

Strategies for Coding, Billing, and Getting Paid Appropriately



A Guide for Family Physicians

2007 SUPPLEMENT

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INTRODUCTION

Each January brings changes to every physician office – there are always new and deleted billing codes (CPT and HCPCS II), new deductible amounts to be collected from patients, new and revised billing requirements from health insurance plans, and sometimes new payment amounts from third party payers. It can be challenging for a medical office staff to be aware of all these changes and ready to adapt and implement them in your practice management procedures and the daily work flow of your office. Here's a review of the changes that will most affect family physicians in 2007 and what every practice should know about them.

2007 CPT CHANGES

CODING CHANGES

A total of 645 changes have been made in CPT for the year 2007. While 258 codes have been added, more codes (308) have been deleted and 79 codes have received some type of revision. Overall, there are 50 fewer CPT codes in 2007 than there were in 2006.

A revision of a code can be just as important to a practice as a new or deleted code. While some practices simply verify that all codes on the fee schedule are still current, it is extremely important to be aware of the revisions as well. This is the case with the lesion destruction codes (CPT 1700X and 1711X) this year, and we will review the re-evaluation and re-definition of these codes as these services are often provided by family physicians.

1. Evaluation and Management

A new subsection for *Anticoagulant Management* has been added to the Case Management Services subsection and two new CPT codes are in this new subsection. Codes 99363 and 99364 have been established to report physician management of patients receiving long-term anticoagulant therapy (e.g., Warfarin [Coumadin]) in the office, or outpatient setting including domiciliary, rest home or home settings in 90-day increments. These codes describe the outpatient management of warfarin therapy which includes ordering, review, and interpretation of International Normalized Ratio (INR) testing, communication with patient, and dosage adjustments as appropriate.

CPT Code	Description
99363	Anticoagulant management for an outpatient taking warfarin, physician review and interpretation of INR testing, patient instructions, dosage adjustment (as needed), and ordering of additional tests; initial 90 days of therapy (must include a minimum of 8 INR measurements).
99364	Each subsequent 90 days of therapy (must include a minimum of 3 INR measurements).

These codes are not to be reported if the patient is managed by neither an outpatient pharmacist nor a nurse anticoagulation clinic. To report the codes, the physician must manage the patient for at least 60 continuous days. Any period less than 60 continuous days is not reported. If less than the specified minimum number of services per period is performed, do not report the anticoagulant services. Additionally, these codes are not to be used for mechanical heart valve(s) receiving prothrombin time monitoring using a home device (G0250).

For 2007, Medicare will **not** recognize anticoagulant therapy management as a separately billable and payable service. These services will continue to be bundled with other E/M services. At the annual CPT Symposium sponsored by the AMA, two medical directors for Medicare Administrative Contractors (carriers) voiced their hope that Medicare would reconsider this policy during 2007 and consider separate payment in 2008. Family physicians should monitor the payment guidelines and policies of other payers to assess their payment policy.

2. Surgical Services:

The destruction of lesions codes have been revised to differentiate those codes used for premalignant lesions and those used for benign lesions.

The 1700x group of codes will be used **only** for treatment of premalignant lesions:

CPT Code	Description
17000	Destruction (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (e.g., actinic keratoses); first lesion
17003	Second through 14 lesions, each (list separately in addition to code for first lesion)
17004	15 or more lesions

For this set of codes, you should always expect to use the ICD-9 code 702.0x (actinic keratosis). There is some controversy in the academic world regarding actinic keratoses. Some believe they are pre-cancers, while others believe they are simply early cancers. All agree, however, that they are medically necessary to treat before they become invasive. As such, there is generally insurance coverage for these services.

The 1711x group of codes will be used **only** for treatment of benign lesions:

CPT Code	Description
17110	Destruction (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular lesions; up to 14 lesions
17111	15 or more lesions

Coverage decisions for 17110 and 17111 should be based on medical necessity. Some examples of diagnosis that might be used are below.

