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Will ICD-10 Implementation be Tied to the Sustainable Growth Rate Once Again?

Denise M. Nash, MD, CCS, CIM
Vice President of Compliance and Education
MiraMed Global Services

What is Currently Known: ICD-10 implementation was delayed one year because it was tied to the "One year doc-fix," otherwise known as Protecting Access to Medicare Act of 2014 (PAMA).* This delay, which was passed by Congress and signed by President Obama on April 1, 2014, was a short-term delay to the Medicare physician pay cut.

What This Means: It means that Congress once again must act by April 1, 2015; otherwise, the proposed conversion factor (CF)** of $28.2239 might go into effect. If the proposed CF scheduled from April to December of 2015 is approved, this will mean a 21.2 percent reimbursement decrease compared to the calendar year (CY) of 2014.

The Sustainable Growth Rate (SGR) was created in 1997 by Congress to curb federal spending by restraining the growth of Medicare's reimbursements to physicians. Since 2002, Congress has passed the "doc-fix" to prevent cuts allowing reimbursement to physicians. Although Congress had made significant progress on a Medicare pay reform plan that would provide a permanent, bipartisan solution to the ongoing SGR cuts, the permanent fix stalled over disagreement and key political challenges about how to pay for the SGR reform. Although there is agreement about the need to scrap the SGR, there is little consensus on a replacement. There is also agreement that moving physicians to alternative payment models is the answer, but first a decision has to be made on what to do with the current Medicare physician fee schedule.

Congressional members of the House Energy and Commerce Subcommittee on Health kicked off a two-day meeting on January 21, 2015 entitled "A Permanent Solution to the SGR: The Time is Now." This meeting was set up to

(Continued on page 2)

TABLE *of* CONTENTS

If you have an article or idea to share for *The Code*, please submit to:
Dr. Denise Nash
denise.nash@miramedgs.com

Faith is taking the first step even when you don't see the whole staircase.

Martin Luther King, Jr.

Will ICD-10 Implementation be Tied to the Sustainable Growth Rate Once Again? *(continued from page 1)*

find a way to reform the SGR formula and thereby offsetting the $140 billion the program costs the government. The subcommittee has until March 31, 2015 to find a solution before the PAMA measure expires. This fix is not dependent on who controls the United States Senate. This is a non-partisan non-issue. However, the conundrum remains how to pay for SGR reform in a manner that can pass both Houses of Congress and be signed by the President. To this end, the subcommittee met with Richard Umbdenstock, President and Chief Executive Officer of the American Hospital Association, on January 22, 2015; who proposed combining Parts A and B with a unified deductible and coinsurance. This measure would replace the current cost-sharing structure for acute care coverage (Part A), and physician and outpatient services (Part B). This would translate as a single, combined annual deductible covering all services in Parts A and B of Medicare. It would also mean a uniform coinsurance rate of 20 percent for amounts above that deductible, including inpatient expenses, and have an annual cap on each enrollee's total cost-sharing liabilities.
http://democrats.energycommerce.house.gov/sites/default/files/documents/Testimony-Umbdenstock-HE-SGR-2015-1-22.pdf

The committee has until March 31, 2015 which is when the current patch expires. So, once again we shall wait and see if ICD-10 will be incorporated into the new bill delaying implementation until 2017, which would make many physicians happy as evidenced in an excerpt from a letter dated November 2014 to speaker Boehner from the Medical Society of the State of New York, the Texas Medical Association and the National Physicians' Council for Healthcare Policy asking to delay the ICD-10 implementation until October 2017. The reasons cited were:

- The costs of the new ICD-10 coding and billing mandates scheduled for October of 2015 will force financial disruptions and chaos.
- Patients will lose their doctors!

The onerous penalties tied to these mandates add to the hysteria that is running through physicians' offices and is generating many early retirements.

http://www.mssny.org/MSSNY/Practice_Resources/ICD-10/ICD-10-Boehner-Letter.aspx

So, at this point, it is a wait and see because the American Medical Association is currently working with the House Rules Committee Chair, Pete Sessions (R-TX), and House Energy and Commerce Committee Chair, Fred Upton (R-MI), to add language to a fiscal year 2015 appropriations bill for Health and Human Services (HHS) and the departments of Labor and Education that would grant an additional two-year extension.

