Medical Practice Coding Pro

www.codingprodecisions.com

Practical ICD-9/CPT® news and guidance for physician coders

SPECIAL ISSUE

IN THIS ISSUE

CEU APPROVED

E/M **Understanding E/M**

Beware of EHR systems that allow non-clinicians to complete HPI

Only the treating physician or non-physician practitioner (NPP) can perform the history of present illness (HPI) portion of an office visit — which you've no doubt drummed into your doctors' heads — but be on guard that some electronic health record (EHR) vendors are attempting to stretch that policy.

One Midwest internist complains that electronic templates are encouraging nurses at his practice to collect parts of the HPI. "For example, a patient comes with symptom of 'chest pain' and the office has a template that asks about duration, quality, aggravating factors, etc.," he says. "The nurse documents these elements in the HPI [section] of the template. The physician then comes into the room and confirms this information. The physician signs the note confirming the accuracy, but there is now an electronic, traceable history that shows that the nurse

*(see **E/M**, p. 6)*

CCI Version 20.0

Guard against new transitional care management code bundling edits

If you plan to report a surgical or medical procedure on the same date as a transitional care management (TCM) code (**99495-99496**), check first to see whether the TCM codes are bundled or you may face denial of the 30-day service code.

Version 20.0 of the National Correct Coding Initiative (CCI), effective Jan. 1, 2014, adds thousands of new code pairs that bundle the TCM codes as components of a range of procedures, including minor skin procedures such as abscess drainage (**10060**), fracture care such as clavicle fracture treatment (**23500**) and left heart catheterization (**93452**). Some of the TCM code pairs will allow you to override them with a modifier when appropriate, but many edits will not.

*(see **CCI 20.0**, p. 7)*

2014 CCI policy manual

Review how to bill modifier 59, post-op E/M visits and drug tests

Carefully evaluate your use of modifier **59** (Distinct procedural service) for services that would otherwise be inclusive when billed on the same patient for the same date of service now that Medicare has made changes to Chapter 1 of the 2014 National Correct Coding Initiative (CCI).

In the policy manual, Medicare attempts to better define circumstances when it would be appropriate to use the modifier and when it would not. According to CCI, you could append 59 to the included code in these cases:

- When "a diagnostic procedure precedes a surgical or non-surgical therapeutic procedure and is the basis on which the decision to perform the surgical or non-surgical therapeutic procedure is made," the two would be separately billable, the CCI manual states. For example, if the doctor does a biopsy and waits in surgery for the results before excising a cancerous lesion, the biopsy would be separately billable, explains *Coding Pro* technical adviser Margie Scalley Vaught, CPC, CPC-H, CCS-P, ACS-EM, ACS-OR.

- "If a diagnostic procedure follows a surgical procedure or non-surgical therapeutic procedure at the same patient encounter and the post-procedure diagnostic procedure is not an inherent component or otherwise included (or not separately payable) post-procedure service of the surgical procedure or non-surgical therapeutic procedure," according to CCI. The post-procedure diagnostic test would have to address a separate problem or a separate body area to be payable, Vaught says. One example might be a joint injection to address pain in the wrist and an aspiration procedure in the elbow of the same arm to investigate swelling of that joint, she says.

Because the procedures took place on the same side, it wouldn't be appropriate to append RT and LT, so you're left with modifier 59, Vaught explains.

CCI tells you not to append 59:

- **When "the diagnostic procedure is an inherent component of the surgical or non-surgical therapeutic procedure."** For example, you wouldn't bill for a follow-up diagnostic heart catheterization after a transcatheter aortic valve implant (TAVI) because that work is included in the TAVI procedure.

- **If the same procedure is performed at different anatomic site,** you would not necessarily be able to bill each one separately, CCI states. Separate billing will depend on the code's descriptor and how many units of service Medicare allows for it in its medically unlikely edits (MUEs).

- **When the inclusive service is an E/M visit.** Modifier 59 is never appended to an E/M. Use instead an E/M modifier such as **25** (Significant and separately identifiable E/M service), **24** (Unrelated E/M service) or **57** (Decision for surgery).