ICD-9	Description
216.x	Benign skin lesions
702.1x	Seborrheic keratosis
702.11	Inflamed seborrheic keratosis – can be painful, itchy, may bleed and can cause illness
078.0	Molluscum contagiosum – a public health problem
078.10	Warts – can be disabling and disruptive to ADLs
078.11	Genital Warts – can be a public health nightmare as they can be malignant precursors
706.2	Cyst – may be draining or inflamed

3. Medicine Services

Most notable of the changes to the Medicine section is the addition of subheadings to the Pulmonary procedures subsection to accommodate the addition of codes for ventilator management. These services are not provided in the physician's office, but are sometimes provided by the family physician in an acute care hospital, long-term acute care facility, or nursing home environment.

The new codes are:

Old Codes	New Codes
94656 Initial Vent	94002 Initial Vent
94657 Subsequent Vent	94003 Subsequent Vent
94004 Nursing Facility Vent per day	
94005 Home Vent per month	

The services included in these new codes are 1) reviewing the patient's chart, 2) seeing the patient, 3) writing notes, and 4) communicating with other health care professionals and the patient's family/care-giver. It is worth remembering that most payers do not pay for an evaluation and management service on the same day as ventilator management services.

4. Continuous Nebulizer Administration

Two new codes have been added to CPT in 2007 to describe continuous inhalation treatment with aerosol medication. The codes are time-based for the first hour and there is an add-on code for each additional hour. The codes are:

94644	Continuous inhalation treatment with aerosol medication for acute airway obstruction; first hour
94645	Each additional hour (list separately in addition to code for primary procedure)

5. Pulmonary Function Testing

Some family physicians have begun to use inhaled insulin with their patients. A question often arises about the appropriate diagnosis to use when performing the baseline Pulmonary Function Test (PFT) prior to initiation of therapy, and then for the monitoring PFTs during the course of therapy. Here are some suggestions:

Baseline PFT	V72.85, other specified examination; the underlying condition being treated would be listed as an additional diabetes diagnosis
Monitoring PFT	V58.83, encounter for therapeutic drug monitoring (with appropriate V58.6 code, long-term (current) drug use); again, the underlying condition being treated would be listed as an additional diagnosis

6. HCPCS Level II Changes

HCPCS code G0107, Colorectal Cancer Screening, Fecal-Occult Blood Tests (FOBT), 1-3 Simultaneous Determinations has been deleted. You can continue to provide this test for Medicare patients, but report it with CPT code 92270 beginning January 1, 2007.

As always, every family physician should check the list of HCPCS Level II codes in the J Code category to determine if all injectable medications being used in the practice are being appropriately reported.

7. Sodium Hyaluronate Injections

For family physicians who provide intra-articular injections, in particular, injecting a Sodium Hyaluronate medication (Supartz or Synvisc) into the joint, there is a coding change for this medication. Two 2006 HCPCS codes have been deleted: J7317 (Sodium Hyaluronate Injection) and J7320 (Hylan G-F 20 Injection). They have been replaced with J7319 – Sodium Hyaluronate Injection. You should update your coding database and fee schedules immediately with this new information.

Subsequent to the publication of the HCPCS Level II book, CMS developed new "Q" codes to differentiate between the dosing differences. These codes should be used in place of the newly developed "J" codes for this medication.

Q4083	Supartz or Hyalgan, injection, per dose
Q4084	Synvisc, injection, per dose
Q4085	Euflexxa, injection, per dose
Q4086	Orthovisc, injection, per dose

CHANGES IN THE MEDICARE PHYSICIAN FEE SCHEDULE

Section 1848 (C)2 of the Omnibus Budget Reconciliation Act of 1990 requires the Centers for Medicare and Medicaid Services (CMS) to comprehensively review all relative values in the Resource-Based Relative Value Scale (RBRVS) systems at least every five years and make needed adjustments. During 2005, the third five-year review was done and those changes will be implemented in 2007.

