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Internal Medicine Coding Alert

Know Thy Payer to Code Starred Procedures Correctly

For many coders, a star beside a procedure in CPT represents profound mystery. Many are confused about how to use starred procedure codes for Medicare versus private payers, whether to charge an office visit with a starred procedure, and how to handle coding for follow-up care.

The first key to unraveling the mystery of the stars is simple, says **Jan Rasmussen, CPC,** who is president of the Eau Claire, Wisc.-based Professional Coding Solutions, which provides coding support, compliance review and contract coding to physicians nationwide, and is also a member of the AAPC National Advisory Board and serves as the AAPC liaison to the American Medical Association.

"Know thy payer," Rasmussen says. "You have to know who your payers are and what their policies are."

Is the payer Medicare or a private payer? And if it is a private payer, does the payer recognize starred procedures or does it follow Medicare guidelines? When the office signs a contract, Rasmussen says, be sure to examine the language carefully so you know the answers to these questions.

The Concept Behind the Stars

A star (*) beside a procedure code in the CPT manual denotes a relatively minor surgical procedure that can require variable amounts of preoperative and post-operative services. Because the pre-op and post-op care that is required can vary, CPT does not assign the normal "global package" to these procedures as it does to other surgical procedure codes. Instead, it marks them with a star to indicate that only the procedure itself is included in the payment. Offices can code pre-op and post-op care separately as necessary on an individual basis.

While many private payers follow the CPT guidelines, Medicare does not embrace the "star" philosophy, instead assigning global periods of 0 to 10 days to the services it considers to be minor procedures. Services provided to the patient related to the procedure during that global period are covered under the fee for the procedure. Check with your local carrier to determine the global period for a particular starred procedure code.

The differing policies of Medicare and CPT on starred procedures can make coding very confusing. While many private payers follow CPT on starred procedures, others have adopted Medicare's guidelines.

Some private payers in Florida have even adopted their own rules for starred procedures, not following Medicare or CPT guidelines, which makes coding extremely difficult, says **Sharon O'Leary, CPC,** coding coordinator and chief compliance officer at Physician Associates of Florida, a 70-physician practice in Central Florida, and president of the Greater Orlando AAPC chapter.

Once again, the key is to know your payer's policies before coding.

New Patient: Starred versus Global

Once you know whether your payer recognizes starred procedures, you can develop a coding strategy. The following scenario from Rasmussen will walk you through coding a starred procedure provided to a new patient when the payer recognizes starred procedures and when the payer follows Medicare guidelines.

For example, a new female patient comes in with a sebaceous cyst on her shoulder. The internist performs a cursory exam limited to the immediate area and says the cyst should be drained because it appears to be infected and is

growing. The history is focused only on the cyst, and the decision-making does not indicate any differential diagnosis being ruled out. The physician performs the incision and drainage and tells the patient to return in one week for follow-up.

When Payer Recognizes Starred Procedures

If the patient has coverage with a private payer that recognizes starred procedures, report 10060* (Incision and drainage of abscess [e.g., carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia; simple or single) along with 99025 (Initial [new patient] visit when starred [*] surgical procedure constitutes major service at that visit). Code 99025 is a special code used only when a starred procedure is the major service provided to a new patient at a first appointment. The follow-up visit is coded at the appropriate established patient E/M level (99211-99215) with a diagnosis of V67.00 (Follow-up examination following surgery, unspecified) or V58.3 (Attention to surgical dressings and sutures), as appropriate. Or, if the patient returns with an infection at the cyst site at the follow-up visit, code the appropriate E/M with a diagnosis of 998.59 (Other postoperative infection).

Medicare or Carrier that Follows Medicare Policy

If the patient is covered by Medicare or a carrier that pays according to Medicare guidelines, report 10060* only. Medicare does not recognize or pay for 99025, so it cannot be used. Because Medicare has assigned a global period of 10 days to 10060*, payment for that code covers all care associated with the procedure for that period of time, including follow-up visits and even care related to a postoperative infection.

