



Linking Your Work and Revenue

Toledo Academy of Medicine endorses Superior Resources

We are pleased and honored to announce that the Toledo Academy of Medicine has approved Superior Resources as an endorsed business for the next two years.

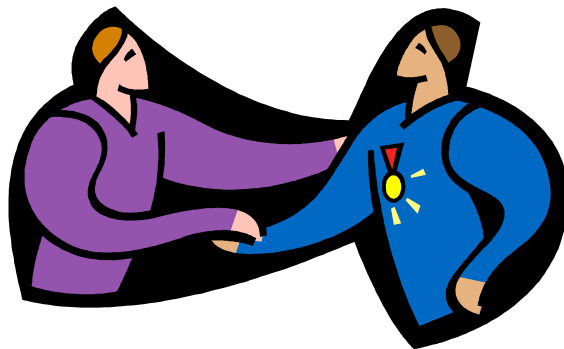
Of course, The Academy is not responsible for our work and they asked us to remind

physicians that we are legally obligated to report fraud.

Superior Resources will continue to provide The Academy of Medicine with a monthly Coding Confidential column for the *Communique*. In addition, all members of The Academy will receive a

0.5% discount on our standard rates.

As the county medical association, many physicians look to The Academy of Medicine for services and advise. We appreciate their acknowledgement of the quality of our services, and we are very proud to be accepted.



From Our President

So much is happening in the world of medical billing right now. As of the time of this writing, the 21.5% Medicare rate reduction went into effect and Medicare is holding all claims until 3/14/10 in hopes Congress acts to remove the reduction perma-

nently or to pass some kind of Health Care Reform. Hopefully by the time you are reading this, that has changed. Superior Resources is working diligently to keep our practices up-to-date with all the changes.

I will be presenting Linking

Work And Revenue: Global Surgery on March 10 at 5:30 pm at the AAPC Chapter meeting. For more information on this meeting or to schedule a presentation, please call Superior Resources. I hope to see you there.

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Special points of interest:

- Some BCBS Plans are reducing payment of E&M services billed with modifier 25 to 50%
- Initial Hospital visits must include a detailed history or exam. If that is not documented, bill a subsequent hospital visit.
- Paramount has changed the Prestige fee schedule to equal the Elite fee schedule

Coding Confidential

Welcome to Coding Confidential, where we answer your questions on how to code and bill to ensure you get fair payment for the services you've rendered.

Q: What constitutes a complex, as opposed to simple, medical decision making component?

A: MDM is rated as Straightforward, Low, Moderate, or High, not "simple" and "complex". MDM is determined by 3 components: Diagnosis/Management Options, Data, and Risk. Two of the three components must meet or exceed the visit level.

Diagnosis and Management Options allow 1 point for each self-limited or minor diagnosis treated and each stable, established diagnosis that is treated or directly affects the treatment, 2 points for each established diagnosis which is worsening, 3 points for each diagnosis determined that visit that does not require additional work up, and 4 points for each diagnosis determined that visit that does require additional workup. So if the patient has a cold, it would be 1 point (self limited diagnosis). A patient with diabetes who comes in for a blood sugar check and has their hypertensive meds refilled would be 2 points (2 established, stable diagnosis). A total of 1 point is Straightforward, 2 is Low, 3 is Moderate, and 4 or more is High

Type of Data is scored similarly. One point for reviewing or ordering labs,

Radiology, or medical testing. One point for discussing test results with the patient, 1 point for deciding to get old records, 2 points for independent review of images/tracings/specimen, and 2 points for reviewing and summarizing old records. Again, a total of 1 point is Straightforward, 2 is Low, 3 is Moderate, and 4 or more is High

Risk is determined by the table of risk, which is found on Medicare's website at http://www.cms.hhs.gov/MLNProducts/downloads/eval_mgmt_serv_guide.pdf on page 22. Prescription Drug Management is Moderate risk, for example,



while an acute, chronic illness or injury that poses a threat to life or bodily function (eg multiple trauma, acute MI) is High.

So, a patient who comes in with a cold and is told to rest and gargle would have 1 point for diagnosis management, 0 points for type of data, and Minimal Risk, so it would be Straightforward MDM.

A patient with diabetes who comes in for a blood sugar check and has their hypertensive meds refilled and is given orders to get their blood sugar rechecked in 3 weeks, would have 2 points for Diagnosis Management, 2 points for Data Type (reading the current Blood Sugar lab and ordering the new lab), and

Moderate risk (prescription drug management), so the MDM would be Low since 2 of the elements are low and only 1 is high.

For more information, I would recommend reviewing Medicare's Evaluation and Management Guide.

