

Specialty Coding

Tuesday April 26th 2016; 0800-0900
Thursday April 28th 2016; 1400-1500

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- Specialty Coding Basics
- External Cause of Injury Codes: How to appropriately use ICD-10-CM V, W, X, and Y codes
- Anesthesia Coding and Billing
- Pain Management
- Billing for Obstetrics Professional Services under Bundled or Global Codes
- Orthopedics
- Physical Therapy
- Mental Health
- Resources
- Summary

Specialty Coding Basics



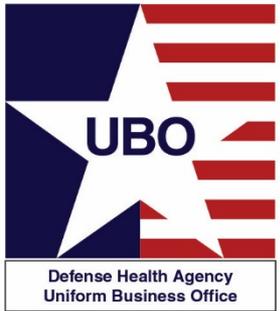


Specialty Coding Basics: What is Specialty Coding?

- According to the Centers for Medicare and Medicaid Services, specialty codes are self-designated codes that describe the kind of medicine physicians, non-physician practitioners, or other healthcare providers/suppliers practice.
- At the time of enrollment, Medicare assigns a two-digit specialty code that corresponds to the specialty type declared by the applicant on the enrollment form.
- Specialty codes help to immediately identify providers at the claim level
- While provider specialty codes serve as administrative identifiers, they are also used to facilitate the implementation of nationwide standards of code sets used in the HIPAA-compliant electronic health care transactions for the MHS.

Code	Code Physician Specialty
01	General Practice
02	General Surgery
03	Allergy/Immunology
04	Otolaryngology

SPECIALTY CODE	DESCRIPTION	PROVIDER TAXONOMY CODE	PROVIDER TAXONOMY DESCRIPTION: TYPE, CLASSIFICATION, SPECIALIZATION
01	Physician/General Practice	208D00000X	Allopathic & Osteopathic Physicians/General Practice
02	Physician/General Surgery	208600000X 2086H0002X 2086S0120X	Allopathic & Osteopathic Physicians/Surgery Allopathic & Osteopathic Physicians/Surgery/Hospice and Palliative Medicine Allopathic & Osteopathic Physicians/Surgery/Pediatric Surgery



External Cause of Injury Codes: V Codes, W Codes, X Codes, Y Codes, Oh My!



- External Cause codes provide vital health statistic information to national and state health agencies but there is no national requirement mandating ICD-10-CM external cause code reporting
- MHS uses External Cause codes to acquire data on external injuries in the MHS population (e.g., Y99.1, Military activity)
- ICD-9-CM External causes of injuries (E000-E999)
- In ICD-10-CM:
 - Chapter Injury, Poisoning, Other Consequences of External Causes (S19 -00-T88)
 - Chapter 20: External Causes of Morbidity (V00-Y99)



External Cause of Injury Codes: Why are they important?

- Help determine necessary infection and disease control prevention measures
- Help identify specific high incidence causes of injuries in a particular geographic region
- Used to effectively evaluate injury intervention programs
- Help identify populations that are at high risk for a particular injury

- Used with any codes from A00.0- T88.9, Z00-Z99
- Cannot be used as primary diagnosis
- Uses characters V, W, X, and Y
- Poisoning codes are combination codes in ICD-10-CM
- Additional external codes needed when poisoned by drug or chemical



- Injuries are a major cause of mortality, morbidity, and disability
- Care of patients who suffer intentional and unintentional injuries and poisonings contributes to the increase in medical care costs
- External causes of injury and poisoning codes are intended to provide data for injury research and evaluation of injury prevention strategies
- M2 Data Quality Standard Coding Error Report: C.10.a.1.c

C.10. Data Quality Coding Error Reports	Count	Percentage
<p>A series of Data Quality reports were developed to detect and report errors in coding that require correction. These reports must be run each data month for each parent DMIS ID to respond to the following questions:(Question 11 (a, b, c) of DQ Statement)</p>		
<p>a) CAPER Errors</p>		
<p>(1) Total <u>Invalid Outpatient Encounters</u> (for RNs or techs) Corrected / Total <u>Invalid Outpatient Encounters</u> (for RNs or techs) Detected (total a-d below)</p>	a(1) ___ / ___	a(1) _____ %
<p>(a) Total from Encounters with Invalid E&M Codes Report for RNs/techs (exclude TCONS)</p>	(a) _____	
<p>(b) Total from Encounters with Incorrectly coded Immunizations Report</p>	(b) _____	
<p>(c) Total from Encounters with Injury Related Codes with No Injury Related Flag Report</p>	(c) _____	