CMS gave practices less than a month to learn and integrate its new CCI coding policies. CMS released the manual Dec. 2, 2013, and its policies took effect Jan. 1, 2014. Watch for these additional changes:

- **Avoid billing an E/M service during a global surgical period for any complication that arises from the surgery**, even when the complication requires a return trip to the operating room. While a separate procedure in the OR to address a complication may be billable, a separate E/M service is not, CCI clarifies. The 2013 manual stated that E/M visits are included if they are "related to complications of surgery that do not require additional trips to the operating room," but that line has been deleted. The 2014 manual states simply, "related to complications of the surgery" (Chapter 1).

- **Follow CCI edits for discharge day management services.** The CCI manual expands on CPT 2014 guidance for hospital discharge codes **99238-99239**, which states you can't report the discharge code with **99234-99236** (Observation or inpatient hospital care) or **99231-99233** (Subsequent hospital care). CCI states that in addition, you can't report discharge day management services with **99218-99220** (Initial observation), **99201-99215** (Office/outpatient visit) or **99281-99285** (ED visit). This guidance codifies edits issued in CCI 19.3 (Chapter 11).

- **Don't try to bill more than one unit of service for urine drug screens G0434** (CLIA-waived and moderate complexity) or **G0431** (High-complexity method). Drug screens are another area where CMS is striving for clarity. The unit of service for each code is once "per patient encounter," CCI states. The code includes all drug screening tests that are administered during the patient encounter (Chapter 12, p. 12). — *Julia Kyles (jkyles@decisionhealth.com) and Laura Evans (levans@decisionhealth.com)*

Getting paid

Verify your payers' policy on bilateral use of cerumen removal code

Now that Medicare has stated clearly that it will pay for only one unit of **69210** (Removal, impacted cerumen), regardless of whether one or two ears are treated, you'll want to check with your other payers on this issue — particularly the ones that follow Medicare physician fee schedule policies.

Recall that in the 2014 CPT Manual, the AMA included guidance that the code is unilateral and that practices should append modifier **50** (Bilateral procedure) when both ears are treated (*Coding Pro 1/14*).

But CMS had other ideas, and in the 2014 Medicare physician fee schedule relative value file, the agency awarded 69210 a bilateral payment indicator of "2," meaning bilateral pay rules do not apply, so Medicare will not pay additional money when the 50 modifier is appended.

You also can't get paid by Medicare for more than one unit of the code — CMS recently issued a medically unlikely edit (MUE) of 1 unit for the service.

No substitute modifier is available. Trying to get to two units of service by using modifier **76** (Repeat procedure) isn't accurate because that modifier is for repeating the service on the same anatomical site, says Stephanie Fiedler, director of revenue management for YAI in New York City. One coding manager who spoke on condition of anonymity went as far as to say it could be seen by an auditor as gaming the system.

CMS staked out its position in this year's fee schedule when it said that it disagreed with the AMA Relative Value Update Committee's decision to allow bilateral billing, stating that: "we disagree with the assumption by the AMA RUC that the procedure will be furnished in both ears only 10% of the time as the physiologic processes that create cerumen impaction likely would affect both ears. Given this, we will continue to allow only one unit of CPT 69210 to be billed when furnished bilaterally. We do not believe the AMA RUC's recommended value reflects this and therefore, we will maintain the CY 2013 work value of 0.61 for CPT code 69210 when the service is furnished."

Payers that tell you they always follow Medicare payment rules likely will implement the same payment rules now, says Jan Rasmussen, owner of Professional Coding Solutions in Holcombe, Wis. When they don't say they follow Medicare across the board, you need to query them to get their policies.

Some payers, such as Regence Blue Cross Blue Shield in Oregon and Blue Cross Blue Shield of North Carolina, have released notices telling providers to use modifier 50 when 69210 is done bilaterally.

Specialty groups such as the American Academy of Otolaryngology-Head and Neck Surgery and private payers, among them Priority Health and Blue Cross/Blue Shield of North Carolina, have posted guidance that modifier 50 along with two units is the appropriate billing for 69210 for dates of service on or after Jan. 1, 2014.

Here are some other details to keep in mind about billing 69210:

An E/M service done on the same date of service is bundled into 69210, according to National Correct Coding Initiative (CCI) edits. You may overrule the edit with a modifier when appropriate, such as when the reason for the E/M visit is for a medically necessary reason unrelated to the cerumen removal. Make sure documentation supports that the E/M service was significant and separately identifiable before you report it, recommends Kent Moore, senior strategist for physician payment for the American Academy of Family Physicians in a recent blog post. If it's appropriate to bill the two services separately, add modifier **25** (Significant, separately identifiable E/M) to the E/M service to make sure it gets paid, he says.