*The Senate passed house bill (HR) 4302 64-35 March of 2013. Section 212 of the bill reads: "The Secretary of Health and Human Services may not, prior to October 1, 2015, adopt ICD–10 code sets as the standard for code sets under section 1173(c) of the Social Security Act (42 U.S.C. 1320d–2(c)) and section 162.1002 of title 45, Code of Federal Regulations."

**The CF for CY 2014 Professional Service Fee (PSF) was $35.8228. The CY 2015 PFS CF (January - March 2015): $35.8013. The proposed CY 2015 PFS CF (April - December 2015): $28.2239.

For additional information on HR4015:
http://democrats.energycommerce.house.gov/sites/default/files/documents/Section-by-Section-Summary-HR-4015-2014-2-6.pdf

How One Encounter May Be Billed to Medicare as Both a New Patient Visit and an Established Patient Visit

Joette Derricks, CPC, CHC, CMPE, CSSGB
Vice President of Regulatory Affairs & Research
Anesthesia Business Consultants, LLC

Medicare payments to hospitals for evaluation and management (E/M) outpatient clinic visits vary on the basis of whether patients are new or established. An established patient has been treated more than once at the same hospital during a three-year period. The Centers for Medicare & Medicaid Services (CMS) found in its improper payment reviews for 2008 through 2011 that E/M services were frequently miscoded. In addition, in 2009, two health care entities paid more than $10 million to settle allegations that they fraudulently billed Medicare for E/M services (OEI 04-10-00180). In a 2014 report, the Office of Inspector General (OIG) found that CMS made $7.5 million in incorrect outpatient payments to hospitals for clinic visits for calendar years (CYs) 2010 and 2011 (A-04-12-06154). A follow up report released this month by the OIG found that incorrect payments are still occurring. The report, *CMS Did Not Always Correctly Make Clinic Visit Payments to Hospitals for Calendar Year 2012,* covered $19,273,921 in Medicare payments to hospitals for clinic visits with dates of service during CY 2012. The OIG limited their review to HCPCS codes 99203 to 99205 on outpatient claims and they randomly selected 110 line items totaling $11,626 for review.

The OIG found:

- For 72 line items, hospitals incorrectly used new patient HCPCS codes to identify clinic visits for established patients, resulting in incorrect payments totaling $2,046.
- For 21 line items, in addition to incorrectly using new patient HCPCS codes for established patients, hospitals did not use correct HCPCS codes to describe the levels of services furnished, resulting in incorrect payments totaling $614.

On the basis of the sample results, the OIG estimated that CMS made incorrect payments to hospitals for clinic visits totaling $4,558,590 for CY 2012.

Federal regulations require hospitals to report the HCPCS codes that describe new and established clinic visits and CMS has on various occasions clarified the difference between a new and established patient.

> *"[T]he meanings of ''new'' and ''established'' pertain to whether or not the patient already has a hospital medical record number. If the patient has a hospital medical record that was created within the past three years, that patient is considered an established patient to the hospital. The same patient could be "new" to the physician but an ''established'' patient to the hospital."*

Since the patient may have been seen in any area of the hospital, it is quite possible that the patient is a new patient to the physician while being an established patient to the hospital. CMS' definition of a new or established patient for a physician or other qualified healthcare professional is:

> *"Interpret the phrase "new patient" to mean a patient who has not received any professional services, i.e., E/M service or other face-to-face service (e.g., surgical procedure) from the physician or physician group practice (same physician specialty) within the previous three years. For example, if a professional component of a previous procedure is billed in a three year time period, e.g., a lab interpretation is billed and no E/M service or other face-to-face service with the patient is performed, then this patient remains a new patient for the initial visit. An interpretation of a diagnostic test, reading an x-ray or EKG etc., in the absence of an E/M service or other face-to-face service with the patient does not affect the designation of a new patient."*

The hospitals that were part of the sample attributed the incorrect payments to staff making clerical and programing errors, not verifying whether the patient was registered as an inpatient or outpatient of the hospital within the past three years, not following hospital procedures, not fully understanding Medicare billing requirements for clinic visits and relying on the code that the treating physician billed for that visit.