Anesthesia Coding and Billing



- Determine the appropriate CPT[®] code(s) for the surgical procedure(s) performed.
- Crosswalk the CPT[®] code(s) to the appropriate ASA code.
- Determine the appropriate number of base units.
- Determine the appropriate number of time units.
- Assign the appropriate modifier to identify the anesthesia provider.
- Assign the appropriate modifier to identify MAC services, when appropriate.
- Assign the appropriate physical status modifier.
- If applicable, assign the appropriate qualifying circumstance code(s).
- Determine the appropriate CPT[®] code(s) for any additional services or procedures performed.
- Determine the total units for the anesthesia services.

- Topical infiltration
- Local anesthesia
- Metacarpal/Metatarsal/Digital blocks
- Regional anesthesia
- Peripheral nerve blocks
- Epidural or spinal anesthesia
- Monitored anesthesia care (MAC)
- General anesthesia

- Pre-anesthesia record completed by the anesthesia provider
- Anesthesia report completed by the anesthesia provider
- Post-anesthesia record completed by the anesthesia provider and the post-anesthesia care unit (PACU) team
- Surgeon's operative report



Anesthesia Coding and Billing: Anesthesia Documentation



STONY BROOK

ANESTHESIA RECORD

(SAMPLE RECORD FOR EPIDURAL Anesthesia, Ana 100023)

PRE-PROCEDURE

Identified: GND Bands Cues/Signs
 Machine Check at: 7:00
 NPO Since: 12:00
 Pre-Op BP: 114/60 P 60
 O₂ Sat: RR
 Date: 12/31/11 Time: 7:00
 Pre Chart and Lab Date Reviewed

OBSTETRIC

Sex: F Time of Del: 1330
 I-D INTERVAL: _____
 APGAR: 9 2 5 Min.

LABS

TIME	PreOp		
		pH	
		PCO ₂	
		PO ₂	
		HCO ₃ /BE	
		Hgb/Hct	
		Pits	
		K/Ca	
		Na/gluc	

Anesth Start 1: 12/31/11 7:00
 Anesth End 1: 7:00
 Anesth Start 2: 1330
 Anesth End 2: _____
 Anesth Start 3: _____
 Anesth End 3: _____

Surg Start: _____
 Surg Fin: _____

Safety Belt On Axillary Roll
 Airboard Restraints Arms Tucked
 Pressure points checked and padded
 Eyes Taped

ANESTHESIA TEAM: Schabel / Mhamed
 SURGICAL TEAM: Royles
 Dx: UP
 PROCEDURE: vaginal delivery

MONITORS AND EQUIPMENT

Sash PreOid Esoph Other
 Non-Invasive BP Left Right
 Pulse Oximeter Oxygen Sensor
 End Tidal CO₂ Gas Analyzer
 Temp. Nerve Stimulator
 Arway Humidifier Fluid Warmer
 NG / OG Tube Foley Catheter
 Art. Line In OR
 CVP In OR
 PA Line In OR
 TVisi EKG
 EKG TEE
 CFB Forced Air
 Warming Blanket Cooling Blanket
 Other

TIME	7:00	7:30	8:30	9:30	11:30	11:30	13:30	TOTAL
Oxygen (L/min)								
N ₂ (L/min)								
FiO ₂ (Vol %)								
Propofol 175mc								
Rantonyl 50mg								
bupiv 0.625% after 10 min								
epidural 6cc								
Tidal Volume/Resp. Rate								
Peak Pressure/PEEP								
EKG								
% O ₂ Inspired								
O ₂ Saturation								
End Tidal CO ₂								
Temp: C F								
PAS/PAD (mmHg)								
CVP/PCWP (mmHg)								
BIS Monitoring								
Fluids: LR 1205								
Urine (ml)								
EBL (ml)								
Medical/Surgical History								
ASA								
Medications: Vitamins								
Allergies: NKDA								
Weight: 70 kg								
Symbols for Remarks								
Position: 67 4UP								