Instrumentation must be used. In revising the code, CPT reiterates that this code is not appropriate for simply removing ear wax that is not impacted or does not require instruments. That work, when appropriate, is bundled into your E/M code selection.

Audiologists may not bill 69210 under Medicare guidelines. To avoid a denial, a physician who provides impacted cerumen removal services on the same date of service as audiology services is instructed to report **G0268**, removal of impacted cerumen, instead of the CPT code. — *Scott Kraft (pbnfeedback@decisionhealth.com)*

Transition to ICD-10

Use separate codes for skin abscess and cellulitis in ICD-10

Here's a case where ICD-10 may help practices clarify their services for payers more easily. In ICD-10, you'll no longer report the same code for cellulitis and abscess as

you do in ICD-9. Instead, the two conditions each have a separate code series.

For practices that do wound care, this may help clarify the medical necessity of some of your abscess debridements, points out *Coding Pro* technical adviser Margie Scalley Vaught, CPC, CPC-H, CCS-P, ACS-EM, ACS-OR.

"When you're doing multiple debridements of an abscess, the cellulitis code didn't give the full magnitude of an abscess," she says. With cellulitis, the skin is just turning different colors with pain and swelling, Vaught explains. "I could see medical necessity issues coming up with payers who want to know why you're doing multiple debridements for that." Having the more specific abscess codes to report in ICD-10 should help you avoid those issues, she adds.

In ICD-10, you'll find cutaneous abscesses listed with codes for furuncles (boils) and carbuncles (painful cluster of boils) in the **L02** code series. Cellulitis, meanwhile, is grouped alongside codes for acute lymphangitis (inflammation of the lymphatic channels) in the **L03** series.

You'll also need to make sure to correctly pair your CPT debridement codes with your ICD-10 codes. For example, the list of codes below would be used only for subcutaneous debridement codes such as **11042** and **11045**. For debridement of abscesses at the muscular or fascial level, you'd report codes from the musculoskeletal chapter of ICD-10. For example, when coding intramuscular abscesses, the ICD-10 index directs you to the myositis code series (**M60**). — *Laura Evans (levans@decisionhealth.com)*

Ask the Expert

E/M to address patient problem OK to bill with diagnostic colonoscopy

Question: *Would it be appropriate to bill an E/M service for the following case? The patient was referred by Dr. John Smith for a colonoscopy for colon cancer prevention. Patient is a 45-year-old male who has had recent rectal bleeding, reports abdominal pain and constipation. A colonoscopy done about 10 years ago showed diverticulosis.*

Here's how to map cellulitis & abscess between ICD-9 and ICD-10

ICD-9 – combined abscess/cellulitis codes	ICD-10: Separate Abscess & Cellulitis codes	
681.0 Cellulitis and abscess of finger	L02.51 Cutaneous abscess of hand*	L03.01 Cellulitis of finger*
681.1 Cellulitis and abscess of toe	L02.61 Cutaneous abscess of foot*	L03.03 Cellulitis of toe*
682.0 Celulitis and abscess of face	L02.02 Cutaneous abscess of face	L03.211 Cellulitis of face
682.1 Cellulitis and abscess of neck	L02.11 Cutaneous abscess of neck	L03.221 Cellulitis of neck
682.2 Cellulitis and abscess of trunk	L02.211 Cutaneous abscess of abdominal wall L02.212 Cutaneous abscess of back [except buttock] L02.213 Cutaneous abscess of chest wall L02.214 Cutaneous abscess of groin L02.215 Cutaneous abscess of perineum L02.216 Cutaneous abscess of umbilicus L02.219 Cutaneous abscess of trunk, unspecified	L03.311 Cellulitis of abdominal wall L03.312 Cellulitis of back [except buttock] L03.313 Cellulitis of chest wall L03.314 Cellulitis of groin L03.315 Cellulitis of perineum L03.316 Cellulitis of umbilicus L03.319 Cellulitis of trunk, unspecified
682.3 Cellulitis and abscess of upper arm and forearm	L02.41 Cutaneous abscess of limb*	L03.11 Cellulitis of limb*
682.4 Cellulitis and abscess of hand	L02.51 Cutaneous abscess of hand*	L03.11 Cellulitis of limb*
682.5 Cellulitis and abscess of buttock	L02.31 Cutaneous abscess of buttock	L03.317 Cellulitus of buttock
682.6 Cellulitis and abscess of leg	L02.41 Cutaneous abscess of limb*	L03.11 Cellulitis of limb*
682.7 Cellulitis and abscess of foot	L02.61 Cutaneous abscess of foot*	L03.11 Cellulitis of limb*
682.8 Cellulitis and abscess of other specified sites	L02.818 Cutaneous abscess of other sites	L03.818 Cellulitis of other sites
**More specific six-character codes required.*		