The OIG report recommends that CMS review and recoup funds paid in error to hospitals for new patients when the patient's classification was not in accordance with the guideline. Since this recent study is in follow up to two prior studies, it is likely that the OIG will continue to pursue this issue.

All hospitals should review their policies and procedures to ensure that the type of clerical errors and misunderstandings identified in the report are not occurring at their facilities. In addition, hospital compliance departments may want to initiate their own internal review and self-disclose any errors.

Your present circumstances don't determine where you can go;
they merely determine where you start.

Nido Qubein

CMS Released Four New Subset Modifiers for Modifier 59

Evan Lendle Ramos, RN, CCS
Senior Manager, Training Department
MiraMed Philippines Group, LLC—Philippines Branch

Last August 15, 2014, Centers for Medicare & Medicaid Services (CMS) issued specific modifiers for "Distinct Procedural Service" with an effective date of January 1, 2015 and an implementation date of January 5, 2015.

CMS established four new Healthcare Common Procedure Coding System (HCPCS) modifiers XE, XS, XP, XU referred collectively as -X{EPSU} modifiers as the specific subsets of Modifier 59. The four new modifiers are a more selective version of Modifier 59. Please note that it is not appropriate to include both Modifier 59 and the new subset modifier on the same line.

CATALYST CREATING THE FOUR SUBSET MODIFIERS:

- As per CMS transmittal 1422, because it can be so broadly applied, some providers incorrectly consider it to be the "modifier to use to bypass National Correct Coding Initiative (NCCI)," it is the most widely used modifier.
- Furthermore, it was also pointed out that Modifier 59 is associated with considerable abuse and high levels of manual audit activity, leading to reviews, appeals and even civil fraud and abuse cases. Please note that this is not entirely due to incorrect -59 Modifier usage as other errors can and do exist on a -59 line. However, it has been observed that incorrect modifier usage was a major contributor although error code definitions do not allow an exact breakdown.

(Continued on page 5)

CMS Released Four New Subset Modifiers for Modifier 59 *(Continued from page 4)*

ANATOMY OF THE FOUR SUBSET MODIFIERS:

Modifier	Expanded Name	Description
XE	Separate Encounter	A Service That Is Distinct Because It Occurred During A Separate Encounter (Same Date Of Service)
XP	Separate Practitioner	A Service That Is Distinct Because It Was Performed By A Different Practitioner (Maybe The Same Encounter, Same Clinic/TIN, Different Provider Specialty)
XS*	Separate Structure	A Service That Is Distinct Because It Was Performed On A Separate Organ/Structure (Same Encounter)
XU	Unusual Non-Overlapping Service	The Use Of A Service That Is Distinct Because It Does Not Overlap Usual Components Of The Main Service

*Cannot be described by one of the more specific anatomic NCCI-associated modifiers – i.e., RT, LT, E1-E4, FA, F1-F9, TA, T1-T9, LC, LD, RC, LM, or RI.

CORRECT USE OF -X {EPSU}:

- XE Covers Separate Encounters: Patient receives an infusion of antibiotics in the morning and returns in the afternoon to receive another infusion of antibiotics.
- XP Covers a Separate Practitioner: One physician does a laparoscopic appendectomy in the morning and then later returns to the OR and has a laparoscopic hernia repair done by a different MD.
- XS Covers a Separate Structure: A patient has a skin lesion of the arm removed by laser and then a biopsy of a lesion on the leg.
- XU Covers an Unusual Non-Overlapping Service

INCORRECT USE OF –X {EPSU} or -59:

- Procedures in the same anatomical site (i.e.: digit, breast) even with incision lengthening or contiguous incision.
- CPT identified “separate” procedures performed in the same session, same anatomic site or orifice.
- Laparoscopic procedure converted to open procedure.
- Incisional repairs are part of the global surgical package, including deliveries and cosmetic improvement of a previous scar at the location of the current incision.
- Contiguous structures (i.e.: duodenum/jejunum) in the same anatomic site or organ system. (See Coding Guidelines “Different Organs/Contiguous Structures” and CCI Policy Manual, chapter 1. (CMS))
- Modifier XP should not be used to identify two providers of the same specialty in the same clinic to bypass global surgery package rules, new-patient visit edits, or other same-specialty rules.