DATE: _____

REMARKS

bicitra 30cc
 Lorac 1cc L3-4
 OCSr Ozone
 Oparasthena
 O 1st dose 3cc
 lido 1.5% Epi 120ml
 Cath 10 cm at skin
 Cath 4 cm in space

1400 cath out
 Hip Intact

FLUID TOTALS

LR _____ EBL _____
 URINE _____

Post-Op Disposition

AICU ASU
 Other _____ Holding Area

BP _____ P _____ R _____
 O₂ Sat _____
 Condition _____

- **AA** Anesthesia services performed personally by anesthesiologist
- **AD** Medical supervision by a physician: more than four concurrent anesthesia procedures
- **QK** Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals
- **QY** Medical direction of one certified registered nurse anesthetist (CRNA) by an anesthesiologist
- **QX** CRNA service: with medical direction by a physician
- **QZ** CRNA service: without medical direction by a physician
- **QS** Monitored anesthesia care service
- **G8** Monitored anesthesia care (MAC) for deep complex, complicated, or markedly invasive surgical procedure
- **G9** Monitored anesthesia care for patient who has history of severe cardiopulmonary condition

Modifier	Description	Base Unit Value
• P1	A normal health patient	0
• P2	A patient with mild systemic disease	0
• P3	A patient with severe systemic disease	1
• P4	A patient with severe systemic disease that is a constant threat to life	2
• P5	A moribund patient who is not expected to survive without the operation	3
• P6	A declared brain-dead patient whose organs are being removed for donor purposes	0

Anesthesia Team:

- Anesthesiologist
- Anesthesiology Fellow
- Anesthesiology Resident
- Nurse Anesthetist
- Anesthesiologist Assistant
- Student Nurse Anesthetist
- Anesthesiologist Assistant Student

Teaching physician must:

- Be available immediately to furnish services during the entire procedure
- Document
- Presence during all critical (or key) portions of the procedure
- Involvement in cases with residents
- Availability of another teaching anesthesiologist as necessary
- Modifier AA & GC

- Based on a recent data analysis, coders are coding anesthesia by entering 1 under minutes of service as a default. This reflects an inaccurate count since it gets translated in the system to 1 unit which is 15 minutes.
- Assignment of correct Medical Expense and Performance Reporting System (MEPRS) code is necessary for correct assignment of place of service.
 - Current MHS systems only allows Anesthesia services to be entered under B MEPRS which reflects an incorrect place of service while inpatient professional services are captured under A MEPRS.

An Anesthesia Crosswalk links surgical procedures performed to the appropriate service code

Procedure: Coronary artery bypass, vein only (33510)

ASA Crosswalk Options:

- **00562** Anesthesia for procedures on heart, pericardial sac, and great vessels of chest; with pump oxygenator, age 1 or older for all non-coronary bypass procedures or for re-operation for coronary bypass more than 1 month after original operation
 - (Base = 20)
- **00566** Anesthesia for direct coronary artery bypass grafting; without pump oxygenator
 - (Base = 25)
- **00567** Anesthesia for direct coronary artery bypass grafting; with pump oxygenator
 - (Base = 18)

These codes include all services integral to anesthesia procedure such as preparation, monitoring, and evaluation. In certain circumstances, modifier 59 (Distinct Procedural Service) should be appended to the CPT® code for the procedure(s) performed.

- Laryngoscopy (31505, 31515, 31527)
- Bronchoscopy (31622, 31645, 31646)
- Introduction of needle or catheter (36000-36015)
- Venipuncture or transfusion (36400-35440)
- Blood sample procurement through existing lines
- Otorhinolaryngologic services (92511-92520, 92543)
- CPR (92950)
- Temporary transcutaneous pacemaker (92953)
- Cardioversion (92960)
- ECG/EKG (93000-93010)
- Cardiovascular Stress Tests (93015-93018)

- Retrobulbar injection (67500)
- Interpretation of lab tests (81000-81015, 82013, 82205, 82270, 82271)
- Injections and IV drug administration (96360-96375)
- Esophageal, gastric intubation (91000, 91055, 91105)
- Injection of diagnostic or therapeutic substances (62310-62311, 62318-62319)
- Nerve blocks (64400-64530)
- Transesophageal echo (TEE) (93312-93318)

- Currently anesthesia billing is based on a flat rate for each anesthesia procedure regardless of the minutes of service, locality, or provider type.
 - DHA UBO develops the flat rate based on the CMS' National Average Minutes of service for each procedure, the base units for each procedure, and CMS' National Average Conversion factor.
 - TRICARE Anesthesia Reimbursement Formula: $(\text{Time Units} + \text{Base Units}) \times \text{National Average Conversion Factor}$
 - Total units for a procedure is determined by adding the base units for the procedure to the average units of service for the procedure (which is derived from the average minutes of service for the procedure).
 - Then total units for the procedure is multiplied by CMS' National Average Conversion factor to determine the rate for anesthesia procedure.