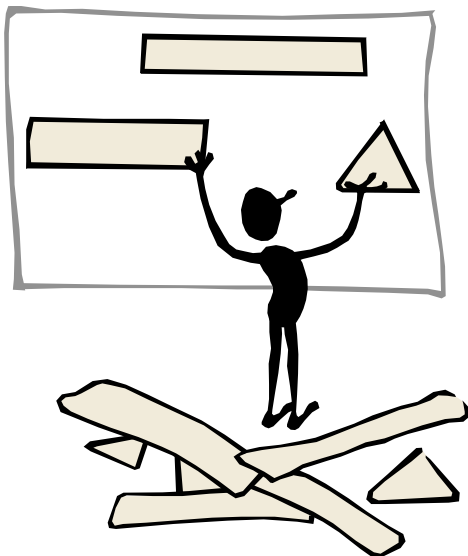
Coding Confidential is an information resource provided to clients of Superior Resources. Coding Confidential is written by Kathy Stull, CPC, CMRS. Ms. Stull is president of Superior Resources, Inc. and has over 23 years experience in coding and billing. She has been a Certified Professional Coder since 2004 and a Certified Medical Reimbursement Specialist since 2008. She obtained a specialty certificate in E&M coding from the American Academy of Professional Coders in 2006. Ms. Stull is a popular speaker on Coding, Billing and Compliance in the NW Ohio area. If you have a question for Coding Confidential, e-mail it to

KathyStull@superiorresources.info. We'll respond to you and, possibly, include your question here.

Plans are Changing

These are difficult economic times and to cope, many insurance carriers are making changes. Many of these changes will have an adverse effect on your receivables.

Medicare is now requiring all medical records, as well as the claim form and any letters, to be signed. Medical record signatures must include the date and time the record was signed. Electronic signatures are only accepted if they include "Signed by" or "reviewed by" before the signature. At this time, ProMedica's operative notes do not contain the correct wording, according to Medicare. Hand signatures must be legible enough for Medicare to read every letter in the signature.



BCBS, for plans sold by Horizon in NJ, will now allow office visits at 50% if the claim requires modifier 25. This means any OV done with an injection, an EKG, an immunization, or any other procedure in the CPT book, will incur a 50% reduction. We have talked to our local BCBS and there is nothing they can do about this. Right now, this effects only plans sold by Horizon BCBS of NJ, which includes several Toledo Area employers. BCBS will not allow providers to be par with BCBS or Anthem, but not Horizon. This is not a fair payment reduction and it is not Industry Standard payment. I have heard rumblings from

NJ about a potential class action suit; barring that or enough complaints to make Horizon to change its mind, there is nothing that can be done about this reduction.

Medicare has revised its instructions on Consultations again, and again, it means a reduction in payment to physicians. Previously, Medicare had advised inpatient consultations should now be billed as "Initial Visits" with

CPT codes 99221, 99222, and 99223. CPT 99221—Initial Hospital visit, Low requires the physician has taken, at least, a detailed history and exam. A detailed history must include 4 elements of HPI (location, quality, severity, duration, timing, context, modifying factors, and/or associated signs and symptoms), Review of 2-9 body systems,

and 2 elements of Personal, family and social history. A Detailed exam must include 2-7 body areas or systems with detail or 12 bulleted elements in at least 2 systems. If the physician does not document a Detailed History and Exam, you must bill a level 1 (problem-focused history and exam) or level 2 (expanded problem focused history and exam) subsequent hospital visit with CPTs 99231 or 99232. There is a new crosswalk on page 4 that shows the effect of this change.

Paramount has given physicians good

news in regards to the Paramount Prestige fee schedule. Paramount Prestige is a Medicare Supplement HMO policy, so it pays from the HMO fee schedule, which is lower than Medicare's fee schedule. For a level 3 office visit, Medicare would leave an \$11.92 coinsurance, but because Paramount Prestige's fee schedule was lower, the physician would have to write off, for example, an additional \$5.26 and could only bill the patient for \$6.66. Effective 2/15/23010, Paramount has made the Prestige fee schedule equal to the Elite fee schedule. Elite is Paramount's Medicare Advantage HMO.

Medicare Secondary Payor is not paying consultation codes. If another insurance is primary and Medicare is secondary, you can bill the primary carrier according to Medicare rules, or you can bill the primary carrier with the consult code. After the primary carrier has paid, change the code to the admit or subsequent visit code, but do not change the fee. Bill Medicare with the new code, but the payment information from the consult.

Anthem is not paying consultation codes for their Medicare Advantage plans, but will pay them for other plans.

Worker's Compensation is still paying consultation codes.

United Healthcare is still paying consultation codes. However, UHC also owes or administers plans for **AARP**, **SecureHorizons**, **Evercare**, and **AmeriChoice** all of which will follow Medicare and not pay consultation codes.

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▶ **The Link between your
Work and your Revenue**



Superior Resources, Inc offers expert medical coding and billing services and assistance. We specialize in specialists, so we understand the barriers you face. From full-service billing plans to auditing, consulting and credentialing, we tailor our services to fit your needs. For more information, visit us on the web at www.SuperiorResources.info or call 419 794 1006 or toll free at 866 731 0712.

Consultation Crosswalk

Consultation Codes billed in 2009	Medicare Code for 2010
99251—Inpatient consultation level 1	99231—Subsequent hospital visit level 1
99252—Inpatient consultation level 2	99232—Subsequent hospital visit level 2
99253—Inpatient consultation level 3	99221—Initial hospital visit level 1
99254—Inpatient consultation level 4	99222—Initial hospital visit level 2
99255—Inpatient consultation level 5	99223—Initial hospital visit level 3