(Continued on page 6)

CMS Released Four New Subset Modifiers for Modifier 59 *(Continued from page 5)*

CMS added that it will not stop recognizing the Modifier 59 but it emphasize that Modifier 59 should not be used when a more descriptive modifier is available. Also, please note, this modifier subset does not apply to OP Therapy. CMS will follow-up with specific guidelines.

Other Source: http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1422OTN.pdf

PLEASE TAKE A MOMENT …

It is our mission to grow and improve this newsletter with each issue. In order to accomplish this goal we need your help! Your input is extremely valuable. Please take a moment to answer the following:

- Tell us what you would like to see in future publications.
- What types of articles would be most beneficial?
- Has this newsletter been of value to you?
- Would you be interested in submitting an article for publication?

You may send your responses via e-mail to kim.capello@miramedgs.com

Successful people maintain a positive focus in life no matter what is going on around them. They stay focused on their past successes rather than their past failures, and on the next action steps they need to take to get them closer to the fulfillment of their goals rather than all the other distractions that life presents to them.

Jack Canfield

Brush Up On Medical Terminology

Evan Lendle Ramos, RN, CCS
Senior Manager, Training Department
MiraMed Philippines Group, LLC—Philippines Branch

DIGESTIVE SYSTEM

Term	Word Origin	Definition
Achalasia	**A-** without **-chalasia** condition of relaxation	Impairment of esophageal peristalsis along with the lower esophageal sphincter's inability to relax
Anodontia	**An-** no, not, without **odont/o** teeth **-ia** condition	Either complete or partial lack of teeth
Appendicitis	**Appendic/o** appendix **-itis** inflammation	Inflammation of the vermiform appendix
Ascites		Excessive intraperitoneal fluid
Cheilitis	**Cheil/o** lip **-itis** inflammation	Inflammation of lips
Cholecystitis	**Cholecyst/o** gallbladder **-itis** inflammation	Inflammation of the gallbladder
Choledocholithiasis	**Choledoch/o** common bile duct **lith/o** stones **-iasis** presence of	Presence of stones in the common bile duct
Cholelithiasis	**Chol/e** gall, bile **lith/o** stones **-iasis** presence of	Presence of stones in the gallbladder
Cirrhosis	**Cirrh/o** orange-yellow **-osis** abnormal condition	Chronic degenerative disease of the liver commonly associated with alcohol abuse, chronic liver disease, biliary tract disorder
Diarrhea	**dia-** through, complete **-rrhea** discharge, flow	Abnormal discharge of watery, semisolid stools
Diverticulitis	**Diverticul/o** diverticulum **-itis** inflammation	Inflammation occurring secondary to the occurrence of diverticulosis
Dysphagia	**dys-** difficult, bad **-phagia** condition of swallowing, eating	Difficulty in swallowing
Esophageal atresia	**esophag/o** esophagus **-eal** pertaining to **a-** no, not, without **-tresia** condition of an opening	Esophagus that ends in a blind pouch and therefore lacks an opening into stomach

(Continued on page 8)

Brush Up On Medical Terminology *(continued from page 7)*

Halitosis	**halit/o** breath **-osis** abnormal condition	Bad-smelling breath
Omphalocele	**Omphal/o** umbilicus **-cele** herniation, protrusion	A congenital herniation at the umbilicus
Pancreatitis	**Pancreat/o** pancreas **-itis** inflammation	Inflammation of pancreas
Peristalsis	**peri-** surrounding **-stalsis** contraction	contract and relax in a wavelike movement
Proctitis	**Proct/o** rectum and anus **-itis** inflammation	Inflammation of the rectum and anus
Ptyalism	**Ptyal/o** saliva **-ism** condition	Condition of excessive salivation
Pyloric stenosis	**Pylor/o** pylorus **-ic** pertaining to stenosis narrowing	Condition which the muscle between the stomach and the small intestine narrows or fails to open adequately to allow partially digested food into the duodenum

Coding Case Scenario

Evan Lendle Ramos, RN, CCS
Senior Manager, Training Department
MiraMed Philippines Group, LLC—Philippines Branch

Each month we will offer a coding question for our staff to solve. If you'd like to quiz yourself, feel free. We will gladly let you know the results of your answer. The first coder from each Team (United States, Philippines and India) who correctly answers will be given a prize and recognition in the next issue of our newsletter.

