Part B Insider (Multispecialty) Coding Alert

Starred Procedures: Will RVUs Go up for Formerly Starred Procedures?

Consultant predicts new onslaught of audits, scrutiny for modifier -25

Doing away with the starred designation may eliminate some confusion, but it could also eliminate some reimbursement.

Unless the relative value units (RVUs) for these procedures go up to compensate for the new global period, providers will end up losing money, says **Robert Burleigh** with Brandywine Consulting in Malvern, Pa. "You've lost on one end and not gained on the other."

In the past, you may have billed for a procedure that reimbursed $45 and an evaluation and management visit that paid $40. Now, unless you can justify that separate E/M visit , you may be stuck billing only for the $45 procedure. Even if the reimbursement for that procedure rises to $55 to compensate, you'll still be out $30.

"As a practical matter, the practices will be resentful of the newest assault on their income," Burleigh says.

The idea behind the starred procedure designation was that there's no "typical" situation with minor surgeries as with major surgeries, says **Susan Callaway**, an independent coding auditor and trainer in North Augusta, S.C. "Each case might have a different amount of pre- and post-op work depending on the needs of the patient," she says.

But coders often stopped reading there and didn't realize you couldn't automatically bill an E/M visit before and after every single minor surgery. The CPT book went on to explain that you had to decide whether there was a significant E/M provided before billing.

You were never supposed to bill separately for E/M that was inherently necessary to determine whether the patient could undergo the procedure, and any prep work, Callaway says. But if the patient needed an evaluation of signs and symptoms to figure out "whether the procedure was necessary, or if the E/M was for a different problem altogether, you could bill an E/M," she adds.

Callaway gives the example of a patient who falls and cuts his hand. The doctor will have to determine the nature of the injury and whether there are other complaints, examine the wound for foreign bodies, assess the patient's tetanus status and then repair the laceration. You wouldn't bill for an E/M because all of these steps are part of the laceration repair.

Also, if the patient was new and the E/M service wasn't separately billable, you could bill 99025 (Initial [new patient] visit when starred surgical procedure constitutes major service at that visit) to cover the cost of setting up a new patient.

"From a provider standpoint, there is a possibility that it will in some ways simplify the process," Burleigh concedes. But even though the change is intended to make life easier for physicians and coders, you can't expect the carriers and other payers to follow in that spirit.

"Payers will use it as a way to ratchet back on how they pay for services," Burleigh says. They'll see it as a "free pass" to stop paying for E/M services. "This is going to become a high-profile OIG Work Plan initiative to do audits on anything billed with the -25 modifier."

Meanwhile, coders will have a learning curve over the next year or so figuring out how, and whether, to bill for E/M visits after minor surgeries, Burleigh says. This will especially be true for practices that thought the separate E/M was a "gimme" and always billed for it separately.

In some cases, these reimbursement pressures may drive physicians to stop providing certain procedures. Of course in emergency medicine, where docs don't have a say as to whether they treat some patients, they may just have to take a loss, Burleigh says.