Answer: "Yes, you can bill an E/M service" in this case, "as long as the record reflects a complete evaluation addressing the reported symptoms of the patient," advises consultant Terry Fletcher, CPC, CCC, CEMC, CMSCS, CCS-P, CCS, CMC, of Laguna Beach, Calif.

The patient has indications that are consistent with covered diagnoses for a diagnostic colonoscopy, so rules for screening colonoscopies (such as bundling an E/M visit) do not apply, she explains. "A screening would be for an age-appropriate, asymptomatic patient."

In addition, Fletcher says, "if the endoscopy is performed on the same date as the E/M, do not forget you will need a 25modifier on the E/M code." — *Laura Evans (levans@decisionhealth.com)*

Diagnosis of depression alone won't support pay for critical care

Question: *Would depression with suicidal tendency support the coding of critical care services? Depression is an illness, but does it "impair a vital organ system such that there is a high probability of imminent or life threatening deterioration in the patient's condition" as required by 99291-99292?*

Answer: Unfortunately, critical care services would not be supported with a diagnosis of depression, responds Carol Pohlig, BSN, RN, CPC, ACS, senior coding and education specialist in the office of clinical documentation at the University of Pennsylvania Department of Medicine.

It's important to bear in mind that critical care and depression treatment are covered as separate benefits, she explains. "Critical care for acute hospitalizations are paid under a medical benefit. Depression is treated and reimbursed under a behavioral health benefit."

Payers often deny claims under the medical benefit when submitted with a psychiatric diagnosis, Pohlig points out. Nevertheless, if the patient was also experiencing medical complications from an attempted suicide, those medical complications (depending on the severity) may be managed and reported as critical care if the codes' other criteria are met, she adds. Note that "inpatient psychiatric stays are not reported as critical care but with the appropriate psychiatric codes." — Laura Evans (*levans@decisionhealth.com*)

Watch out for bundling of dermal shave codes with AK treatment

Question: *The doctor did two dermal shaving procedures and treatment of actinic keratosis (AK) on a patient with a history of melanoma. One lesion was 4.0 cm on the trunk so I used code* ***11303****. The second lesion was less than 0.5 cm on the wrist so I used code* ***11300-51****. The AK was on the knee so I used code* ***17000-51****. Codes 11303 and 11300 were denied as "mutually exclusive based on the NCCI as published/maintained by CMS" by Anthem Blue Cross. The code for the AK was paid. Can you tell me what I did wrong? Did I use the wrong modifier? Should I have combined the two lesions and only billed the 11303? Any help would be greatly appreciated.*

Answer: First of all, modifier 51 (Multiple procedures) should not be used in this case because the shaving and actinic keratosis treatment were done in totally different anatomic locations, points out Coding Pro technical advisor Margie Scalley Vaught, CPC, CPC-H, CCS-P, ACS-OR, ACS-EM.

Keep in mind that National Correct Coding Initiative (CCI) edits bundle the shaving codes, 11300 and 11303 as components of 17000. These are "mutually exclusive" CCI edits, which means that the higher-paying dermal shaving codes will be denied when billed with the comparatively lower-paying lesion destruction code.

The appropriate modifier will override the edits. In this case, you should use **59** (Distinct procedural service).

Also note that many Medicare administrative contractors (MACs) have active local coverage determinations for 17000 that also may affect coverage. — *Laura Evans (levans@decisionhealth.com)*

Compliance

Nashville pediatrician learns the hard way that upcoding doesn't pay

Advise your doctors that upcoding — even of ancillary services such as diagnostic tests — can land them in hot water. In a recent upcoding case, a Nashville pediatrician recently lost his practice and ended up excluded from federal health care programs with $1.6 million in damages and criminal restitution.

