► *Not every vessel the surgeon crosses deserves a code*

Vascular coding basics tell you not to report nonselective catheter placement with selective placement from the same access site. But what if the surgeon positions the catheter in multiple vascular families from the same access site? Our experts have outlined what you should (and shouldn't) do when coding these tricky procedures.

You should code separately each vascular family the surgeon accesses separately, first determining the highest-order branch the physician accesses in each family, says **Sheri Bernard, CPC, CPC-H, CPC-P**, vice president of member relations for the **American Academy of Professional Coders**.

Pay attention to whether the physician catheterized more than one vascular family during the procedure.

**Example:** From a right femoral access point, the physician positions the catheter in the right subclavian artery, performs imaging and then repositions the catheter in the right common carotid artery. Both of these vessels are branches of the brachiocephalic/innominate artery that arises at the aortic arch, and they both represent second-order selective catheter positions.

For the initial second-order catheter position above the diaphragm, you should report 36216 (*Selective catheter placement, arterial system; initial second-order thoracic or brachiocephalic branch, within a vascular family*). Report the second cath position with +36218 (... *additional second-order, third-order, and beyond, thoracic or brachiocephalic branch, within a vascular family [list in addition to code for initial second- or third-order vessel as appropriate]*).

**Don't miss:** You should assign all additional second- and third-order branches within the same vascular family using either 36218 or +36248 (*Selective catheter placement, arterial system; additional second-order, third-order, and beyond, abdominal, pelvic, or lower-extremity artery branch, within a vascular family [list in addition to code for initial second- or third-order vessel as appropriate]*).

**Important distinction:** You'll use 36215-36218 to report thoracic and brachiocephalic selective arterial pro-

cedures, and 36245-36248 to report abdominal, pelvic and leg selective arterial procedures.

In other words, you should use 36215-36218 for arteries above the diaphragm and 36245-36248 for arteries below the diaphragm, says **Jackie Miller, RHIA, CPC**, senior consultant with **Coding Strategies Inc.** in Powder Springs, GA. You should look to 36014-36015 for selective pulmonary artery catheterization.

**Great resource:** CPT Appendix L, "Vascular Families," lists the first, second, third and higher order branches for each vascular family. This is a simple way to determine whether the surgeon is addressing more than one vascular family — identify individual vessels and determine the order of each vessel treated.

Be aware, however that you should not code for any branches the surgeon must cross as a pathway to the second- or third-order branches beyond.

In other words, you should code only the highest-order catheter placement the physician achieved within each vascular family, Bernard says. Avoid coding the lower-order catheter placements that are "on the way to" the higher-order position.

If the physician performs a selective and nonselective catheter placement through the same vascular access site, you should not separately report the nonselective placement because payers would consider this "en route" to the selective catheter position, Bernard says.

But if two access sites are involved in the procedure (one selective, the other nonselective), you should report both the selective catheter placement (such as 36245) and the nonselective catheter placement (such as 36140, *Introduction of needle or intracatheter; extremity artery*).

**Remember:** You should attach modifier 59 (*Distinct procedural service*) to the nonselective catheter placement code to illustrate that it occurred by way of a different access site.

**Translation:** Use modifier 59 whenever you report a lower-order catheter placement with a higher-order catheter placement. ■

## REHAB PROVIDERS

### Perfect What You Know About Certifications

#### ► *Plus: Your progress report deadlines aren't what they used to be*

When the Medicare Physician Fee Schedule Final Rule hit the press last November, rehab providers were happy to see certification periods extend to 90 days on Jan. 1, 2008. If you've been applying this new guideline since the beginning of the year, you're on the right track, but CMS has a few more bones to pick when it comes down to the details.

Read on to learn more about what recently released CMS transmittal 88 (CR 5921) has to say about your physician certifications.

#### 90 Days Isn't Always The Magic # For POCs

One of the first points the transmittal brings up is that certification intervals aren't *automatically* 90 days. Instead, they may be "90 calendar days *or less*, based on an individual's needs," CMS states (emphasis added). This was implemented on June 9 and retroactive to Jan. 1.

**Example:** Suppose you do an evaluation of a Medicare patient and establish a plan of care for therapy two times a week for eight weeks. "When the physician signs and dates that plan of care, the certification will only be valid for those 16 visits — which would equal out to about 56 days, as opposed to 90," explains **Rick Gawenda, PT**, director of PM&R at **Detroit Receiving Hospital** and owner of **Gawenda Seminars**.