- CY2016 Anesthesia Rate Table Chart

1	CY 2016 UBO Anesthesia Rate Table			
2	CPT Code	2016 Rate	Short Descriptor	Long Descriptor
9	00124	\$ 153.07	ANESTH, EAR EXAM	ANESTHESIA EXTERNAL, MIDDLE & INNER EAR W/BIOPSY; OTOSCOPY
10	00126	\$ 139.44	ANESTH, TYMPANOTOMY	ANESTHESIA EXTERNAL, MIDDLE & INNER EAR W/BIOPI; TYMPANOSTOMY
11	00140	\$ 202.78	ANESTH, PROCEDURES ON EYE	ANESTHESIA FOR PROCEDURES ON EYE;NOT OTHERWISE SPECIFIED
12	00142	\$ 138.56	ANESTH, LENS SURGERY	ANESTHESIA FOR PROCEDURES ON EYE;LENS SURGERY
13	00144	\$ 259.30	ANESTH, CORNEAL TRANSPLANT	ANESTHESIA EYE; CORNEAL TRANSPLANT
14	00145	\$ 260.40	ANESTH, VITRECTOMY	ANESTHESIA FOR PROCEDURES ON EYE;VITRECTOMY
15	00147	\$ 174.41	ANESTH, IRIDECTOMY	ANESTHESIA FOR PROCEDURES ON EYE;IRIDECTOMY
16	00148	\$ 159.23	ANESTH, EYE EXAM	ANESTHESIA FOR PROCEDURES ON EYE;OPHTHALMOSCOPY
17	00160	\$ 240.39	ANESTH, NOSE/SINUS SURGERY	ANESTHESIA NOSE AND ACCESSORY SINUSES; NOS
18	00162	\$ 452.63	ANESTH, NOSE/SINUS SURGERY	ANESTHESIA NOSE AND ACCESSORY SINUSES; RADICAL SURGERY
19	00164	\$ 195.52	ANESTH, BIOPSY OF NOSE	ANESTHESIA NOSE AND ACCESSORY SINUSES; BIOPSY, SOFT TISSUE
20	00170	\$ 230.71	ANESTH, PROCEDURE ON MOUTH	ANESTHESIA INTRAORAL PROCEDURES W/BIOPSY; NOS
21	00172	\$ 420.08	ANESTH, CLEFT PALATE REPAIR	ANESTHESIA INTRAORAL PROCEDURES W/BIOPI; REPAIR CLEFT PALATE
22	00174	\$ 341.56	ANESTH, PHARYNGEAL SURGERY	ANESTH INTRAORAL PROC W/BIOPSY; EXCISE RETROPHARYNGEAL TUMOR
23	00176	\$ 791.55	ANESTH, PHARYNGEAL SURGERY	ANESTHESIA INTRAORAL PROCEDURES W/BIOPSY; RADICAL SURGERY
24	00190	\$ 313.41	ANESTH, FACIAL BONE SURGERY	ANESTHESIA PROCEDURES ON FACIAL BONES; NOS
25	00192	\$ 393.46	ANESTH, FACIAL BONE SURGERY	ANESTH FACIAL BONES; RADICAL SURGERY (INCLUDES PROGNATHISM)
26	00210	\$ 549.18	ANESTH, OPEN HEAD SURGERY	ANESTHESIA INTRACRANIAL PROCEDURES; NOS
	00211	\$ 219.94	ANESTH, CRANIOTOMY OR ECTOMY FOR EVAC	ANESTHESIA FOR CRANIOTOMY OR CRANIECTOMY FOR EVACUATION OF HEMATOMA
27				
28	00212	\$ 235.33	ANESTH, SKULL DRAINAGE	ANESTHESIA FOR INTRACRANIAL PROCEDURES;SUBDURAL TAPS
29	00214	\$ 351.68	ANESTH, SKULL DRAINAGE	ANESTHESIA,INTRACRANIAL PROC;BURR HOLES,INC VENTRICULOGRAPHY
30	00215	\$ 440.53	ANESTH, SKULL FRACTURE	ANESTH ELEVATE DEPRESSED SKULL FX,EXTRADURAL,SIMPLE/COMPOUND
31	00216	\$ 776.81	ANESTH, HEAD VESSEL SURGERY	ANESTHESIA FOR INTRACRANIAL PROCEDURES;VASCULAR PROCEDURES
32	00218	\$ 636.49	ANESTH, SPECIAL HEAD SURGERY	ANESTHESIA INTRACRANIAL PROCEDURES IN SITTING POSITION
33	00220	\$ 398.96	ANESTH, INTRCRN NERVE	ANES, INTRACRANIAL PROCS; CEREBROSPINAL FLUID SHUNTING PROCS
34	00222	\$ 263.92	ANESTH, HEAD NERVE SURGERY	ANESTHESIA FOR ELECTROCOAGULATION OF INTRACRANIAL NERVE

