Issue No. 8 Volume No. 1 November 2014

THE CODE

The Official Medical Coding Newsletter of MiraMed, A Global Services Company

When to Apply Modifiers

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Part 7

In part 6 of this article we discussed modifiers that may be applied when a primary surgeon requires assistance during a procedure either by another surgeon or assistant and, therefore, it might be necessary to append modifier 80, 81, 82, or AS.

Below are situations that you might encounter when a procedural service is rendered in a particular location, i.e., rural area, Health Professional Shortage Area (HPSA) and teaching facility.

Modifier AQ - Physician Providing a Service in a HPSA

For services rendered in a zip code area subject to HPSA payment, AQ modifier must be appended to the claim in order to be eligible for the bonus payment.* The key to eligibility is where the service is actually provided (place of service). Payment will be made as long as the specific location of the service is within an area designated as an HPSA.

Append

- When services are provided in zip code areas that do not fall entirely within a designated full county HPSA bonus area;
- When services are provided in a zip code area that falls partially within a full county HPSA but is not considered to be in that county based on the United States Postal Service (USPS) dominance decision;
- When services are provided in a zip code area that falls partially within a non-full county HPSA; and
- When services are provided in a zip code are that was not included in the automated file of HPSA areas based on the date of the data run used to create the file.

(Continued on page 2)

If you have an article or idea to share for *The Code*, please submit to:
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Always be a first-rate version of yourself, instead of a second-rate version of somebody else.

Judy Garland

When to Apply Modifiers *(continued from page 1)*

Do Not Use When**

- Services fall entirely in a county designated as a full-county HPSA; or
- Services fall entirely within the county, through a USPS determination of dominance; or
- Services fall entirely within a partial county HPSA.

*Modifiers QU and QB were utilized prior to January 1, 2006 claims submission.

**Do not append modifier as services will automatically be qualified for the bonus payment.

http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c04.pdf

http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HPSAPSAPhysicianBonuses/index.html?redirect=/hpsapsaphysicianbonuses/

Modifier GC – This Service Has Been Performed in Part by a Resident Under the Direction of a Teaching Physician.

Services furnished in teaching settings are paid through the Medicare Physician Fee Schedule (PFS) if the services are personally furnished by a physician, by a resident when a teaching physician is physically present during the critical or key portions of the service or by a resident under a primary care exception within an approved Graduate Medical Education (GME) Program. Usage of modifier GC requires the participation of the teaching physician in the management of the patient. The coder must combine the documentation of both the resident and the teaching physician in order to bill the services for the teaching physicians. Remember that documentation by the resident of the presence and participation of the teaching physician is not sufficient to establish the presence and participation of the teaching physician. Before billing for services, the coder needs to verify that the combined entries into the medical record by the teaching physician and the resident constitute the documentation for the service and together must support the medical necessity of the service. Please note that modifier GC is informational only (no impact on reimbursement) and may be submitted with all HCPCS and CPT codes.

Do Not Use When

- The teaching physician is not involved in any portion of the service.

Note: In order to pay a teaching physician under Part B, the teaching physician must at least be physically present during the key portion of a service rendered as documented in the medical record made by a resident or intern.

Definitions:

- **Resident:** An individual who participates in an approved graduate medical education (GME) program or a physician who is not in an approved GME program but who is authorized to practice only in a hospital setting. The term includes interns and fellows in GME programs recognized as approved for purposes of direct GME payments made by the Fiscal Intermediary (FI). Receiving a staff or faculty appointment or participating in a fellowship does not by itself alter the status of "resident". Additionally, this status remains unaffected regardless of whether a hospital includes the physician in its full time equivalency count of residents.

(Continued on page 3)

When to Apply Modifiers *(continued from page 2)*

- **Student:** An individual who participates in an accredited educational program (e.g., a medical school) that is not an approved GME program. A student is never considered to be an intern or a resident. Medicare does not pay for any service furnished by a student.

- **Teaching Physician:** A physician (other than another resident) who involves residents in the care of his or her patients.

- **Critical or Key Portion:** Pursuant to 42 CFR 415.172 (b), documentation must identify, at a minimum, the service furnished, the participation of the teaching physician in providing the service, and whether the teaching physician was physically present.

- **Physically Present:** The teaching physician is located in the same room (or partitioned or curtained area, if the room is subdivided to accommodate multiple patients) as the patient and/or performs a face-to-face service.

CMS Pub. 100-02, Chapter 15, Section 30
CMS Pub. 100-04, Chapter 12, Section 100

(To be continued in the next issue.)

