Part B Insider (Multispecialty) Coding Alert

Part B Revenue Booster: Avoid These Common Errors to Increase Pay in 2013's Hardest-Hit Specialties

Prepare now to avoid losing money on your oncology, ophthalmology, cardiology services.

If the 2013 Medicare Physician Fee Schedule is finalized, cardiology, ophthalmology, and radiation oncology practices are targeted to take significant cuts to their Part B payments. But if your physician fits into one of these specialties, you can take action now to ensure that you aren't making any of the common mistakes that befall coders, and you can maximize your income to hopefully offset the upcoming cuts.

Background: The full extent of the proposed changes to the 2013 Fee Schedule mean that radiation oncologists could see a startling 14 percent cut to their total Medicare reimbursement in 2013. In addition, cardiologists and ophthalmologists could face multiple procedure payment reductions for their imaging services, which could mean a 25 percent reduction off the technical components of these procedures.

All of this adds up to massive potential losses for these specialists if the Fee Schedule is finalized later this year. Although you can't change CMS's plans, you can ensure that you aren't writing off potential income in other areas. Check out these three common mistakes to make sure you are collecting all you deserve.

Mistake 1: Ophthalmologists Writing Off Eye Exam When Patient Refuses Dilation.

Most Medicare carriers assume that a dilated fundus exam will be a part of any comprehensive eye exam you perform and bill with 92004 (Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient, one or more visits) or 92014 (Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; comprehensive, established patient, one or more visits).

Without dilation, you cannot perform the fundus exam -- and without the fundus exam, you don't have a comprehensive service. The issue is confusing because CPT® states that a comprehensive ophthalmological service \"often includes\" examination with dilation, therefore dilation is not necessarily required to bill 92004 or 92014. However, some payers and state specific guidelines may have their own dilation requirements. For example, Trailblazer says the 92004/92014 exams should be done under dilation unless \"medically contraindicated.\" Check with your carrier if you receive a denial you think is unfounded.

Important: Note the phrase \"one or more visits\" in the code descriptions. The dilated part of the exam does not have to be performed on the same day as the rest of the exam. If the patient comes back to complete the exam another day, you can report 92004 or 92014 once, with either date as the date of service.

Example: An ophthalmologist is following up with a patient every 12 months for cataracts. During the first visit, the patient has no time for the dilated exam. He returns to the clinic two weeks later for dilation. He has no other medical conditions. Bill one unit of 92014, and list the date of the first visit as the date of service. However, do not submit the bill to the payer until after the dilation appointment is complete. You want to ensure that the patient actually returns for the dilation before you bill the payer.

Mistake 2: Cardiologists Listing the Wrong Primary Codes for Biventricular Upgrade Cases

When CPT® introduced new codes for pacemaker revisions, many coders were confused about which add-on codes went with which primary codes, causing slowed claims and reimbursement. However, finding the proper code combination is much simpler now that the AMA recently published an official correction to the primary codes you may report with

+33225 (Insertion of pacing electrode, cardiac venous system, for left ventricular pacing, at time of insertion of pacing cardioverter-defibrillator or pacemaker pulse generator [including upgrade to dual chamber system and pocket revision] [List separately in addition to code for primary procedure]).

The corrections document for AMA's CPT® 2012 manual revises the parenthetical instruction following +33225. The revision adds four codes to the list of possible primary codes for +33225:

- 33228, Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; dual lead system
- 33229, ... multiple lead system
- 33263, Removal of pacing cardioverter-defibrillator pulse generator with replacement of pacing cardioverter-defibrillator pulse generator; dual lead system
- 33264, ... multiple lead system.

The addition of these to the list of primary codes resolves an issue many coders have confronted since the codes became effective in January.

Affected cases are upgrades from a single- or dual-lead pacemaker or implantable cardioverter-defibrillator system to a biventricular (BiV) system. Specifically, the cases involve the physician placing the left ventricle lead (+33225), changing the pulse generator, and connecting previously placed lead(s) to the new battery.

For example, suppose the physician removes an existing single pacer generator, inserts a BiV pacer generator, connects the existing right ventricle (RV) lead, and implants and connects a new left ventricle (LV) lead. The 2012 coding guidelines originally published didn't offer clear guidance on how to code this scenario.