- Updated every calendar year, generally in July

- Begins: When the anesthesia provider prepares the patient for the induction of anesthesia in the operating room or equivalent area
- Ends: When the anesthesia provider is no longer in personal attendance (patient is safely placed under post-operative supervision)
- American Medical Association (AMA) and American Society of Anesthesiologists (ASA) recommend that 1 unit of time is equal to 15 minutes of anesthesia time
- Round time to the next unit after 7 ½ minutes is reached.
 - Some payers, including Medicare, do not follow the above recommendation.
- *Anesthesia Charge = (Base units + Time units + Modifying units) x \$ Conversion Factor*



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Pain Management



Epidurals

- If epidural is the route of administration for anesthesia, post-operative pain management is not separately reportable
 - When separately reportable:
 - Based on spinal region
 - Time placing the epidural must be carved out of the total anesthesia time

Two types

- Single Injection (62310 – 62311)
 - 01996 is not appropriate and cannot report 01996 for subsequent daily hospital management
- Continuous Infusion or Intermittent Bolus (62318-62319). Include catheter placement. Append modifier 59

Nerve Blocks

- If epidural is the route of administration for anesthesia, post-operative pain management is not separately reportable
 - When separately reportable:
 - Based on the nerve being blocked
 - Single injection
 - Continuous infusion by catheter
 - Brachial plexus, sciatic nerve, femoral nerve, lumbar plexus
- Time performing block must be carved out of the total anesthesia time

Billing for Obstetrics (OB) Professional Services under Bundled or Global Codes





Issue: Normally, OB encounters in MTFs are documented with a series of HCPCS codes - 0500, 0501F, 0502F, and 0503F - that are not reimbursed under TRICARE and do not have DHA UBO billing rates

Most payers reimburse routine OB professional services based on global or bundled packages of services rather than itemized charges

