



Connecticut Coders Quarterly

Newsletter of the Connecticut Chapter of the AAPC

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Save the date for our Annual
CT Chapter AAPC confer-
ence!

Friday, October 15, 2004
8:00 AM—4:00 PM

Courtyard by Marriott

Coders Limericks

by Tony Fusco

There was a smart coder named
Carol
Who gave not a care to apparel
She said as a joke
If her practice went broke
We can all come to work in a bar-
rel!

A frugal coder named Marylou
Hit the lotto for millions its true
She decided to splurge
To give into the urge
To skip work a day, wouldn't you?

When billing I have to admit
All these numbers just give me a fit
Come 5 o'clock Friday
As I head down the freeway
You know, I just don't give a darn!

A Note from the President's Desk

Dear Chapter Members

I hope all of you are enjoying your summer!

Our chapter will resume our meetings in Sep-
tember. We are also will have our annual
chapter conference on October 15, 2004 and
are pleased to announce our guest speaker will
be Connecticut's Attorney General Richard
Blumenthal. Please watch for registration in
the mail.

AAPC Local Chapters are growing in Con-
necticut. We presently have 5 chapters in Con-
necticut. The following are the towns and con-
tact persons. You are welcome to attend
meetings and events:

Hartford Chapter: President Rosemary

Cadarette, CPC rcadarette@prohealthmd.com

Southeastern Chapter: President Mary Anne
Lamb, CPC yakr@juno.com

Southwestern Chapter: President Stephen
Sharma, CPC tssharr@bpthosp.org

Torrington Chapter: President Edy Skovira,
CPC ecosko@aol.com

Have a great summer and remember we will be
taking nominations for officers for 2005 at the
September meeting. Please feel free to contact
me if you have any questions or comments.

Sincerely,

Brenda Dombkowski, CPC

President, Connecticut Chapter

Josh Copel, MD Speaks to Coders on Maternal Fetal Medicine

By Laurel Poletti, RN, BSN, MS, CPT

If you didn't make it to the May chapter meeting you missed out on the opportunity to be both entertained and enlightened by Dr. Josh Copel, Professor and Chief of Maternal Fetal Medicine at the Yale School of Medicine and Fellow of the Society of Maternal Fetal Medicine. While charting the course of obstetric ultrasound coding, Dr. Copel shared his own metamorphosis from coding curmudgeon, to coding sleuth, to coding aficionado whose encouragement has helped create some recent CPT revisions in obstetric ultrasound coding. Professor Copel's depth of understanding was demonstrated by his insights into reimbursement debacles, RVUs and budget neutrality, compliance mandates, and the history of CPT changes in Obstetric ultrasound. Some of the highlights included:

2001 additions to CPT:

76818 Fetal biophysical profile; with non-stress testing

76819 Fetal biophysical profile; without non-stress testing

Both codes include the interpretation and report. The OB practitioner who performs the entire exam utilizes CPT 76818. CPT 76819 is utilized when the biophysical profile is performed by the Radiologist. 76819 could be used by any MD, not just a radiologist, who performs a BPP without doing the NST. Obs who perform the full BPP should not unbundled by using -19 + 59025, but if

they do just the ultrasound portion they should use -19.

Dr. Copel recommends utilizing 76815, the code for limited obstetric ultrasound when an amniotic fluid index is performed. If the AFI is performed with non-stress testing, use code CPT 59025 in addition.

2002 additions to CPT:

59001 Therapeutic amniotic fluid reduction

This procedure is performed in the treatment of twin-twin transfusion syndrome or severe polyhydramnios. As this code includes ultrasound guidance for the procedure don't bill for it additionally.

2003 additions to CPT:

76801 Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (less than 14 weeks, 0 days), transabdominal approach, single or first gestation

76802 ; each additional gestation

76805 Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (greater than 14 weeks, 0 days), transabdominal approach, single or first gestation

76810 ; each additional gestation

These codes are for basic ultrasound services, which should include evaluation of fetal number and presentation, fetal life, placental location, amniotic fluid, gestational age, a basic anatomic survey, and maternal pelvic anatomy. The anatomic survey should include visualization of the stomach, kidneys, bladder, ventral wall, spine, the 4 heart chambers and the intracranial anatomy including the lateral ventricles and posterior fossa.

Also added in 2003 were:

76811 Ultrasound, pregnant uterus, real time with image documentation, maternal evaluation plus detailed fetal anatomic evaluation, transabdominal approach, single or first gestation

76812 ; each additional gestation

Dr. Copel reported and concurred with the Society of Maternal Fetal Medicine's position on these codes:

"...The SMFM believes that the new code describes an examination involving significantly more work, and requiring greater expertise than that required for 76805. Additionally, sophisticated equipment, rather than typical office level ultrasound machines, will be required to obtain the necessary imaging detail. The level

of expertise required to perform this examination can only be obtained through the extended education beyond residency that is required in a fellowship in Maternal-Fetal Medicine or Radiology...Use of this code by general obstetricians should be the exception, not the rule."

