

Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: 3 Ways To Ease Coding Woes With The Fee Schedule Database

Proper modifier use, RVU information and more is just a download away

If you are looking for a one-stop resource for many common coding queries, Medicare's [Physician fee schedule](#) database provides a wealth of coding information in an easy-to-use format. Here are three reasons you'll want to refer to this tool.

Number 1: Track RVUs

You can determine approximate Medicare reimbursement for any procedure by referring to the physician [fee schedule](#) database (go to: www.cms.hhs.gov/physicians/pfs/default.asp). The database provides a thorough breakdown of relative values for both facility and non-facility settings. Surgery practices will be interested in one of two figures:

1. In-office: For services the surgeon provides in his own office, look to the "Fully Implemented Non-Facility Total" column. This number describes the relative value units (RVU) allotted for all aspects of a particular procedure (physician work, malpractice expense, equipment costs, etc.). Multiply the RVU total in this column by the national conversion factor (37.8975), for an approximate reimbursement value, says **Anita L. Carter, LPN, CPC**, an instructor at **A+ Medical Management and Education**, a school for billing and coding in Absecon, NJ.

Example: The surgeon performs diagnostic colonoscopy (45378, Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen[s] by brushing or washing, with or without colon decompression [separate procedure]) in the office. To determine payment, multiply 10.13 RVUs, found in the "Fully Implemented Non-Facility Total" column, by 37.895. The result - \$384 - represents a national average payment. Actual reimbursement varies according to geographic location and cost-of-living adjustments.

2. In the hospital: For services the surgeon provides in a facility setting, add together totals from "work RVU" and "MP [malpractice] RVU" columns and multiply this total by 37.8975 to determine reimbursement. In this case, the surgeon will gain payment only for his effort and "expense," while the facility will earn separate reimbursement for equipment costs, etc.

Example: The surgeon performs colostomy revision (44340, Revision of colostomy; simple [release of superficial scar] [separate procedure]) in the hospital operating room. Add together the "work RVU" and "MP RVU" columns to arrive at an RVU total of 8.69 (7.71 + 0.98). Multiply the RVU total by the national conversion rate for an approximate payment of \$329 (8.69 x 37.8975). The hospital will receive additional payment for use of its facility, staff, etc.

How it helps you: Knowing relative values allows you to monitor carrier payments for accuracy, Carter says. "[The database] is a great resource for coders, billers and students to determine the approximate Medicare reimbursement for any procedure," she says. For instance, payers will sometimes mistakenly make multiple-procedure fee reductions for add-on procedures. If you suspect your payer has done this, you can use the fee schedule to check.

Example: The surgeon performs complex wound repair on a 12-cm laceration of the scalp (13121, Repair, complex, scalp, arms and/or legs; 2.6 cm to 7.5 cm and +13122, ...each additional 5 cm or less [list separately in addition to code for primary procedure]) in a facility. The payer reimburses \$205 to the surgeon. To check this amount, add work and malpractice RVUs for 13121 and 13122 for a total of 6.35 RVUs ($4.32 + 0.29 + [1.59 + 0.15] = 6.35$) and multiply the total by the conversion factor for an estimated payment of \$240.

In this case, because the estimated payment is substantially higher than the actual payment, you can likely assume that the payer mistakenly applied a multiple-procedure reduction to the already discounted add-on procedure 13122. With this knowledge in hand, you can ask the payer for a correction.

Number 2: Find Global Periods

You can locate the global period information in the column labeled "Global Days." Major surgical procedures (including common general surgery procedures such as hernia repairs, burn treatment, mastectomies, etc.) include a 90-day global period.

Lesser surgical procedures may include a global period of 10 days (for example, 19101, Biopsy of breast; open, incisional) or zero days (for example, 19100, Biopsy of breast; percutaneous, needle core, not using imaging guidance [separate procedure]), says **Barbara J. Cobuzzi, CPC, CPC-H, CHBME**, president of **CRN Healthcare Solutions** in Shrewsbury, NJ.