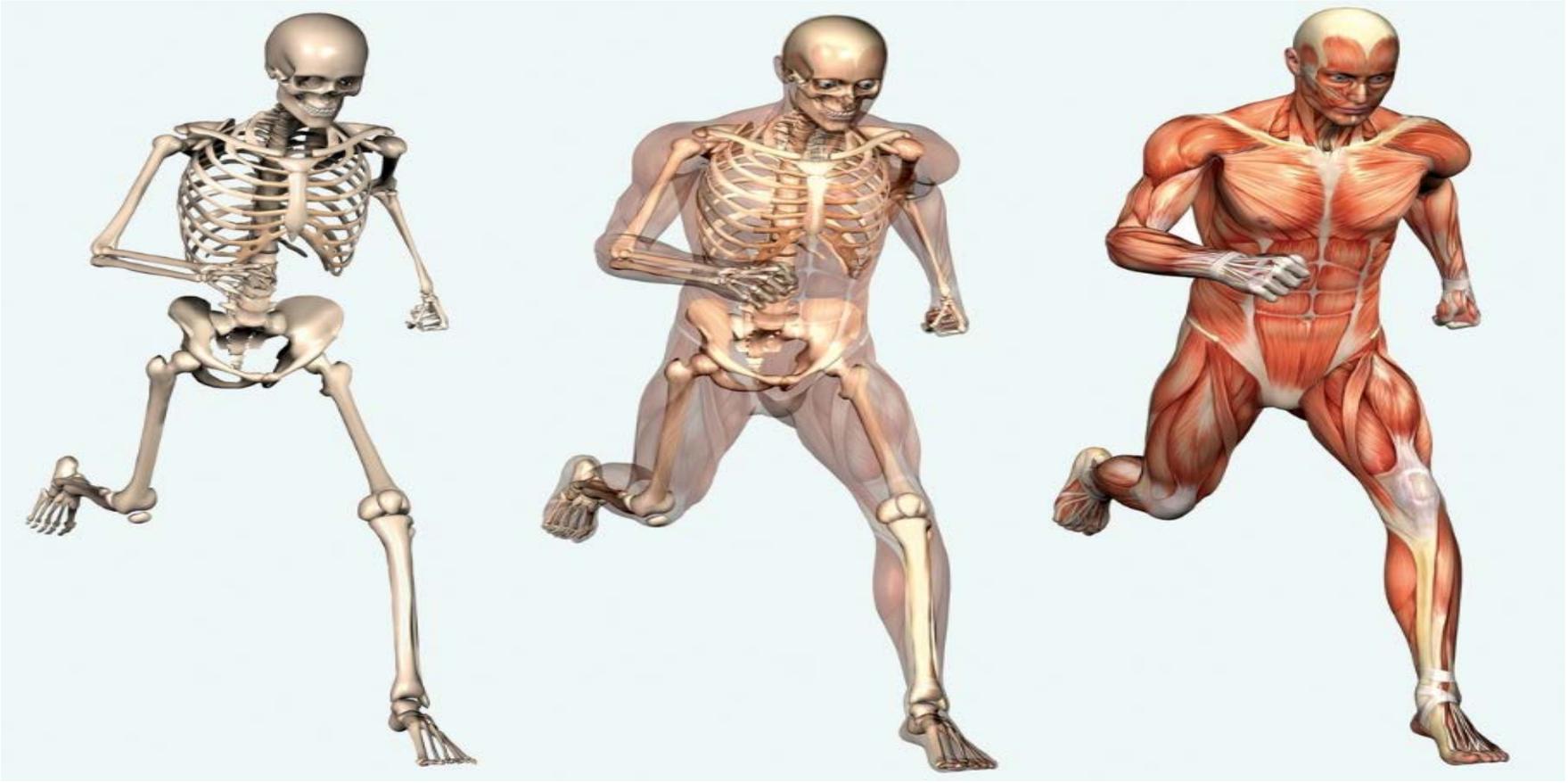
- The global packages apply to routine care provided to patients during the antepartum, the delivery, and the postpartum periods
- DHA UBO rates established for these global OB codes are based on TRICARE allowable charges:
 - At the discretion of the Services, NCR MD, and their MTFs, the global or bundled OB procedures may be coded and billed

- Billing staff must rely on coding support to assign the global or bundled CPT codes prior to billing
 - List below are the relevant procedures that have DHA UBO billing rates

Global Maternity Services Including Antepartum, Delivery, and Postpartum Care: 59400, 59510, 59610, 59618

- **Antepartum Care Only:** 59425, 59426
- **Delivery Only:** 59409, 59514, 59612, 59620
- **Delivery and Postpartum Care Only:** 59410, 59515, 59614, 59622
- **Postpartum Care Only:** 59430

Orthopedics



- Orthopedics coding is unique in that new coding and billing guidelines are published annually.
- New CMS mandatory demonstration project: Comprehensive Care for Joint Replacement payment model (CCJR) began April 1st, 2016 in 67 metropolitan statistical areas (MSAs)
 - CMS bundles payments for nearly all Part A and B services related to hip and knee replacement surgeries--demonstration hospitals will be accountable for quality and cost of care for an inpatient stay that results in DRG 469 and 470, along with all related care provided during the 90-day period following discharge
 - TRICARE is similarly performing demonstration, “TRICARE Bundled Payment for lower Extremity Joint Replacement or Reattachment (LEJR) Surgeries”
 - Demonstration hospitals will be accountable for quality and cost of care for an inpatient stay that results in DRG 470, along with all related care provided during the 90-day period following discharge.