Additional new codes in 2003:

76815 Ultrasound, pregnant uterus, real time with image documentation, limited (eg, fetal heart beat, placental location, fetal position and/or qualitative amniotic fluid volume), one or more fetuses

Dr. Copel cautions use CPT 76815 once per exam, not once per element.

76816 Ultrasound, pregnant uterus, real time with image documentation, follow-up (eg, re-evaluation of fetal size by measuring standard growth parameters and amniotic fluid volume, re-evaluation of organ system(s) suspected or confirmed to be abnormal on a previous scan), transabdominal approach, per fetus.

Dr. Copel reminded the audience to utilize CPT 76816 with modifier -59 for each additional fetus scanned. He also discussed what code to use when the patient has returned much later in the pregnancy. His advice: ask is the decision to perform the scan based upon a new or the same indication? If the indication is new, use CPT 76905, if it is the same, use 76816.

76817 Ultrasound, pregnant uterus, real time with image documentation, transvaginal

If transvaginal examination is done in addition to transabdominal obstetric ultrasound, use 76817 in addition to the appropriate transabdominal exam code.

2004 additions to obstetric ultrasound coding saw the inclusion of some of the treatments available in Maternal Fetal Medicine.

59070 Transabdominal amnioinfusion

59072 Umbilical cord occlusion

59074 Fetal fluid aspiration

59076 Fetal shunt placement

59897 Other unlisted fetal procedure

Coming soon to a CPT book near you? Dr. Copel predicts we will soon see the addition of codes for umbilical artery (for the evaluation of growth restriction) and middle cerebral artery (for evaluation of fetal anemia) Doppler examinations. With Dr. Josh Copel in hot pursuit of CPT's revision there's hope that coding for these very sophisticated services for these very vulnerable patients will continue to advance.

You can send your articles to our editor, Corinne Fisher at 737-2957, 737-4108 or corinne.fisher@yale.edu and earn extra CEUs!

ICD-9-CM Diagnosis Codes and the Physician Role when Ordering Diagnostic Tests

By Kathleen Kowalchik, RN, CPC, CPC-H, CCS-P, CCS

In 2003 CMS published 2 Program Memorandum for physicians regarding diagnosis coding, B-03-045 June 6, 2003 and B-03-046 June 10, 2003. These memorandums serve as a reminder that in order to comply with HIPAA transactions and code sets:

All claims submitted to Medicare Part B (except ambulance claims) must have an ICD-9-CM diagnosis code effective 10/1/03. Although HIPAA applies to electronic transactions, CMS has included all claims paper or electronic in the requirement.

CMS provided coding guidance for physicians in memorandums B-03-045 and B-03-046. Included are:

Claims should contain the ICD-9-CM diagnosis code that provides the highest degree of accuracy and completeness.

In the context of ICD-9-CM coding, the “highest degree of specificity” refers to assigning the most precise ICD-9-CM diagnosis code that most accurately explains the narrative description of the symptom, condition or diagnosis.

Level of specificity refers to appropriate coding of all digits. ICD-9-CM diagnosis codes are composed of 3, 4, or 5-digits. If 4th and/or 5th digits are provided in ICD-9-CM, they are required.

An example is Type II Diabetes Mellitus without complications. Claims containing incomplete diagnosis codes 250 or 250.0 are not acceptable. The correct level of specificity for claim submission is 250.00.

CMS reminds referring providers that they have responsibilities when ordering diagnostic tests. Section 4317 (b) of the Balanced Budget Act *requires* the ordering physician or practitioner to provide diagnosis code(s) or narrative diagnosis at the time the test is ordered. It is the responsibility of the ordering physician to provide adequate diagnostic information when ordering diagnostic tests, so that the facility i.e. hospital or lab can appropriately submit the claim for their services.

Since 'rule out', 'suspected', or 'probable' diagnoses may not be coded as if they exist, the ordering physician should provide information relating to the condition to the highest degree of certainty for that encounter, i.e. the signs, symptoms or abnormal test results.

Laboratories will request diagnostic information from the ordering physician or practitioner if it is not provided at the time the test is ordered. The diagnosis submitted must support medical necessity for the diagnostic test or procedure. The patient's medical record maintained by the ordering physician must contain supporting documentation. If Medicare denies the hospital or lab claim, Medicare requires an appeal to include documentation from the ordering physician's record.

The practitioner or office manager should remember that if the physician fails to include sufficient diagnostic information when ordering testing, requests for additional diagnoses or documentation might come from either the performing facility or Medicare or both. Medicare contrac-

tors (including the performing hospital's Medicare Fiscal Intermediary) may request additional documentation directly from the ordering physician/practitioner to support medical necessity for lab services.