For five years, the doctor billed Tennessee's Medicaid program (TennCare) for comprehensive infant auditory exams even though he actually performed lower-paying

audiology screenings, according to a release from the U.S. Attorney's Office of the Middle District of Tennessee. The pediatrician, Edward "Eddie" Hamilton, M.D., also routinely upcoded his practice's urinalysis tests as microscopic, when in fact no microscopy had been performed.

In fact, his practice, Centennial Pediatrics, P.C., didn't even own the equipment necessary to perform either the comprehensive audiology tests or microscopic urinalysis, the U.S. Attorney noted.

Hamilton compounded his error by ignoring the pleas of his staff to stop upcoding the services or to purchase the necessary equipment. "Interesting what doctors are doing to keep their incomes up. How blatant can you be?" observes consultant Maxine Lewis, CPC, president of Medical Coding & Reimbursement Management in Cincinnati. "There's greed involved here," she adds.

The doctor pleaded guilty to a misdemeanor count of health care fraud, was forced to divest his pediatric practice and pay the fines pursuant to both the criminal plea and civil settlement. He was also excluded from participating in any federal health care program for 20 years.

Hamilton's case was first reported by a whistleblower, but Lewis says many of the cases she's seen "have been picked up by data mining. Nobody has to say anything — it comes out in his claims history," she explains.

"With computers, Medicare and private payers have so much more information about physicians — they can easily spot over-users."

Report coding concerns to your physicians

The fact that others in the Nashville practice — including office staff, audiologists and partners — warned Hamilton that his billing practices were improper may have allowed them to keep themselves out of trouble, points out *Coding Pro* technical advisor Margie Scalley Vaught, CPC, CPC-H, CCS-P, ACS-EM, ACS-OR.

"We have always told groups that if one goes down, they all go down," she notes. "This appears to show it could go the other way." In compliance situations such as this one, make sure to keep supporting documentation of staff and partner warnings of concern, she advises. In addition, you'll want to keep your health care attorney aware of your concerns, Vaught adds.

Ensure equipment, documentation support ancillary services coding

Many practices focus on auditing E/M services, but don't forget that payers and their auditors also look at ancillary services such as diagnostic tests and other procedures, Vaught warns.

"These can be more easily verified," she says. With E/M, an auditor will review the note and see whether it meets the requirements for the level billed, but for ancillaries, "they ask for a copy of the test and ask what equipment is in the labs."

Those kinds of upcoding cases can range from doctors over-reporting the number of views on an X-ray to blood work that was not done, she says.

Vaught gives the example — drawn from HHS Office of Inspector General files — of an eye practice that billed for laser surgery but didn't have a laser. "How hard was it to find that out? It's one phone call," she observes. The auditor asks, "hello, I'm wondering if you do laser eye surgery in your office?" The staff reply: "I am sorry, we don't have a laser in the office." Now all those bills are brought into question, and the government spent very little money to investigate that." — *Laura Evans (levans@decisionhealth.com)*

E/M

(continued from p. 1)

actually entered most of the HPI. I am not comfortable using the information collected and documented by the nurse in the HPI to 'count' when selecting the E/M level of service."

Medicare administrative contractors (MACs) and other auditors have been cracking down on HPI collection by ancillary staff, including some payers that previously might have permitted the above scenario.

For example, Noridian Administrative Services (MAC Jurisdictions E and F) recently issued the following guidance on its website:

"**Q28.** If someone other than a physician collects the history of present illness (HPI), documents it, then the physician reiterates the HPI with the patient, can the physician then refer to the other person's documentation with the notation, 'I re-obtained the HPI, reviewed the documentation and agree'?

"A28. HPI must be done and individually documented by the physician.

"Q29. An RN or NP obtained the HPI and documents it. The physician then goes over the info with the patient to verify it. Can the M.D. say, 'I verified the HPI with the [patient]. Please see RN/NP documentation above'?

"A29. If that scenario takes place, the information will not be accepted if reviewed. The M.D. must gather and document the HPI themselves. The ROS [review of systems] and PFSH [past family and social history] can be recorded by other staff and the physician then reviews and confirms the information."