An XXX designation means that the global period concept does not apply. An example of this is 15850 (Removal of sutures under anesthesia [other than local], same surgeon).

The YYY global period applies only to unlisted procedure codes (such as 37799, Unlisted procedure, vascular surgery) and indicates that the payer is free to determine a global period for the procedure.

The ZZZ designation denotes an add-on procedure for which the global period is included in the primary procedure. For instance, CMS bundles the global period for add-on procedure +15101 (Split graft, trunk, arms, legs; each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof [list separately in addition to code for primary procedure]) to the 90-day global period of the primary procedure 15100 (... first 100 sq cm or less, or one percent of body area of infants and children [except 15050]).

How it helps you: Global period information is crucial for proper modifier application. For instance, if you provide an E/M service on the same day as another procedure with an XXX, zero- or 10-day global period, you must append modifier 25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) to the E/M service code.

However, if you provide an E/M service that leads to the decision to perform surgery on the same day as a procedure with a 90-day global period, you must instead append modifier 57 (Decision for surgery) to the E/M service code, says **Susan Callaway, CPC, CCS-P**, an independent coding specialist and educator in North Augusta, SC.

Example: The surgeon evaluates a patient for acute right-upper quadrant pain and tenderness. After a full evaluation, the surgeon decides to remove the gallbladder and schedules an immediate laparoscopic cholecystectomy (47562, Laparoscopy, surgical; cholecystectomy).

In this case, the surgeon may claim both the surgical procedure (47562) and the examination that led to the decision to perform the surgery (for example, 99243, Office consultation for a new or established patient ...). To determine whether you should apply modifier 25 or 57 to the E/M code, you must check the global period for the lap chole.

The "Global Days" column of the Physician Fee Schedule shows that 47562 has a 90-day global period. Therefore, you should append modifier 57, rather than 25, to the E/M service code.

Number 3: Better Bilateral Billing

You can easily determine whether you may report a given code with modifier 50 (Bilateral procedure) to describe a bilateral procedure by checking the "Bilat Surg" column of the fee schedule database.

If you find a "1" in the Bilat Surg column, you may report that code with modifier 50 to denote a bilateral surgery. But if the Bilat Surg column contains a "0," you shouldn't use modifier 50 with that particular code.

For example, colonoscopies and cholecystectomies will never be performed bilaterally because the patient has only one colon and one gallbladder, says M. **Trayser Dunaway, MD**, a general surgeon in Camden, S.C.

If the Bilat Surg column contains a "2," the code descriptor includes bilateral procedures and you should not append any modifiers. A "9" indicates that the concept of bilateral procedure does not apply. How it helps you: Because modifier 50 can increase reimbursement to 150 percent, you'll want to know when it's appropriate to apply the modifier, says **Heather Corcoran**, coding manager at **CGH Billing Services** in Louisville, Ky.

Example 1: The surgeon performs repair of initial inguinal hernia (49495, Repair, initial inguinal hernia, full-term infant under age 6 months, or preterm infant over 50 weeks postconception age and under age 6 months at the time of surgery, with or without hydrocelectomy; reducible) on both the left and right sides for a 5-month-old infant. The Bilat Surg column of the fee schedule database shows a "1" indicator, meaning you may apply modifier 50 in this case.

Example 2: The surgeon performs lymphadenectomy on both sides of the pelvis using a scope (38571, Laparoscopy, surgical; with bilateral total pelvic lymphadenectomy). If you check the fee schedule database for this case, you will notice that code 38571 contains a "2" indicator in the Bilat Surg column. This means that the code already describes a bilateral procedure, and you may not append modifier 50 to receive additional compensation.

Important: CMS is updating the Medicare physician fee schedule this fall - and the biggest change affects the bilateral status of dozens of codes. For more information, see "Medicare Cuts Payment for Arterial Procedures" earlier in this issue.