Part B Insider (Multispecialty) Coding Alert

Part B Mythbuster: Are You Making This Medical Decision-Making Mistake?

This MAC clears up 6 pressing issues.

If you're under the impression that only comorbidity counts as a risk factor when tallying your medical decision-making (MDM) level, you could be selling your practice short. That's the word from a March 31 "Part B Ask the Contractor Teleconference" hosted by the Part B MAC National Government Services, where reps answered questions about everything from E/M coding to balance billing. Read on for insights from the call that can help you tighten up your claims.

Risk Factors Include Array of Options

A Part B practice asked the NGS experts what the MAC considers "risk factors" under "risk management" in the MDM. "Is it comorbidity? Or complications associated with the surgery?" the practice asked.

"There are a wide variety of risk factors that we consider" NGS reps replied. "I won't be able to capture all of them here, but they certainly include comorbidities, patient age, complications associated with that surgery, prior problems the patient had with anesthesia, patient weight, other complications the beneficiary may have experienced with prior surgeries, and others we aren't capturing, but it certainly goes beyond comorbidity when we're thinking about risk management in terms of surgery."

"The answer is sort of 'all of the above,' added NGS Medical Director **Laurence Clark, MD,** "because if you think about it clinically, you're fitting an individual's own unique risk factors into the expected cardiovascular, endocrine, physiologic demands of the surgical procedure itself."

Where Is National X{EPSU} Guidance?

Some Part B MACs have offered a few examples to explain how to properly use the new X{EPSU} modifiers, but CMS itself is still tight-lipped on the subject, which has frustrated many practices looking for guidance.

"CMS is working on additional guidance regarding those modifiers, as well as examples, and more definitive specifications on when to use those modifiers," said NGS's **Andrea Freibauer** during the call. "So at this point in time you can use those X modifiers. However, you can still feel free to use the 59 modifier (Distinct procedural service) as appropriate. And as soon as CMS publishes additional clarification and information, we will be getting it out to you in the provider community."

Currently, all of the X modifiers "have the same exact editing specifications as the 59," Freibauer said. "If you aren't comfortable using the X modifiers yet, it is absolutely fine to use the 59."

Keep Working toward ICD-10

Although some practices continue to keep their fingers crossed hoping for an ICD-10 delay rather than preparing proactively, you shouldn't bet the farm on a delay. "Many of you have been hearing rumors about ICD-10, but nothing has come across that this is going to be delayed again," said NGS's **Jim Bavoso** during the call. "So we need to make sure everybody is aware that ICD-10 will be going into effect Oct. 1, 2015, which is right around the corner. Yes, it was delayed once, I don't think it will be delayed again."

Testing: CMS and the contractors "have been in the process of allowing providers, billing services and so on to test their capabilities with the contractors," Bavoso said. If you would like to participate in ICD-10 testing, contact your local MAC

and ask how to apply.

Can 'Pain Level' Be Used Twice?

Another caller to the forum asked whether the pain level documented in the exam could also be used under "constitutional" in the review of systems (ROS).

"Yes, if you have a pain level that the patient states during the ROS, you can use that as the pain level documented in the exam," the NGS rep said. "The medical directors concurred that this would be admissible." You should also include some general constitutional language such as the temperature, etc., she added.

Medicare Requires E/M Face-to-Face

Another participant in the call asked whether a pediatric practice can report a code from the 99211-99215 office visit series for visits between the pediatrician and the parent without the child being present if 100 percent of the visit was on counseling. Although many private payers allow this based on CPT's language that the visits in this category can involve time "with the patient and/or family," Medicare does not.

"All E/M services being billed to Medicare require that the patient be present even during times for counseling," the NGS rep replied. "I have to admit we don't often see pediatric billing and it's a little bit unusual for a patient to be billing the Medicare system, but again, despite the fact that it's counseling and these are circumstances we don't normally see, the rules are the same□the patient has to be present for a face-to-face E/M to be billed to Medicare."

Medicare Won't Pay Statutorily Excluded Services

One caller asked about a patient who has both Medicare and Medicaid. She wanted to know what happens if a patient gets refraction and an E/M, and the refraction is denied. "If Medicare puts the exam toward the patient's deductible, we are not allowed to bill a refraction because it's inclusive and Medicaid [may] pick it up. However, because Medicare covered part of that exam, can we bill the refraction separately? It's a little confusing," she said.

Refraction "is actually considered a statutorily excluded code, so Medicare will never pay it" Bavoso said. "If you bill for it separately you'll get a denial. No monies will apply to the deductible. At that point, you'd be able to submit it to the Medicaid program and they'll take it from that point on whether it's covered or not."

However, don't try to balance bill a qualified Medicare beneficiary (QMB) who is on both Medicare and Medicaid, Bavoso said. "According to the CMS publication 'Dual Eligible Beneficiaries on the Medicare and Medicaid Programs,' (ICN 006977), published in Nov. 2014, it tells you that the doctor cannot balance bill a patient when they're dual eligible," he said.

In black and white: "You are subject to sanctions if you bill a QMB for amounts above the Medicare and Medicaid payments (even when Medicaid pays nothing)," the document says.

Nail Down Billing Provider or Risk PQRS

Another caller to the forum asked about a situation where a physician-owned group employs a physical therapist (PT). "Is it okay to bill the physical therapy under the supervising or referring provider's ID, or does it have to be billed under the PT?" she asked, adding that her practice is trying to collect for PQRS measures related to physical therapy.

If the PT is enrolled in the Medicare program, bill with the PT's provider number, Bavoso said. "This way, you can then utilize the codes for the PT billing the codes for PQRS purposes." If it looks like the physician performed the service, you could potentially have problems with PQRS down the road if you want to bill one of the PT measures and you aren't using the group reporting option (GPRO), he explained.