The revisions are perhaps the largest revisions ever for services related to patient evaluation and management (E/M). The changes involve increasing the work component of the relative value units (RVUs) assigned to certain services and changing the methodology for calculating the practice expense component.

The table below illustrates the results of the review for E/M services most frequently used by family physicians.

2007 Work RVU Changes

	Code	2006 Work RVU	2007 Work RVU	Change	% Increase in RVU
Office - New	99201	0.45	0.45	0.00	
	99202	0.88	0.88	0.00	
	99203	1.34	1.34	0.00	
	99204	2.00	2.30	0.30	15.00%
	99205	2.67	3.00	0.33	12.40%
Office - Established	99211	0.17	0.17	0.00	
	99212	0.45	0.45	0.00	
	99213	0.67	0.92	0.25	37.30%
	99214	1.10	1.42	0.32	29.10%
	99215	1.77	2.00	0.23	13.00%
Initial Hospital	99221	1.28	1.88	0.60	40.60%
	99222	2.14	2.56	0.42	19.60%
	99223	2.99	3.78	0.79	26.40%
Hospital - Subsequent	99231	0.64	0.76	0.12	18.80%
	99232	1.06	1.39	0.33	31.10%
	99233	1.51	2.00	0.49	32.50%
Hospital - Discharge	99238	1.28	1.28	0.00	
	99239	1.75	1.90	0.15	8.60%
Office - Consultation	99241	0.64	0.64	0.00	
	99242	1.29	1.34	0.05	3.90%
	99243	1.72	1.88	0.16	9.30%
	99244	2.58	3.02	0.44	17.10%
	99245	3.42	3.77	0.35	10.20%
Inpatient Consult	99251	0.66	1.00	0.34	51.50%
	99252	1.32	1.50	0.18	13.60%
	99253	1.82	2.27	0.45	24.70%
	99254	2.64	3.29	0.65	24.60%

These changes have resulted in increased payments for many E/M services. Office visits, consultations (outpatient and inpatient), hospital visits, critical care services, and emergency room care are among the services that should see an increase in payment at some levels.

Under the new payment rule, payment for CPT codes 99213 and 99214 – two codes that family physicians use most for Medicare patients – will increase. The table below illustrates the expected changes for new and established patient office visits.

Medicare Reimbursement California Area 99

CPT	2006 Allowance	2007 Allowance	Change
99201	\$37.56	\$36.46	-\$1.10
99202	\$66.50	\$63.47	-\$3.03
99203	\$98.73	\$93.77	-\$4.96
99204	\$139.52	\$142.19	+\$2.67
99205	\$177.09	\$178.24	+\$1.15
99211	\$22.33	\$20.78	-\$1.55
99212	\$39.56	\$37.65	-\$1.91
99213	\$53.94	\$60.86	+\$6.92
99214	\$84.47	\$92.16	+\$7.69
99215	\$122.45	\$124.40	+\$1.95

The Tax Relief and Health Care Act of 2006 set the 2007 (H.R. 6111) conversion factor for physician payment at the same level as in 2006 (\$37.8975), reversing the statutorily mandated five percent negative update. However, as the above table illustrates, it does not maintain 2007 physician payments at 2006 levels. There are a number of other factors that affect payment rates for 2007. Other changes adopted in the physician fee schedule final rule that affect 2007 payment rates include changes in the practice expense RVU-setting methodology, refinements to the practice expense RVUs, and re-weighting of geographic adjustment factors.

Additionally, the legislation included a provision to pay physicians an additional 1.5 percent if they participate in a quality-reporting program. There are very specific rules and timeframes for participation. Any interested provider should contact the CMS for additional details.

Further, CMS plans to implement a system for physicians to report quality measures for services performed from July 1, 2007 – December 31, 2007. The measures are set forth under the current CMS Physician Voluntary Reporting Program. Family physicians who wish to participate in this program should go to www.cms.hhs.gov/PVRP for a program description and more information.