The problem: The logical assumption is that you should report +33225 with the applicable generator change code when a case involves LV lead placement (+33225) and generator change (such as 33228, 33229, 33263, or 33264). But CPT® did not list the new generator change codes as acceptable primary codes for +33225.

Result: When practices attempted to report the generator change codes along with +33225, they received denials. Now, with the publication of the errata, you know that you may report the pulse generator removal and replacement as a primary code and also report +33225 for the placement of the new LV lead. Experts advise choosing the pulse generator replacement code based on the device the patient leaves the encounter with. So if the patient goes from a double-lead system to a multiple-lead system, the recommended pulse generator code would be for a multiple-lead system (33229 or 33264).

Resource: The correction document is available online at www.ama-assn.org/resources/doc/cpt/cpt-corrections.pdf. Note that it makes one other change to the parenthetical note with +33225, deleting 33222 (Revision or relocation of skin pocket for pacemaker) from the list of primary codes.

Mistake 3: Oncologists Improperly Billing J0881 and J0885

Codes J0881 and J0885 rank among the most frequently-billed codes by oncologists, but these J-codes for erythropoiesis stimulating agents (ESAs) carry a heavy load of very specific reporting requirements and volatile reimbursement rates. To be sure your claims for these frequently reported codes are as clean and accurate as possible, apply the tips below for the following codes:

- J0881, Injection, darbepoetin alfa, 1 mcg (non-ESRD use)
- J0885, Injection, epoetin alfa (for non-ESRD use), 1000 units. Code J0881 is appropriate to report the supply of Aranesp.

Both codes indicate they are specific to \"non-ESRD use.\" ESRD is short for end stage renal disease. Consequently, these codes are appropriate when the injection is connected to oncologic use.

Read through the ESA NCD, and you'll find a list of specific conditions that indicate ESA treatment is reasonable and necessary for anemia caused by myelosuppressive anticancer chemotherapy in:

- Solid tumors
- Multiple myeloma
- Lymphoma
- Lymphocytic leukemia.

The NCD also describes recommended dosages for beginning treatment, as well as conditions for coverage to continue treatment based upon how the patient's numbers change over time (as this change indicates the efficacy of the treatment course). Additionally, the NCD states, \"ESA treatment duration for each course of chemotherapy includes the 8 weeks following the final dose of myelosuppressive chemotherapy in a chemotherapy regimen.\"

Because of the above conditions, when you report J0881and J0885, Medicare requires you to report \"the most recent hematocrit [HCT] or hemoglobin [HGB] reading available when the billed ESA dose was administered,\" according to MLN Matters MM5699.

You should report the test results in item 19 if you use the CMS-1500 paper claim form, MM5699 indicates. If you use electronic claims (837P), follow this direction from MM5699: \"Report the hemoglobin or hematocrit readings in Loop 2400 MEA segment. The specifics are MEA01=TR (for test results), MEA02=R1 (for hemoglobin) or R2 (for hematocrit), and MEA03=the test results. The test results should be entered as follows: TR= test results, R1=hemoglobin or R2=hematocrit (a 2-byte alpha-numeric element), and the most recent numeric test result (a 3-byte numeric element [xx.x]). Results exceeding 3-byte numeric elements (10.50) are reported as 10.5.\"

Example: \"If the most recent hemoglobin test results are 10.50, providers should enter: TR/R1/10.5, or, if the most recent hematocrit results are 32.3, providers would enter:TR/R2/32.3,\" MM5699 explains.

Important: Another key to proper J0881 and J0885 payment is understanding the following modifiers:

- EA, Erythropoetic stimulating agent (ESA) administered to treat anemia due to anticancer chemotherapy
- EB, Erythropoetic stimulating agent (ESA) administered to treat anemia due to anticancer radiotherapy
- EC, Erythropoetic stimulating agent (ESA) administered to treat anemia not due to anticancer radiotherapy or anticancer chemotherapy.

Requirement: All of your non-ESRD ESA claims must include one of the above modifiers on the same line as your ESA HCPCS code.