- Problem Codes
 - 21805: Open treatment of rib fracture without fixation, each; Deleted due to low utilization/no longer standard of practice.
 - Must now report an E/M code for treatment of uncomplicated rib fracture and report 21811-21813 for open treatments with internal fixations
 - CPT code 99214: Outpatient doctor visit, level 4
 - No over-documenting, no upcoding!
 - CPT code 20610: Aspiration and/or injections; major joint or bursa
 - Ultrasound guidance for knee injections should not be a routine policy and can only be billed when at least one of the medical necessity requirements has been met and thoroughly documented
 - If aspiration and injection performed in same session, bill only one unit 20610.
 - Append appropriate site modifier to code 20610 (RT/LT) unilateral or modifier (50) bilateral.
 - Drug codes must be reported on separate line for each site being injected with a modifier (RT or LT).
 - Evaluation and management codes will not be routinely billed with joint injections. When a separately identifiable service has been provided and thoroughly documented, they may be billed with modifier 25
 - If the E/M service is significant and separately identifiable from the typical pre-service work of 20610, you may report the E/M service separately with modifier 25

- Appropriate use of a modifier is necessary to generate a clean claim
 - E.g., reporting a global code when someone else has already reported the same code with a technical component modifier will lead to denial unless appropriate use of modifier 26 applies
- If appending modifier 52 (Reduced services) or 22 (Increased procedural services), submit additional medical documentation in order to avoid a denial
- Make sure documentation proves medical necessity
- Always bill the appropriate level of service, starting from the time the Provider speaks to the patient to the time the Provider leaves the patient



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Physical Therapy



- Physical Therapy providers experience higher rates of auditing and denials than most other specialty practices.
 - Medical necessity
 - In this case, avoid cheat sheets. do not copy the codes supplied in the patient referral. Use the physician diagnosis to inform you on the patient's situation, sure; but then use your own clinical judgment and skills as a medical professional to diagnose the patient based on what you're actually going to treat
 - Functional limitation
 - Eligible professionals who fail to complete FLR will not receive reimbursement for their services
 - Pre-certification and Pre-authorization
- “All notes made in a patient’s DoD Health Record describing treatment [or counseling] will be completed by health care providers who have either directly or indirectly provided care to that patient. Documentation of indirect care is made when, for example, a provider is asked to consult on a patient, review data from the record, and enter a comment based on the review without interacting directly with the patient.”
(DoD Instruction 6040.45, “Service Treatment Record (STR) and Non-Service Treatment Record (NSTR) Life Cycle Management” (11/16/15), Enclosure 3, ¶3k)
- Plan of Care is usually undated, missing rendered services, or nonexistent

- Outpatient Rehabilitation Therapy Services must be provided by a qualified professional as defined in Chapter 15 of the Medicare Benefit Policy Manual.
 - A qualified professional means a physical therapist, occupational therapist, physician, nurse practitioner, clinical nurse specialist, or physician's assistant, who is licensed or certified by the state to perform therapy services, and who also may appropriately perform therapy services under Medicare policies.



- Payers, including Medicare, may have therapy caps.
- Remain aware of the Medicare Therapy Cap Limits for the year:
 - The therapy cap limits for 2016 are:
 - \$1,960 for physical therapy (PT) and speech-language pathology (SLP) services combined
- If treatment exceeds therapy cap, and the additional treatment is supported by medical necessity, an automatic exception using the KX modifier is used.
- By attaching the KX modifier to a therapy procedure code that is subject to the cap limit, the provider is attesting that the services billed:
 - Qualified for the cap exception
 - Are reasonable and necessary services that require the skills of a therapist; and
 - Are justified by appropriate documentation in the medical record.
- The threshold amounts for 2016 are:
 - \$3,700 for PT and SLP combined
 - Treatment after \$3700 requires a manual medical review for exemption and reimbursement.
 - As of April 1st, 2013 Medicare Administrative Contractors (MAC) will work through Recovery Audit Contractors (RAC) to establish medical necessity. RACs are allowed 10 days to respond to documentation detailing medical necessity.