Direction: Code for ICD-9-CM Diagnosis and its corresponding ICD-10-CM

The 40 year old female patient was diagnosed with breast cancer three years ago and had undergone partial mastectomy on her right breast. Her estrogen receptor status is positive. Her antineoplastic therapy had ended eight months ago. As per CT imaging, there was no evidence of malignancy or recurrence. The patient came in to her physician to receive her first intravenous infusion of Herceptin and was advised to receive this treatment every week for five years. The physician told the patient that Herceptin is an antineoplastic monoclonal antibody drug that attaches itself to cancer cells and signals the immune system to destroy them. The drug is considered long-term therapy for consolidative treatment of her breast cancer.

Correct Answer from Previous Case Scenario:

Category	Condition	ICD 9-CM	ICD 10-CM
Principal Diagnosis	Calculus of gallbladder and bile duct with other cholecystitis and obstruction	574.71	K80.65
Secondary Diagnosis	Acute pancreatitis	577.0	K85.1
Secondary Diagnosis	Hypertensive chronic kidney disease stage II	403.90	I12.9
Secondary Diagnosis	CKD stage II	585.2	N18.2
Secondary Diagnosis	Diabetes mellitus without complication	250.00	E11.9

RATIONALE

Principal Diagnosis: Although the patient came in to ER for suspected gallstone pancreatitis, the main reason for the patient's admission to the hospital and the need for surgery were the gall stones and the bile duct stones. Hence our principal diagnosis is 574.71 (ICD-9-CM), K80.65 (ICD-10-CM).

As per ICD-9-CM and ICD-10-CM Coding Guideline Section II.J Admission from Outpatient Surgery: When a patient receives surgery in the hospital's outpatient surgery department and is subsequently admitted for continuing inpatient care at the same hospital, the following guidelines should be followed in selecting the principal diagnosis for inpatient admission:

- If the reason for the inpatient admission is a complication, assign the complication as the principal diagnosis.
- If no complication, or other condition, is documented as the reason for the inpatient admission, assign the reason for the outpatient surgery as principal diagnosis.
- If the reason for the inpatient admission is another condition unrelated to the surgery, assign the unrelated condition as the principal diagnosis.

Secondary Diagnosis: Both ICD-9-CM code 403.90 / ICD-10-CM code I12.9 have the same guidelines pertaining with Hypertension associated with Chronic Kidney Disease. As per the chapter specific guideline; both ICD-9-CM and ICD-10-CM presume a cause-and-effect relationship and classifies Chronic Kidney Disease with hypertension as Hypertensive Chronic Kidney Diseases.

Both ICD-9-CM and ICD-10-CM pointed out that if the type of Diabetes is not documented in the medical record, the default is Type II.

In addition, as per Coding Clinic, Fourth Quarter 2004, Pages 53 to 56: Effective October 1, 2004, changes have been made to the fifth digits applicable to category 250, Diabetes mellitus. This change has been made to make the classification consistent with current terminology used to describe diabetes mellitus. The two main types of diabetes are no longer properly referred to as "insulin-dependent" and "noninsulin dependent." The current distinction is now based on the functioning of the pancreatic beta cells.

CONGRATULATIONS!

Last Month's Winner from the Philippines:

Jeffrey A. Ildefonzo

Degree: B.S. in Nursing

Coding Experience: 1 year and 5 months

Certification: CCA

Specialty: Outpatient Professional and Facility Coding in ED and ANC

Last Month's Winner from India:

Sivaraman Sivasubramanian

Degree: M.Sc (Bio Tech), PGDBI (Bio Informatics)

Coding Experience: 5 years and 4 months

Certification: CPC

Specialty: Radiology