"Medicare does not pay for any complications that do not require a return trip to the operating room," Rasmussen notes.

Established Patients: When to Bill an E/M

Coding a starred procedure performed on an established patient has different challenges because 99025 does not apply, and an E/M visit can only be coded in certain circumstances.

When the starred procedure is the major service at the visit, only the starred procedure itself can be coded for Medicare and for private payers. However, CPT says an E/M code can be used with a starred procedure if a significant, separately identifiable service is also provided at the same visit. Rasmussen says carriers do not expect to see an E/M coded on the same day as a starred procedure on a routine basis.

A good rule of thumb is to look at whether the doctor performed a more extensive, medically necessary history/review of systems and examined areas outside the immediate body area where the procedure was performed in an effort to rule out differential diagnoses. Rasmussen notes, for example, that a separate E/M would not be coded for an established patient in the scenario above where the doctor drained a sebaceous cyst. Only the starred procedure (10060*) would be billed, because the reason for the visit was the cyst and the doctor did not examine other areas of the body or perform a workup for differential diagnoses.

A separate E/M could be reported in the following example, however, for both Medicare and for payers that recognize starred procedures. A patient complains of shoulder pain. In the course of taking a history, the internist discovers that the patient has had fevers, swelling, aches and pains in other joints, and a tick bite within the last year. The doctor performs a workup to rule out rheumatoid arthritis, osteoarthritis and Lyme disease. At the end of the workup, the physician decides that the pain is probably bursitis and gives the patient an injection.

The injection is coded with 20610* (Arthrocentesis, aspiration and/or injection; major joint or bursa [e.g., shoulder, hip, knee joint, subacromial bursa]), with a diagnosis of 719.41 (Pain in joint; arthralgia; shoulder region). Bursitis cannot be coded because it is a "probable" diagnosis. The office also reports the appropriate E/M code, appended with the -25 modifier (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service). Rasmussen notes that it is not necessary to list different diagnoses for the office visit and the starred procedure.

A separate E/M may also be coded for Medicare and private payers if the patient came to the office with another complaint, such as hypertension, and mentioned the shoulder pain and received an injection for it during the visit. O'Leary notes that the key to billing an E/M with a starred procedure is that the patient has a complaint that requires significant, separately identifiable services beyond the starred procedure. If the visit meets the required two of three components for an E/M, she says, "we will bill for a low-level office visit with the -25 modifier."

Another scenario where a separate E/M could be charged for both Medicare and private payers is if the physician saw the patient for shoulder pain, but asked the patient to return in two weeks for an injection if not better. The appropriate level of E/M would be charged for the first visit, and 20610* would be coded when the patient returns for the injection.

Capture All Reimbursement for Starred Procedures

When your payer follows CPT guidelines for starred procedures, it's important to make sure you capture all associated costs and follow-up care.

For example, AMA noted in a recent clarification on starred procedures in the May 2001 CPT Assistant that anesthesia is among the services that can be reported separately from the starred procedure. Although AMA may have expected coders to know that, "this is the first time they put it in writing, to my knowledge," notes Rasmussen.

Additional reimbursement for a local anesthetic may be only a few dollars, but it can help cover the cost of those supplies, says Rasmussen. However, she says that Medicare will not cover it and that other payers also may follow Medicare's lead and therefore not pay separately for the anesthesia.

"Is it worth trying? You bet! I don't think anyone ever thought to bill the anesthetic separately," says Rasmussen. Many offices may also be missing out on revenue associated with starred procedures by not charging for suture removal and by not billing follow-up visits. O'Leary notes that charging for follow-up visits, which often carry a co-pay, can make some patients unhappy. However, she says, "unless the carrier has specific language that you may not bill a follow-up, I follow AMA guidelines and encourage our physicians to bill follow-up visits."