Mental Health





- Mental health needs are most often caught at the forefront by Primary Care providers.
- Access to psychiatrists may take weeks or months. Primary Care Providers become a patient's first line of defense.
- Mental health services often go underpaid or unpaid. However, there are specific ways to bill in order to get the payment Provider's deserve
- Payers use their own standards for what constitutes medical necessity and are not always forthcoming about denial details

- 99354 and 99355: These codes are now applied to prolonged outpatient psychotherapy services, in addition to prolonged outpatient Evaluation and Management (E/M) services
- +99354: Prolonged E&M for psychotherapy service(s) (beyond the typical service time of the primary procedure) in office of other outpatient setting requiring direct patient contact beyond the usual service; first hour, list separately in addition to code for office or other outpatient E&M or psychotherapy service
 - +99355: For each additional 30 minutes beyond the first 60 minutes of prolonged services. Additional services must exceed 15 minutes in order to report.

- List the medical diagnoses first
 - By listing co-morbidities before the mental health condition so that the claim is not dismissed by payers
 - Medicare will continue to pay 100% of the allowable amount so listing co-morbidities first on the claim is not necessary
- Bill E/M codes based on time
 - When medically necessary, Medicare will cover multiple mental health care services the same day, such as “structured assessment and intervention” services for alcohol and/or substance abuse (G0396 and G0397) and thus, other payers may follow suit
 - G0396, which describes 15-30 minutes of structured alcohol and/or substance abuse (other than tobacco) receives lower reimbursement than a Level 3 established office visit code 99213, with an average service time of 15 minutes
- Instead of using psychotherapy codes with E/M services (90805, 90807), bill using the appropriate E/M code from the 99xxx series of codes (i.e., 99211, 99212, etc.) and a timed add-on code for the psychotherapy.

- Don't forget the modifier!
 - **25 Modifier:** Significant, Separately Identifiable E/M Service by the Same Physician on the Same Day of the Procedure or Other Service
 - **51 Modifier:** Multiple surgeries performed on the same day, during the same surgical session
 - **59 Modifier:** Used when a Provider may need to indicate that a procedure or service was distinct or independent from other services performed on the same day
 - **GT Modifier:** Via interactive audio and video telecommunications systems
- In the case of telemedicine, providers will use the same CPT and HCPCS codes as with face-to-face services. However, providers may use modifiers (GT, U1-UD) after the code. Requirements may vary by payer.
- Bill outpatient services rendered by a clinical social worker (CSW) on the CMS-1500 claim form and 837P electronic claim format even if services were rendered by a CSW employed by the hospital or under arrangement with the hospital.

Resources



- General Specialty Coding Questions
 - MTF Colleagues
 - Service and NCR MD DHA UBO Points of Contact
 - DHA UBO Helpdesk
 - 202-776-1532 or DHA UBO.Helpdesk@altarum.org
 - DHA UBO Web Site
 - <http://www.health.mil/Military-Health-Topics/Business-Support/Uniform-Business-Office/Patient-Categories>
- Questions regarding MTF-specific billing practices, denials management and onsite billing resources can be addressed to:
 - *Air Force*: Data Quality Patient File/NED Error/TOPA SMEs
 - *Army*: MTFs should contact their PAD & local CHCS offices
 - *Navy*: MTFs should contact their PAD Officer
 - *NCR MD*: MTFs should contact their PAD Officer



- 2016 CPT® Professional Edition
- 2015 ICD-9-CM
- 2016 HCPCS Level II
- 2016 ASA Relative Value Guide
- 2016 ASA Crosswalk
- 2016 Coding and Payment Guide for Anesthesia Services
- CMS Claims Processing Manual, Chapter 12, Section 50
- 2016 ASA Standards Guidelines and Statements
- DHA UBO Denials Management Webinar
- Optum Uniform Billing Editor
- MCPO Helpdesk
- UBO Helpdesk

Summary



- **FIX ERRORS BEFORE THEY HAPPEN**
 - Be proactive when you are coding and billing
- **STAY CURRENT**
 - Stay up-to-date on billing and coding guidelines and requirements. Coding will change as new codes are introduced and older ones phased out. Check on new protocols in medical coding regularly. Study new codes and be aware of how they affect billing.
- **BE DILIGENT**
 - Always double check claim before submitting it. Simple clerical errors like missing digits or misspelled names can be the difference between an approved and a rejected claim
- **COMMUNICATE**
 - Do so regularly and effectively with providers and coders. Don't be afraid to ask questions about possible errors on the claim.
- **FOLLOW THROUGH**
 - Follow up with payer representatives. He/she may be able to alert you to any errors they've already caught so you can begin work on making a new, error-free claim



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