Note: The quality reporting provisions of H.R. 6111 are somewhat ambiguous and not well-documented. Several professional medical organizations are seeking clarification on the intent for implementation of these upcoming provisions. Family physicians should watch their national and state academy newsletters and Web sites closely for new information as it is available.

H.R. 6111 has additionally established a Medicare physician reporting program for 2008 under which physicians would report quality measures that must be endorsed by a consensus organization, such as the National Quality Forum or the Ambulatory Quality Alliance. CMS must publish a set of quality measures to be used in 2008 for public comment by August 15, 2007 and finalize the set by November 15, 2007.

OTHER MEDICARE CHANGES

There are several other changes in Medicare policy/coverage to which all family physicians should pay close attention.

The annual deductible for Medicare patients is increased to \$131.00 beginning January 1, 2007. Your patients may not be aware of this change – be prepared to address their questions.

Beginning January 1, 2007, Medicare will expand its preventive services benefits, as provided for in the Deficit Reduction Act of 2005 (DRA). Medicare will pay for preventive ultrasound screening for abdominal aortic aneurysm (AAA) for at-risk beneficiaries as part of the “Welcome to Medicare” physical. AAA affects six to nine percent of men over 65 and is the tenth leading cause of death for men over 55. The screening will be available to:

- Men aged 65-75 who have smoked at least 100 cigarettes in their lifetimes;
- Individuals with a family history of AAAs; and,
- Any other individuals recommended for screening by the U.S. Preventive Services Task Force.

The Part B deductible is waived for this screening test. If the screening is provided in a physician office, the service is billed to the carrier using the HCPCS code G0389. If a family physician cannot determine whether or not the beneficiary has previously had an AAA screening or a question of medical necessity exists, the provider should ask the patient to sign an Advanced Beneficiary Notice (ABN) and bill the service to Medicare with the GA modifier (ABN on file).

The 2007 Final Rule exempts the colorectal cancer screening benefit from the Part B deductible, eliminating a potential financial barrier to using this benefit. Remember, since HCPCS code G0107 (FOBT, 1-3 determinations) has been terminated, you will now report this service with CPT 82270.

This Final Rule also codifies in regulation a DRA provision that adds diabetes outpatient self-management training and medical nutrition therapy services to the list of covered and separately payable services included in the Federally Qualified Health Center benefit, making these services more available to beneficiaries in underserved areas, whether rural or urban.

There is a new CMS 1500 claim form that may be used starting January 1, 2007. The changes are few but important – make sure you know how to complete it. For Medicare claims go to www.medicarenhic.com/providers/pubs/form1500guide_oct06.pdf.

The deadline for mandatory use of the National Provider Identifier is approaching (May 23, 2007) – if you haven't secured your number yet, now is the time to get it. Go to <https://nppes.cms.hhs.gov>. Group practices should decide how to determine their subparts. Remember, no health plan, not even Medicare, can instruct a provider on how to enumerate subparts. This is a business decision that the organization provider must make considering its unique business operations. To visit Medicare's Subparts Expectation Paper go to www.cms.hhs.gov/NationalProidentStand/Downloads/Medsubparts01252006.pdf.

SUMMARY

At first glance, there may not appear to be that many changes for 2007. Although subtle, the changes are poised to have an impact on any medical practice. It is important that each practice:

- Review coding changes and update/revise charge reporting system – i.e., superbill, charge ticket, etc.;
- Update fee schedule if needed;
- Monitor payers to ensure proper reimbursement is being allowed for each service;
- Review new CMS 1500 claim format and make any necessary changes to either electronic format or hard copy format; and,
- Be prepared to begin using the National Provider Identifier as of May 23, 2007, if not requested to do so before.

For a complete discussion of general coding issues, consult CAFP's publication, ***Strategies for Coding, Billing, and Getting Paid Appropriately***, available on CAFP's Web site at www.familydocs.org.

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