



October 1, 2010



President's Message

I am sure everyone is back into the swing-of-things now that Fall is here and the dog-days of Summer are gone.

Effective October 1, 2010, the ICD-9 CM 2011 diagnosis codes are required. (go to <http://www.codingtrainer.com/2011icd9.pdf>) For 2011, there are 130 new codes, 16 revised codes and 13 inactive codes. Shortly, the AMA will announce the 2011 changes for CPT and CMS will reveal their 2011 payment and policy changes to the Medicare Physician Fee Schedule.

Some specialty areas impacted (but not limited to) include: Orthopedics, Gastroenterology, Radiology, General Surgery and Cardiology. In December we should learn what HCPCS Level II changes we can expect for 2011.

This is always an exciting time for healthcare practices and facilities! And YES, to all of those who know me - I am still just as zany about coding, billing and compliance as I was 10 years ago.

We hope you enjoyed our inaugural issue of the CodingTrainer.com Newsletter. We have a dedicated "Code Note" column which will highlight find a Compliance Section as well. Look for the "Compliance Nook" which is appearing different coding issues each month.

We will always include a Medicare issue or concern in each Newsletter edition. From time-to-time, you will also for the first time in this Newsletter.

Please feel free to share this Newsletter with your professional colleagues. Education and training of a healthcare professional have always been core principles of our company. We all benefit by

staying current about matters that affect our operations.

Enjoy!

Debbie



Planned Medicare Reimbursement Cuts 'will never take place'

If U.S. Sen. Benjamin Cardin states that physicians, especially those in primary care, could get a bigger paycheck. While the health care reform law will widen access to health care coverage for 98 percent of Americans, Cardin, a Maryland Democrat, said the law doesn't address major issues like Medicare reimbursement rates, which are slated to be cut by 21 percent in December. "I am committed to making sure this cut never takes place," Cardin said.

Cardin said he would support fixing the Medicare Sustainable Growth Rate, a metric designed to help the federal government decide how much it could increase or shrink reimbursements for doctors who care for individuals 65 and older.

He said the Patient Protection and Affordable Care act does not address long-term care or create a permanent fix the Medicare system. The problem is that the rate of growth in Medicare expenses is far outpacing the rate of growth in the gross domestic product.

"The bill is far from perfect. It's a beginning, not an end," Cardin said. Cardin said the government

also needs to work to revamp the reimbursement rate for physicians and reform tort law.

Instead of physicians being paid on the basis of the volume of patients they see, Cardin said doctors should be paid on the quality of care they provide.

Cardin said he introduced a bill in the Senate to repeal the 1997 law that changed the physician reimbursement rate. He also said that he wants to work on medical malpractice issues to lower malpractice insurance premiums while making sure the patient is still protected. Currently, some physicians pay anywhere from \$100,000 to \$150,000 for malpractice insurance.

"I'm fully prepared to engage in tort reform," he said. Cardin addressed concerns that the health care reform law will lead to rationing of health care. He said health care reform will give more people access to primary care and clinics, making them less likely to use emergency services, which are a bigger cost to the health care system.



Medicare Timely Filing Changes

President Obama signed into law the Patient Protection and Affordable Care Act (PPACA), which amended the time period for filing Medicare fee-for-service (FFS) claims as one of many provisions aimed at curbing fraud, waste, and abuse in the Medicare program.

The time period for filing Medicare FFS claims is specified in Sections 1814(a), 1835(a)(1), and 1842(b)(3) of the Social Security Act and in the Code of Federal Regulations (CFR), 42 CFR Section 424.44. Section 6404 of the PPACA amended the timely filing requirements to reduce the maximum time period for submission of all Medicare FFS claims to one calendar year after the date of service.

Under the new law, claims for services furnished on or after January 1, 2010, must be filed within one calendar year after the date of service. In addition, Section 6404 mandates that claims for

services furnished before January 1, 2010, must be filed no later than December 31, 2010.

The following rules apply to claims with dates of service prior to January 1, 2010. Claims with dates of service before October 1, 2009, must follow the pre-PPACA timely filing rules. Claims with dates of service October 1, 2009, through December 31, 2009, must be submitted by December 31, 2010.

Section 6404 of the PPACA also permits the Secretary to make certain exceptions to the one-year filing deadline. At this time, no exceptions have been established. However, proposals for exceptions will be specified in future proposed rulemaking.