Similarly, WPS (Jurisdictions 5 and 8) states that only the physician or NPP performing the service can obtain the HPI.

Ancillary staff can serve as scribes while the physician dictates the HPI, says Palmetto GBA (Jurisdiction 11), but "only the physician or NPP who is conducting the E/M visit can perform the history of present illness (HPI). This is physician work and not relegated to ancillary staff."

If you are using a nurse as a scribe, make sure the record reflects the following, Palmetto states:

- Who performed the service,
- Who recorded the service,
- A notation from the physician/NPP that he/she reviewed the documentation for accuracy and
- Signature and date by the performing physician/NPP.

Make sure to check your own MAC policies on that issue.

"In the E/M documentation guidelines, if they had wanted someone else to do the HPI, they would have stated that," points out Coding Pro technical adviser Margie Scalley Vaught, CPC, CPC-H, CCS-P, ACS-EM, ACS-OR. "They specifically noted that the ROS and PFSH could be obtained by ancillary staff."

More EHR oversight in your future

Practices should expect more scrutiny from their MACs of E/M services documented with an EHR template. A January HHS Office of Inspector General report recommended that Medicare start checking those notes for sloppy cloned-note errors.

The report specifically mentions "copy-pasting" and "overdocumentation" — the signal features of cloned notes. CMS is mainly interested in lazy shortcuts that, intentionally or not, misrepresent what the physician did, say billing experts.

Often the issue is simple carelessness as physicians become more reliant on EHR copy-paste functions.

If a doctor is tempted to paste in a past ROS and PFSH, remind him or her to carefully edit these elements to make sure they apply to the patient's new HPI, experts recommend.

"[Recently] I saw one hospital's H&P for which the history of present illness said 'nausea, vomiting, low blood count,' etc.," says Dianne Wilkinson, RHIT, compliance auditor and educator for West Tennessee Healthcare in Jackson, Tenn. "The 14-system ROS was there too and under GI, it said 'no nausea/vomiting.' That's the kind of thing that screams, 'I'm a template and no one reviewed me.'" — *Laura Evans (levans@decisionhealth.com)*

CCI 20.0

(continued from p. 1)

The new code pairs likely will impact payment for patients who have reached the end of their transitional care after a hospital stay and then develop a new problem that you must address, warns Connie Zeller, CPC, clinical content editor at Contexo Media.

For example, a patient was hospitalized for pneumonia and released into transitional care but then developed an infected cyst that had to be lanced 30 days after discharge. If both the TCM code and the incision and drainage code are reported on the same date, only the I&D code will get paid because of the new edits.

Some services that should be separately payable will be bundled, Zeller explains. She recommends practices carefully document and bill for their services anyway. "CCI edits aren't set in stone, and one day they could be rolled back," she says. "If that happens, you would then be able to rebill the services that were denied."

New codes include E/M, anesthesia

Many of the remaining new code pairs in Version 20.0 bundle various component services into new 2014 CPT codes that Medicare considers inclusive. For example, code **10030** (Image-guided catheter fluid drainage) includes most E/M codes (e.g., **99211-99239**), wound repair, topical anesthesia (e.g., injection codes **62310-64530**), intraoperative monitoring (including electrocardiograms, **93000-93042**) and such procedures as negative pressure wound therapy (**G0456** and **G0457**) in addition to nail trimming (**G0127**).

Note: For the full list of services Medicare policy states are included in most surgical and medical procedures, see Chapter 1 of the CCI Policy Manual.

Here are additional changes in CCI Version 20.0:

- **CMS adds code pairs for already-bundled new consult codes.** The 2014 CPT codes for interprofessional

telephone/Internet consultations (**99446-99449**) came in for special attention in CCI Version 20.0 — you'll find them bundled as components of anesthesia codes and many surgical, medical and radiological codes. CCI added the new edits even though CMS already gave codes 99446-99449 the payment status "B" (bundled) in the 2014 Medicare physician fee schedule. In an additional odd move, CCI allows code pairs that bundle 99446-99449 with radiology codes to be unbundled with a modifier. The Medicare fee schedule edits "were applied outside of the parameters of the NCCI edits," a CMS spokesperson explained. For Medicare, at least, phone/Internet consult codes will not be payable, CMS said. But it appears CCI may be keeping the door open to coverage by other payers that license its software.

