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Internal Medicine Coding Alert

Watch Out for 3 CMS Changes That Will Affect Your Practice

Experts reveal a new way to determine modifier 25 use

When you rev staff up for fall, make sure you highlight two new modifier requirements and a bundle break-up.

1: Omit 25 on E/Ms With Global-Free Procedures

Tired of trying to figure out whether modifier 25 is required when you perform E/M services in addition to medicine services? **Good news:** CMS has finally issued a much-needed clarification.

As of Aug. 20, you should only use modifier 25 when your internist provides a significant and separately identifiable E/M service on the same day as a procedure with a global period, says **Jim Collins, CPC, CHCC**, president of Compliant MD Inc. in Matthews, N.C.

Example: An internist performs an established patient E/M service and a stress test during the same visit. Because the recent CMS clarification states that you should only append modifier 25 to an E/M code when a procedure has a global period, you should not use modifier 25 in this situation, Collins says. His rationale: "The stress test does not have a global period."

The National Physician Fee Schedule Relative Value File designates 93015-93018 as XXX codes, which means "the global concept does not apply to the code."

The E/M service is significant and separately identifiable from the stress test, so you can still report both the E/M and stress test codes. You simply do not need to append modifier 25 to the E/M code.

To report the stress test, you should use one of the following codes depending on the internist's documentation:

• 93015--Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with physician supervision, with interpretation and report

• 93016--... physician supervision only, without interpretation and report

• 93017--... tracing only, without interpretation and report

• 93018--... interpretation and report only.

To code the E/M service, you should report the appropriate-level established patient code, for example, 99213 (Office or other outpatient visit for the evaluation and management of an established patient ...) for a level-three E/M service.

Important: Check with your payers for their individually tailored modifier 25 policies. Some insurers may require modifier 25 on an E/M service charged in addition to a code with no global period, such as developmental screening (96110, Developmental testing; limited [e.g., Developmental Screening Test II, Early Language Milestone Screen], with interpretation and report), says **Richard H. Tuck, MD, FAAP,** a nationally recognized coding speaker with PrimeCare of Southeastern Ohio.

For more: You can find the CMS clarification at www.cms.hhs.gov/transmittals/downloads/R954CP.pdf.

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2: Separately Code Critical Care and Discharge

In the most recent National Correct Coding Initiative edits, version 12.2 (effective July 1, 2006), CMS deleted an edit that made critical care codes 99291-99292 components of hospital discharge day management code 99239 (Hospital discharge day management; more than 30 minutes). Now that CMS has deleted this edit, if a patient presents in an emergency situation that requires 30 minutes or more of critical care and is discharged from the hospital that same day, you can bill for both services.

Prior to July 1, CMS considered 99291-99292 (Critical care, evaluation and management of the critically ill or critically injured patient ...) and 99239 to be mutually exclusive services. Mutually exclusive edits pair procedures or services that the physician would not reasonably perform at the same session, at the same anatomic location on the same beneficiary, says **Barbara J. Cobuzzi, MBA**, **CPC, CPC-H, CPC-P, CHCC**, president of CRN Healthcare Solutions, a coding and reimbursement consulting firm in Tinton Falls, N.J.

Previously, if you were to report these two mutually exclusive codes for the same patient during the same session, insurers generally would pay for the comprehensive procedure (in this case 99239) and deny the payment for the component service (99291 and 99292). Due to these problematic edits, payers would reimburse the less expensive service because they include all E/M services provided on the day of discharge in the discharge day management codes.

3: Use 59 When 2 Reasons Prompt Draw, Hydration

A few short months ago, NCCI version 12.1, which took effect April 1, classified 107 codes as components of moderate sedation (99143-99150).

Translation: You should be appending an appropriate modifier (such as modifier 59, Distinct procedural service) to bill for moderate sedation used with intracatheter introduction (36000), venipuncture (36400-36410, 36420-36425), hydration (90760) and many injection procedures. This change is Medicare's way of saying that it won't pay separately for any of these procedures in addition to moderate sedation.

Exception: If the procedures meet the criteria for modifier 59, you can report them together, says **Carol Pohlig, BSN, RN, CPC**, at Hospital of the University of Pennsylvania in Broomall, Pa. In addition, NCCI 12.1 made numerous procedures components of 90760, she says.

For instance, you shouldn't typically report venipuncture requiring a physician's skill in addition to hydration, according to NCCI version 12.1, Pohlig says. But if the blood draw is for a different reason than hydration assessment (such as a CBC to detect infection) and occurs at a separate site from the hydration insertion, you can code both.

In this case, you should report the venipuncture and the hydration (90760, Intravenous infusion, hydration; initial, up to 1 hour), Pohlig says. You would append modifier 59 to the component code: 36410 (Venipuncture, age 3 years or older, necessitating physician's skill [separate procedure], for diagnostic or therapeutic purposes [not to be used for routine venipuncture]).

Good news: The bundles might not affect your reimbursement for non-Medicare payers. Non-Medicare payers may indeed pay for 99143-99150, and you can always specify reimbursement for moderate sedation during your contract negotiations. So don't assume private payers won't reimburse you just because Medicare won't.

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