Releasing Medical Records

Health care providers are required to disclose medical records within a reasonable time, but no more than 21 working days after the date a person in interest requests the disclosure. A health care provider that knowingly and willfully refuses to disclose medical records in violation of Health-General Article § 4-309 (a)(d) is liable for actual damages, is guilty of a misdemeanor, and on conviction is subject to a fine not exceeding \$1,000 for the first offense and not exceeding \$5,000 for each subsequent conviction for a violation of any provision of this subtitle.

The fees that may be charged for preparation and production of medical records may be adjusted annually for inflation using the Consumer Price Index on July 1 of each year. The FY 2007 adjusted rates for medical record copying are as follows: a preparation fee of no more than \$20.52 (Please note that preparation fees can be charged to hospitals and insurance companies, but NOT patients.), plus a fee of no more than 68 cents per page copied, plus the actual cost of shipping and handling. Reasonable fees may be charged for duplicate x-rays.

Health care providers may not refuse to disclose a medical record on the request of a person in

interest because of the failure of the person in interest to pay for health care rendered by the provider. Health care providers may require payment of the preparation, copying, shipping and handling fees and charges before turning the records over to a patient or other authorized individual. Health care providers are required to comply with subpoenas, and no fee may be charged to transfer the records of Medicaid recipients to another provider.

A health care provider or any other person, including an officer or employee of a governmental unit, who knowingly and willfully requests or obtains a medical record under false pretenses or through deception or knowingly and willfully discloses a medical record in violation of this subtitle is guilty of a misdemeanor and on conviction is subject to the following penalties: A fine not exceeding \$50,000, imprisonment for not more than 1 year, or both; If the offense is committed under false pretenses, a fine not exceeding \$100,000, imprisonment for not more than 5 years, or both; and if the offense is committed with intent to sell, transfer, or use individually identifiable health information for commercial advantage, personal gain, or malicious harm, a fine not exceeding \$250,000, imprisonment for not more than 10 years, or both. This subsection does not apply to an officer or employee of a governmental unit that is conducting a criminal investigation.

Being cooperative and timely when a patient requests their medical records avoids complaints to the Board.

Retaining of Medical Records

HIPAA regulations require that patient documents must be kept a minimum of six (6) years. The Medical Records Act states that unless a patient is a minor, medical records, laboratory and X-ray reports must be kept at least five years (see §4-403 below).

Annotated Code of Maryland Health-General Article Title 4. Statistics and Records

§ 4-403

(b) Except for a minor patient, unless a patient is notified, a health care provider may not destroy a medical record or laboratory or X-ray report

about a patient for 5 years after the record or report is made.

(c) In the case of a minor patient, a medical record or laboratory or X-ray report about a minor patient may not be destroyed until the patient attains the age of majority plus 3 years or for 5 years after the record or report is made, whichever is later, unless:

The parent or guardian of the minor patient is notified; or If the medical care documented in the record was provided under § 20-102(c) or § 20-103(c) of this article, the minor patient is notified.

(d) The notice under subsections (b) and (c) of this section shall: Be made by first-class mail to the last known address of the patient; Include the date on which the record of the patient shall be destroyed; and Include a statement that the record or synopsis of the record, if wanted, must be retrieved at a designated location within 30 days of the proposed date of destruction.

(e) After the death, retirement, surrender of the license, or discontinuance of the practice or business of a health care provider, the health care provider, the administrator of the estate, or a designee who agrees to provide for the maintenance of the medical records of the practice or business and who states, in writing to the appropriate health occupation board within a reasonable time, that the records will be maintained in compliance with this section, shall: Forward the notice required in this section before the destruction or transfer of medical records; or Publish a notice in a daily newspaper that is circulated locally for 2 consecutive weeks:

(i) Stating the date that the medical records will be destroyed or transferred; and

(ii) Designating a location, date, and time where the medical records may be retrieved, if wanted.

(f) (1) After consulting with the Association of Maryland Hospitals and Health Systems, the Maryland State Medical Society, and other interested parties, including consumers and payors, the Secretary shall adopt regulations governing the destruction of medical records.

(2) The regulations adopted under this subsection shall:

(i) Specify the manner in which a health care provider shall maintain and store medical records to:

1. Ensure confidentiality; and
2. Provide limited access to the medical records until the records are destroyed; and

(ii) Ensure that the method of destruction renders the medical records unreadable.

(3) The regulations adopted under this subsection may not:

- (i) Require or encourage the destruction of medical records; or
- (ii) Be inconsistent with any provision of law applicable to the maintenance or destruction of medical records.

