Part B Insider (Multispecialty) Coding Alert

REIMBURSEMENT: Make Sure Your Doctor Signs Off On Nurse's Portion Of Visit

Don't miss out on reimbursement for post-bariatric excess skin removal

Heads up: If you-re letting your medical assistant (MA) or registered nurse (RN) document your patients- history of present illness (HPI) for your doctors, you could be heading for an audit nightmare.

Affiliated providers, such as RNs, licensed practical nurses or MAs, can only document the patient's review of systems (ROS) and past family and social history (PFSH) in advance of the evaluation & management (E/M) visit, according to a new FAQ re-sponse from **Palmetto GBA.**

In the past, many coders believed that it was okay for other providers to dictate the patient's HPI, as long as the doctor reviewed it and signed off on it. But Palmetto says it -recently received clarification- from the **Centers for Medicare & Medicaid Services**, stating that the only portions of the history that ancillary staff can dictate are the ROS and PFSH.

-Only the physician or non-physician practitioner who is conducting the E/M visit can perform- the HPI, Palmetto adds. -This is physician work and not relegated to ancillary staff.- The same goes for physical exam and medical decision-making. The ancillary staff can write down the HPI if the physician dictates and performs it, Palmetto adds.

This is an important clarification, says **Linda Martien**, coding consultant with **National Healthcare Review** in Woodland Hills, CA. If your physician is allowing ancillary staff to dictate the HPI, you should put a stop to this practice.

Important: Also, if ancillary staff are performing the ROS and PFSH portions of the E/M visit, then you need to make sure the doctor states in the dictation that he/she reviewed and agrees with that portion of the documentation.

Take Pictures Of Skin Flap

Some other information from recent carrier FAQs:

- **Medicare will cover lipectomy** (removal of excess skin) after bariatric surgery, according to **Cigna Medicare**. Medicare won't pay for cosmetic surgery, but some patients do develop -skin breakdown under excess skin.- If your doctor documents that this excess skin hasn't -responded to conservative measures and is significant enough to merit surgery,- then Medicare may pay for reconstructive surgery, Cigna says.

Documentation: You should make sure the record includes the fact that the patient has tried to comply with the guidelines and life-changing requirements after bariatric surgery, says **Mary Lou Walen**, coding expert with the **American Society for Bariatric Surgery**. A skin flap can weigh up to 75 pounds and make it hard for the patient to exercise, as well as breaking apart and bleeding, she notes

Your doctor should document in progress notes that the patient is having problems due to the pannus (excess skin) and take photos, Walen says. Besides exercise and diet, conservative measures include antibiotic ointment or bath salts, she adds.

- **Optometrists can bill subsequent nursing facility codes** 99307-99310 if they can document two out of three key elements of the visit, Cigna notes. But this is unlikely due to the optometrists- scope of practice.

- **Medicare won't pay for post-operative pain management** except in -rare- cases where the patient needs the

specialized expertise of a pain-management specialist, Cigna says. You would need to document that the pain-management specialist didn't just duplicate the normal post-operative pain management by the operating surgeon.

- **Medicare will cover transtelephonic monitoring** of a cardiac pacemaker, if the services include a minimum of 30-second readable strips of the pacemaker in both free-running mode and magnetic mode (unless magnetic mode is contraindicated.) You also need a minimum 30 seconds of readable ECG strip. This service must be medically necessary, Palmetto cautions.

- A **break between two 60-day locum-tenens arrangements** could be as short as one day, Palmetto notes. For example, if your doctor leaves for a couple of months, returns for a day or two, then leaves again, you could bill for another locum tenens.

- **You should use the ICD-9 code for the test result,** not the reason the physician ordered the test, when billing for test interpretation, **NHIC Medicare** says. -The one exception is a test or x-ray done for screening purposes and the result is pathology,- NHIC says. -In this situation the primary diagnosis should be the screening V code and the procedure code should be billed with the GY modifier.-