The hospital, lab or other facility must meet Medicare's medical necessity requirements. If they are a Medicare Part A provider, the Local Coverage Determinations may be different from the Part B requirements the physician's office is familiar with. If your office is contacted for additional diagnostic information it is because the diagnosis provided was not sufficient to meet medical necessity.

Keeping the patient in mind, the hospital or lab may ask your patient to sign an Advance Beneficiary Notice, or ABN, and accept responsibility for payment, if sufficient diagnostic information is not provided or requests for additional information are ignored. Placing the best interest of the patient at the forefront both the ordering and performing providers should cooperate in requesting and providing appropriate information and services.

Additional guidance for diagnosis coding is available in the Official ICD-9-CM coding guidelines and in CMS Internet Manual Publication 100-4, Claims Processing Manual, Chapter 23, Section 10.

CMS references:

Official ICD-9-CM coding guidelines:

<http://www.cdc.gov/nchs/data/icd9/icdguide.pdf>

Claims Processing Manual, Pub 100-4, Chapter 23 Fee Schedule Administration and Coding Requirements, Section 10, ICD-9-CM Diagnosis and Procedure Codes: http://www.cms.hhs.gov/manuals/104_claims/clm104c23.pdf

B-03-046, Provider Education regarding increased role in ICD-9-CM requirements for claim submission: http://cms.hhs.gov/manuals/pm_trans/B03046.pdf

B-03-045 ICD-9-CM requirements for claim submission: http://cms.hhs.gov/manuals/pm_trans/B03045.pdf

Transmittal 1807, 6/27/03, Clarification regarding ICD-9-CM coding for diagnostic tests Medicare Carrier Manual (deletes the Note in section E in transmittal 1769 below): http://cms.hhs.gov/manuals/pm_trans/R1807B3.pdf

Transmittal 1769, 9/12/02, Clarification regarding ICD-9-CM coding for diagnostic tests, Medicare Carrier Manual: http://cms.hhs.gov/manuals/pm_trans/R1769B3.pdf

AB-03-021, Additional documentation requests for ordering providers of lab services: http://www.cms.hhs.gov/manuals/pm_trans/ab03021.pdf

Connecticut Chapter of the AAPC

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We're on the Web!

www.ctaapc.org

Mailing Address Here

Bulletin Board

Thursday, September 16, 2004, 8:30 AM, Brady Auditorium

“Tricks of the Trade”

Coding, billing, reimbursement, and compliance tricks and tips offered by a variety of experienced professionals.

Friday, October 15th, 8:30 AM—4:00 PM, Courtyard by Marriott

3rd Annual CT AAPC Coding Conference

Please RSVP for meetings at least 3 days prior so hand-outs and refreshments can be ordered. Also, be sure to sign in and indicate if you are a CPC to insure you receive your CEUs.

How to Challenge Those CCI Edits

by Beth Lynch, CPC

Anyone familiar with coding is certainly familiar with CMS' National Correct Coding Initiative (CCI). CCI is published by CMS and one of its contractors, AdminiStar Federal, and it lists what procedures and services cannot be billed at the same time when performed for the same patient on the same date of service

CCI categorizes coding combinations into two categories: codes that are mutually exclusive to one another and are not normally billed together; and codes that are considered a component of the larger, primary code. Modifier indicators tell the coder if a modifier can be used to identify special circumstances when certain codes can be billed together even though they are performed on the same patient on the same day. These modifiers are: E1-E4, FA, F1-F9, LC, LD, LT, RC, RT, TA, T1-T9, 25, 58, 59, 78, 79 and 91. An indicator of 0 next to the CPT code means that a coding combination should never be billed together and there is no modifier that overrides the CCI edit. An indicator of 1 means that a modifier may be used to override the CCI edit, if there are special circumstances present that indicate the services provided warrant separate reimbursement. An indicator of 9 usually means the CCI edit is no longer active and the coding combination in

question may be billed without a modifier.

What some coders may not know is that providers can challenge CCI edits. AdminiStar Federal publishes and updates these edits quarterly. New edits are added, or existing edits are deleted, each quarter. Inquiries and suggestions about CCI edits can be sent to:

NCCI Medical Director Niles Rosen, MD
National Correct Coding Initiative

AdminiStar Federal, Inc

PO Box 50469

Indianapolis, IN 46250-0469

While individual providers and provider groups may contact AdminiStar, it is recommended that providers first check with their national associations and societies to see if a particular issue has been addressed. Having the support of your medical society will only strengthen your case with CMS when trying to challenge an existing CCI edit.

Documentation such as clinical literature and coding guidelines should be included with the doctor's request to remove an existing edit. CMS and AdminiStar will respond to each request and indicate if the edit will remain in place or be removed.