2015 CPT Changes to Care Management Services Require a Monthly Tracking Process

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The Affordable Care Act (ACA) along with the movement to patient-centered medical homes and pay for performance have resulted in additional changes in the 2015 AMA-CPT Codebook to care management services.

The 2015 CPT Codebook includes one new code (99490) and revisions to two current complex chronic care management services (99487 and 99489). All three codes are reported for a calendar month for clinical staff care management and support services, provided under the direction of a physician or other qualified healthcare professional (QHP). To qualify for care management services the patient needs to be residing at their home or in a domiciliary, rest home or assisted living facility. These codes would not be used if the patient is a resident of a nursing or skilled nursing facility.

The physician or QHP must document and share with the patient and/or caregiver a plan of care that addresses the physical, mental, cognitive, social, functional and environmental assessment. The plan must be comprehensive in nature and address all health problems of the patient. It would typically include, but is not limited to, the following elements:

- Problem list
- Expected outcome and prognosis
- Measurable treatment goals
- Symptom management
- Planned interventions
- Medication Management

(Continued on page 4)

2015 CPT Changes to Care Management Services Require a Monthly Tracking Process *(continued from page 3)*

- Community/social services ordered
- Direction and coordination with agencies and specialists unconnected to the practice
- Identification of the individual responsible for each intervention
- Requirements for periodic review
- Revision of the care plan when applicable

The face-to-face and non-face-to-face time spent by the clinical staff in communicating with the patient and/or family, caregivers, other professionals and agencies; and revising, documenting and implementing a care plan or teaching self-management is used in determining the care management clinical staff time for the month. Only the time of the clinical staff of the reporting professional is counted; and when two or more clinical staff members are meeting about the patient only the time of one clinical staff member may be counted.

CPT code 99490, chronic care management services, at least 20 minutes of clinical staff time directed by a physician or QHP, per calendar month with the following required elements:

- Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient;
- Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation or functional decline; and
- Comprehensive care plan established, implemented, revised or monitored.

Services of less than 20 minutes duration, in a calendar month, are not reported separately. The physician or QHP may still report evaluation and management services for specific problems be treated or managed in accordance with the CPT level of care.

CPT 99487 is used for complex chronic care management with the following required elements:

- Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient;
- Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation or functional decline;
- Establishment of substantial revision of a comprehensive care plan;
- Moderate or high complexity medical decision making; and
- 60 minutes of clinical staff time directed by a physician or other QHP, per calendar month.

Complex chronic care management services of less than 60 minutes of duration in a calendar month are not reported separately.

CPT 99489 is each additional 30 minutes of clinical staff time directed by a physician or other QHP, per calendar month (list separately in addition to code for the primary procedure).

Hospital-owned physician enterprises and physician practices are encouraged to develop a tracking system to record the clinical staff time on a daily basis. The tracking system may include, but is not limited to, recording the date of service, the type of intervention provided, whether face-to-face or non-face-to-face, the amount of time spent in the intervention, whom the patient care was coordinated with, and any significant treatment or medication changes, orders or revisions in the care plan.

Brush Up On Medical Terminology: General

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Numbers		
Prefix	**Meaning**	**Example**
mono, uni-	one	monocyte, unilateral
bi-	two	bilateral
tri-	three	triad
quadr-	four	quadriplegia
hex-, sex-	six	hexose
diplo-	double	diplopia

Surgical Procedures		
Suffix	**Meaning**	**Example**
-centesis	puncture a cavity to remove fluid	amniocentesis
-ectomy	surgical removal (excision)	Appendectomy
-ostomy	a new permanent opening	colostomy
-otomy	cutting into (incision)	tracheotomy
-orrhaphy	surgical repair/suture	herniorrhaphy
-opexy	surgical fixation	nephropexy
-oplasty	surgical repair	rhinoplasty
-otripsy	crushing, destroying	lithotripsy

Conditions		
Prefix	**Meaning**	**Example**
ambi-	both	ambidextrous
aniso-	unequal	anisocoria
dys-	bad, painful, difficult	dysphoria
eu-	good, normal	euthanasia
hetero-	different	heterogenous
homo-	same	homogenous
hyper-	excessive, above	hypergastric
hypo-	deficient, below	hypogastric
iso-	equal, same	isotonic
mal-	bad, poor	malaise
megalo-	large	megalocardia

(Continued on page 6)

Brush Up On Medical Terminology: General *(continued from page 5)*

Directions and Positions		
Prefix	Meaning	Example
ab-	away from	abduction
ad-	toward	adduction
ecto, exo-	outside	ectopic, exocrine
endo-	within	endocrine
epi-	above, upon	epicgastric
infra-	below, under	infraclavicular
inter-	between	intervertebral
intra-	within	intramuscular
ipsi-	same	ipsilateral
meso-	middle	mesocephalic
meta-	after, beyond, transformation	metastasis
para-	near, beside, abnormal	parathyroid
peri-	surrounding, around	pericardium
retro-	behind, back	retroversion
trans-	across, through	transurethral

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.