- **You'll need a modifier to report 10030 separately from many excision and injection codes,** among other procedures. For example, the new code for image-guided catheter fluid drainage is bundled as a component of joint injection and aspiration codes **20600-20612**. CCI also added 10030 as a component of the musculoskeletal tissue excision codes, including forearm excision codes **25071-25145**. The edits appear to allow you to unbundle them with a modifier when the fluid drainage addresses a separate and distinct problem.

- **Cardiology codes contain modifier status changes.** Check the edits for such services as insertion of pacing electrode (**33224**) and pacemaker skin pocket relocation codes (**33222-33223**) for the same patient on the same day. CCI Version 20.0 flipped the modifier indicator for a number of those code pairs so that you can no longer use a modifier to unbundle the claims-processing edits to report both services, according to analysis by Frank Cohen of The Frank Cohen Group, LLC.

- **Steer clear of numerous new mutually exclusive edits.** These edits, added to almost every code range, bundle and deny the higher-value code in a pair. For example, you'll want to look out for new pairs that bundle breast biopsy codes **19100** and **19101** as components of breast biopsy add-on codes **19082** and **19084**. In addition, steer clear of a new edit that bundles esophagoscopic dilation code **43213** as a component of esophagoscopic balloon dilation (**43214**) and will not allow use of a modifier to override the edit.

- **CCI invalidates pairs with deleted codes.** Most — though not all — of the 13,000 terminated code pairs in CCI 20.0 involve deleted CPT or HCPCS codes. For example, thanks to one series of deleted pairs, you'll now be able to bill placement or revision of a ventricular assist device (**33990-33993**) on the same date as a nursing facility visit (**99304-99318**). — *Laura Evans (levans@decisionhealth.com)*

Medical Practice Coding Pro Subscriber Services

Vice President: Corinne Kuypers-Denlinger, 1-301-287-2363, email: *cdenlinger@decisionhealth.com*

Editor: Laura Evans, 1-301-287-2376 or fax 1-301-287-2916; email: *levans@decisionhealth.com*

Technical Advisor: Margie Scalley Vaught, CPC, CPC-H, CCS-P, MCS-P, ACS-EM, ACS-OR

Subscriptions: Direct questions about newsletter delivery and account status, toll-free, to 1-855-CALL-DH1 or email to: *customer@decisionhealth.com*.

***Medical Practice Coding Pro* Online:** As a subscriber, you can read and download your newsletter electronically at *www.codingprodecisions.com*. **How to register:** Visit *www.codingprodecisions.com* and fill out the online form. After that, just visit as often as you like. If you have any problems or questions about registering, please call 1-855-CALL-DH1.

Free Internet Forum: To join CodingPro-L, our free Internet forum for coders, billers, managers and administrators, go to *www.decisionhealth.com/codingpro-l-enroll* and fill out the enrollment form.

Conferences: ***Medical Practice Coding Pro*** holds seminars to help you meet coding and billing challenges. For program schedules, call 1-301-287-2684; email: *conference@decisionhealth.com* or visit *www.decisionhealth.com*.

CEUs: Each ***Medical Practice Coding Pro*** has prior approval of the **American Academy of Professional Coders** (AAPC) for 0.5 Continuing Education Units. Granting of this approval in no way constitutes endorsement by the Academy of the program, content or the program sponsor. You can earn your CEUs by passing a five-question quiz delivered through your Coding Pro Decisions website *(www.codingprodecisions.com)*. Once you have logged in, go to the "Library" page, find the issue and click the adjacent hyperlink marked "Quiz." Log in to the Online Quiz System using your Coding Pro Decisions site userID/password.

American Academy of Professional Coders CEU APPROVED

The **American Academy of Professional Coders** (AAPC) has pre-approved ***Coding Pro*** for CEUs toward its CPC® and CPC-H® credentials. For details, contact AAPC directly at 1-800-626-2633 or visit their website *www.aapc.com*.

Board of Medical Specialty Coding & Compliance

Coding Pro is also approved for CEUs from the Board of Medical Specialty Coding (BMSC). 3 CEUs toward its ACS and SCP credentials. Contact BMSC directly for information at 1-800-897-4509; or go to *www.medicalspecialtycoding.com*.