In fact, "most plans of care are not going to be developed for 90 days; this policy just allows the therapist the freedom to establish longer care plans that are 'up to 90 days' if needed."

**Don't miss:** Although your initial certification interval can be up to 90 days, that doesn't mean you can wait that long for the physician's signature. You must obtain a physician's (or NPP's) signature within 30 days of the initial treatment date or significantly modified plan of care, says **Ellen Strunk, PT, MS, GCS**, owner of **Rehab Resources and Consulting** in Birmingham, AL. For initial certifications, remember that the first day of treatment includes your evaluation, CMS stresses.

For recertifications, CMS considers them timely "when dated during the duration of the initial plan of care or within 90 calendar days of the initial treatment under that plan, whichever is less."

#### Know The New Progress Report Deadlines

When CMS changed the certification interval to a maximum of 90 days last November, therapy progress report guidelines suddenly became a little fuzzier.

Previously, progress reports were due once every 10 visits or once every certification interval — whichever came first.

*(Continued on following page)*

## INDUSTRY NOTES

### It's Not Too Late To Participate In PQRI

#### ► *Envious of the 1.5 percent bonuses? You can join the program as of July 1*

If you haven't jumped on the PQRI bandwagon yet, now's the time to get on board.

CMS will honor an alternative reporting period this year that runs between July 1 and Dec. 1. "So insofar as professionals that have not begun to participate, this will give an additional opportunity to begin participation in PQRI for this year," according to information noted on a June 10 CMS open door forum (ODF).

"The incentive payment of 1.5 percent for Part B services will only apply to that second half of the year, July 1 to Dec. 31, but nevertheless, professionals who report this way will be able to get that incentive payment," a CMS official said during the ODF.

For more about the PQRI program, visit the CMS Web site at [www.cms.hhs.gov/pqri](http://www.cms.hhs.gov/pqri). ■

## REHAB PROVIDERS

(Continued from previous page)

But with the much longer, 90-day certification interval, that ruling was a bit outdated.

**The result:** In this transmittal, CMS changed the requirement to state that progress reports are due once every 10 visits or once every 30 calendar days — whichever comes first. “A lot of people thought that since CMS changed the certification interval to 90 days that the progress report would be due only once every 90 days, but now the due date is no longer based on the certification interval,” Strunk says.

This ties into the important clarification that progress reports and recertifications aren’t the same thing — a common misinterpretation, Gawenda points out. “It wouldn’t be uncommon for people to have the physician sign a progress note every 30 days (back when the progress report was due on the certification interval) and count it as a recertification.”

But this won’t work anymore unless your recertification deadline and progress report due date somehow match up, which is unlikely with the new guidelines. Now, in most cases your progress report will be due before you have to recertify. Also, keep in mind that the required elements for a recertification are vastly different from the required elements in a progress report, Gawenda adds.

**Good idea:** To keep your Medicare contractors happy — and to give yourself a better shot at good reimbursement — don’t do the bare minimum when it comes to progress report deadlines.

In this new transmittal, CMS actually encourages (although doesn’t require) therapists to write progress reports more often — and with good reason. “If I write a note on a patient today and don’t write another progress report for 10 visits, and the insurance company is considering a denial, it may go all the way back to that last progress report as its first reference and deny the entire 10 visits in between because there wasn’t enough documentation to support the medical necessity of my treatment and the functional improvement of the patient,” Gawenda says.

### Remember These Facts When Modifying POCs

CMS also had comments on your plans of care. First, the agency officially states that it may be appropriate “to taper the frequency of visits as the patient progresses”

even if you’re providing less therapy than you intended in your plan of care or end your visits sooner than expected. “This means your Medicare contractor can’t deny therapy simply because of a tapered or low frequency of visits,” Gawenda says. In fact, in the directions for contractors, the transmittal states, “Contractors shall not deny services on the basis of a low frequency or duration of treatment.”

**Requirement:** If you make a “significant change” to a plan of care, you must have the physician sign it within 30 days. CMS explains that a significant change would be a change in long-term goals. “This takes away the myth that every time you change something you have to get a physician signature,” Strunk says. “Essentially, as long as the patient is progressing according to the plan, you can alter things like short-term goals or frequency of therapy.”

**Note:** To view the full transmittal, visit [www.cms.hhs.gov/Transmittals/downloads/R88BP.pdf](http://www.cms.hhs.gov/Transmittals/downloads/R88BP.pdf). ■

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