Don't worry when you are not recognized,
but strive to be worthy of recognition.
Abraham Lincoln

ICD-10-CM/PCS Transition

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On March 31, 2014, President Obama signed legislation which delayed the original transition of ICD-10 from October 1, 2014 to October 1, 2015. This transition means that ICD-9 diagnosis and inpatient procedure codes cannot be utilized for services provided on or after October 1, 2015. At that time, ICD-10-CM must be used on all Health Insurance Portability and Accountability Act (HIPAA) transactions, including outpatient claims with date of service October 1, 2015, and ICD-10-CM (Clinical Modification) and ICD-10-PCS (Procedure Coding System) on inpatient claims with discharge date on or after October 1, 2015.

The World Health Organization (WHO) created and adopted ICD-10 in 1994; which has already been implemented in other countries. The ICD-10-CM will be the basis for the new diagnosis coding system which will be implemented in the United States October 1, 2015. The transition into a new coding system is necessary due to:

- **Regulatory Mandates:** Department of Health and Human Services published the ICD-10 federal mandate to upgrade the codes used to describe diagnoses and procedures on clinical transactions (claims, etc.).
- **No Room for Expansion:** Existing ICD-9 codes no longer adequately reflect advances in disease detection and treatment. ICD-9 Diagnosis and Procedure codes are three to five digits in length (~ 18,000 unique codes).
- **Inconsistent Data:** Non-standardized and repetitive code elements with undefined terms result in inconsistent coding.
- **Lack of International Data Sharing**: Unable to compare data internationally.
- **Not Specific:** ICD-9 codes have limited data about patients' medical conditions and hospital inpatient procedures. The ICD-9 code set is over 30 years old and is no longer viable.

Although the United States (US) is currently using ICD-10-CM for mortality reporting, it remains as the only industrialized nation that has not yet implemented ICD-10-CM for morbidity typically coded in healthcare facilities. This makes it difficult to share disease data internationally at a time when such sharing is critical for public health. The US's ability to track and respond to global threats in real time is thus limited.

The migration to ICD-10-CM will require system upgrades including hardware, software and additional storage. The delay will afford facilities and physician practices the time necessary not only to accommodate the new code sets, but to make the necessary changes to reports, applications and interfaces.

In line with this delay, healthcare organizations are taking the opportunity to train and educate staff and physicians on the coding and clinical documentation necessary to meet the increased ICD-10 coding requirements. During this transition, it is important for both facilities and physicians practices to review clinical operation documentation, and policies and procedures, and to update these accordingly to reflect the changes necessary to properly conduct data analysis and report trending.

The transition to ICD-10 involves much more than just coding and Information Technology Systems. The scope of ICD-10 conversion requires an organizational-wide commitment on implementation due to its impact on operating processes, workflows, documentation and vendor and payer communications.

Additional Resources:
www.ncdhhs.gov/pso/
www.physicianauditconsultants.com/icd-10-cm.html
www.health.ny.gov
www.ama-assn.org
www.healthit.gov

Coding Case Scenario

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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 patient was admitted from the ER for chest pain, to rule out Myocardial infarction. The patient also presents with difficulty of breathing and pain upon deep breathing. The patient's family has history of ischemic heart disease. Upon evaluation, patient had hypertension, smoker and overweight. After several diagnostic tests, Myocardial infarction was ruled out. Cardiology is suggesting that the cause of his chest pain was costochondritis.

Physician's Final Diagnoses:

1) Chest pain due to costochondritis;
2) Hypertension;
3) Smoker, current nicotine dependence on cigarettes;
4) Overweight; and
5) Family history of ischemic heart disease.

Correct Answer from Previous Case Scenario:

ICD-9-CM Diagnoses:

860.3: Hemothorax with open wound into thorax

E966: Assault by cutting and piercing instrument

CPT Procedure 32251: Tube thoracostomy, includes connection to drainage system (e.g., water seal), when performed, open (separate procedure)

CONGRATULATIONS!

Last Month's Winner from the Philippines:

Germin Carsten Louis S. Bernardo, RN

Degree: B.S. in Nursing

Coding Experience: 1 year and 10 months

Certification: CCS

Specialties Worked: ER Profee, Ancillary

Last Month's Winner from India:

A. Joseph Alex Stephen

Degree: MPT (Master of Physiotherapy)

Coding Experience: 4 years

Certification: CPC-H

Specialties Worked: ED, Radiology, IVR