Reprints: To request permission to make photocopy reprints of Medical Practice Compliance Alert articles, call 1-855-CALL-DH1 or email customer service at *customer@decisionhealth.com*. Also ask about our copyright waiver, multiple copy and site license programs by calling the same number.

Medical Practice Coding Pro is published monthly by DecisionHealth, Two Washingtonian Center, 9737 Washingtonian Blvd., Ste. 200, Gaithersburg, MD 20878-7364. Price: $397/ year.

2014 vs. 2013 Medicare fees for select codes billed by primary care practices

The following non-facility professional fees are par, national allowable, not adjusted for locality. Fees for 2014 took effect Jan. 1. They are calculated based on 2014 Medicare RVUs and a conversion factor (CF) of $35.8228. Fees for 2013 were calculated with 2013 Medicare RVUs and a CF of $34.0230. The 2014 conversion factor is 5% higher than in 2013. When 2014 fees are lower than 2013, it is the result of reductions in work or practice expense relative value units (RVUs).

HCPCS	DESCRIPTION	Work RVUs	Non-facility Practice Expense RVUs	Malpractice RVUs	Non-facility total RVUs	2013 Non-facility fees	2014 Non-facility fees	Percent change
17003	Destruct premalg les 2-14	0.04	0.23	0.01	0.28	$6.80	$10.03	47%
20610	Drain/inject joint/bursa	0.79	0.8	0.11	1.7	$60.56	$60.90	1%
69210	Remove impacted ear wax uni	0.61	0.72	0.07	1.4	$53.08	$50.15	-6%
71020	Chest x-ray 2vw frontal&latl	0.22	0.63	0.02	0.87	$30.96	$31.17	1%
77080	Dxa bone density axial	0.2	1.16	0.02	1.38	$50.35	$49.44	-2%
90471	Immunization admin	0.17	0.52	0.01	0.7	$25.86	$25.08	-3%
93000	Electrocardiogram complete	0.17	0.28	0.02	0.47	$18.37	$16.84	-8%
93010	Electrocardiogram report	0.17	0.06	0.01	0.24	$8.17	$8.60	5%
93306	Tte w/doppler complete	1.3	5.05	0.05	6.4	$189.51	$229.27	21%
94760	Measure blood oxygen level	0	0.08	0.01	0.09	$3.40	$3.22	-5%
95004	Percut allergy skin tests	0.01	0.16	0.01	0.18	$6.80	$6.45	-5%
95165	Antigen therapy services	0.06	0.29	0.01	0.36	$13.27	$12.90	-3%
96372	Ther/proph/diag inj sc/im	0.17	0.52	0.01	0.7	$25.86	$25.08	-3%
97110	Therapeutic exercises	0.45	0.44	0.01	0.9	$31.98	$32.24	1%
99203	Office/outpatient visit new	1.42	1.47	0.13	3.02	$108.19	$108.18	0%
99204	Office/outpatient visit new	2.43	1.99	0.22	4.64	$164.67	$166.22	1%
99211	Office/outpatient visit est	0.18	0.37	0.01	0.56	$20.41	$20.06	-2%
99212	Office/outpatient visit est	0.48	0.7	0.04	1.22	$43.89	$43.70	0%
99213	Office/outpatient visit est	0.97	1	0.07	2.04	$72.81	$73.08	0%
99214	Office/outpatient visit est	1.5	1.41	0.1	3.01	$106.83	$107.83	1%
99215	Office/outpatient visit est	2.11	1.79	0.13	4.03	$142.90	$144.37	1%
99291	Critical care first hour	4.5	2.84	0.33	7.67	$272.18	$274.76	1%
99306	Nursing facility care init	3.06	1.43	0.22	4.71	$164.33	$168.73	3%
99307	Nursing fac care subseq	0.76	0.45	0.04	1.25	$43.55	$44.78	3%
99308	Nursing fac care subseq	1.16	0.7	0.07	1.93	$67.71	$69.14	2%
99309	Nursing fac care subseq	1.55	0.91	0.08	2.54	$88.80	$90.99	2%
99349	Home visit est patient	2.33	1.11	0.13	3.57	$124.86	$127.89	2%

Source: DecisionHealth analysis of Medicare fee data