# Part B Insider (Multispecialty) Coding Alert

## Billing: 5 Tips You Need to Know for Clean 2015 Claims

**This MAC illuminates several of the most challenging coding issues.**

Your MAC has been processing claims based on the "new" 2015 rules for a few weeks now, but your head may still be spinning over the changes. Sit back and get the scoop on proper claims submissions thanks to the following five tips provided by NGS Medicare's **Nathan L. Kennedy, Jr., CPC, CHC, CPPM, CPC-I** during the MAC's Jan. 27 online conference, "J6 January Quarterly Release Webinar."

**1. Update Your Interventional Cardiology Specialty Code.** "CMS established a new specialty code for interventional cardiology, and that specialty code is C3," Kennedy said. "In the past, interventional cardiology was not an acceptable Medicare specialty and you had to go with cardiology, but now you can submit an application for that specialty if the specialist is new, or you can request a change for someone who's currently enrolled as a cardiologist to make that change to interventional cardiology," he said.

**2. Expand Your Telehealth Options.** "CMS has determined that four new services can be billed via telehealth," Kennedy said. "Those services are annual wellness visits, psychoanalysis, psychotherapy and prolonged E/M services. All of those were added effective Jan. 1. If you perform those types of services and are interested in billing those in your telehealth setting, that is acceptable now and you can do that."

**3. Medically Unlikely Edit Changes.** CMS intends to continue adding new medically unlikely edits (MUEs) this year, so Kennedy wanted to remind providers of a few important points.

"Please remember that an MUE denial is a coding denial, and not a medical necessity denial," Kennedy told practices. "So submitting an advance beneficiary notice (ABN) would not shift liability to the beneficiary," he said.

"CMS also wanted to remind providers that for Medicare, proper reporting of a bilateral surgery is to bill the surgery code on a single claim line with modifier 50 (Bilateral procedure) and one unit of service," Kennedy added. This applies to Part B practices but not ASCs, he said. "ASC providers cannot report modifier 50□it's not acceptable in an ASC setting for the facility fee."

**Remember:** If your claim is denied due to an MUE edit where the units exceed the MUE value, the payer "will deny the entire claim line, it will not split them up and pay some and not others□it will deny everything on that line," Kennedy said.

**4. Hepatitis C Coverage Expands.** Although CMS implemented its Hepatitis C coverage on Jan. 1, the agency actually made this effective for dates of service starting June 2, 2014. "Hepatitis C screening is reported with G0472 (Hepatitis C antibody screening for individual at high risk and other covered indication[s]) and CMS will cover the screening with the appropriate FDA approved lab tests and point of care tests when it's ordered by the beneficiary's primary care physician or practitioner within the context of a primary care setting and performed by an eligible Medicare provider for these service," Kennedy said.

Patients must meet one of two criteria. The first is that the patient is at high risk for hepatitis C; Medicare describes "high risk" as anyone with "a current or past history of illicit injection drug use" as well as those who received a blood transfusion prior to 1992. Repeat annual screenings are available for patients who continue to use illicit drugs following a negative screening result

The second criteria is that anyone born between 1945 and 1965 can get one screening test even if they aren't defined as "high risk." Patients who fall into this category are eligible to get just one hepatitis C test in their lifetime.

**5. Intensive Behavioral Therapy for Obesity Is Payable.** "Effective Jan. 1, 2015 dates of service and after, CMS will cover intensive behavioral therapy for obesity for practitioners furnishing this in a group setting," Kennedy said. Providers should report the group code for each beneficiary participating in the group. "G0473 can be billed for a maximum of ten beneficiaries in the group," Kennedy said. "Deductible and coinsurance do not apply."