(g) (1) A health care provider or any other person who knowingly violates any provision of this subtitle is liable for actual damages.

(2) (i) In addition to any other penalties provided under this article, a health care facility that knowingly violates this section is subject to an administrative fine not exceeding \$10,000 for all violations cited in a single day.

(ii) 1. In addition to any other penalties provided under this article, an individual who knowingly violates this section is subject to the fines provided in sub-subparagraph 2 of this subparagraph if the individual is:

- A. A health care provider, as defined under subsection (a)(1)(i) through (vi) or (viii) through (xx) of this section; or
- B. An agent, employee, officer, or director of a health care provider.

2. The administrative fines applicable to an individual covered under sub-

subparagraph 1 of this subparagraph shall be assessed as follows:

- A. The first fine assessed or first set of fines assessed concurrently for all violations cited in a single day may not exceed \$1,000;
- B. The second fine assessed or second set of fines assessed concurrently for all violations cited in a single day may not exceed \$2,500; and
- C. The third or subsequent fine assessed or third or subsequent set of fines assessed concurrently for all violations cited in a single day may not exceed \$5,000.

We recommends that a practitioner consult his/her health care attorney regarding retirement from practice and retaining of medical records.



Medicare Dispatch

Medicare Physician Signature Requirements

With the advent of the Recovery Audit Contractors (RACs) and their focus on incorrect and inappropriate payments by Medicare, increased scrutiny on the review process of documentation occurred. CMS developed guidelines to identify correct and incorrect documentation of physician signatures. Within the last 5 months CMS has beefed up the Program Integrity Manual regarding acceptable physician signatures.

Basic Requirement

Each provider who has provided or ordered services/procedures must be identified in the patient's medical records. Each signature is to be legible with the provider's first and last name provided along with their credentials. Rationale: It confirms the provider has determined the services/procedures are medically necessary.

Signatures

Acceptable signatures include: handwritten, handwritten initials and electronic signatures. Electronic signatures may be either digitized or electronic. Digital signatures (standard electronic signatures) take the concept of traditional paper-based signing and turn it into an electronic "fingerprint." This "fingerprint" is unique to both the document and the signer and binds both of them together. The digital signature ensures the authenticity of the signer. Electronic signatures are defined as an electronic sound (e.g., audio files of a person's voice), symbol (e.g., a graphic representation of a person in JPEG file), or process (e.g., a procedure that conveys assent), attached to or logically associated with a record, and executed or adopted by a person with the intent to sign the record. An electronic signature is easy to implement, since something as simple as a typed name can serve as one.

A signature stamp is no longer considered to be a valid signature. CMS clarified the use of a signature stamp may result in delayed payment of denied claims. Any transcribed record or report that does not include a valid signature will be denied payment. Also considered to be an unacceptable signature is to write "signing physician" with a physician's named typed along with "signature on file".

Shared Services

In the office setting services may be provided to a patient by a non-physician provider (i.e. Nurse Practitioner, Physician Assistant) as "incident to" the physician's service. When the "incident to" provisions are satisfied, this encounter although provided by the non-physician providers must be signed by the physician.

Unavailable Provider

When a provider in a group practice has either died or has left the medical practice one of the other medical providers who work in the practice may sign on his/her behalf. However, additional information must be documented to indicate where the absent provider has relocated or has died.

Surgical Assistants and Co-Surgeons

Surgical assistants still are not required to sign an operative note as long as the primary surgeon signs it. Co-surgeons are still required to sign

the operative report(s) and this signature must be valid.

Exceptions

Facsimiles of original written or electronic signatures for certification of terminal illness for hospice are permitted. Orders for clinical diagnostic tests are not required to be signed. However, there must be documentation in the medical record by the treating physician that he/she intended for the clinical diagnostic test(s) to be performed. The documentation of the physician intent must be authenticated by physician either with a handwritten or electronic signature.

When a signature is missing from an order, CMS contractors are to altogether disregard the order in the review process. When Medical record entries are missing a signature, the Medicare auditor has the option to use a signature log or an attestation statement by the provider to determine the author's identity.



Question: How would someone code for a surgical procedure assisted by a fully-robotic device?

Answer: Let's start with some background regarding the device. The first fully-robotic device was approved in 2000. The name of the robotic system is da Vinci®. The da Vinci® surgical system is manufactured by Intuitive Surgical Inc. The surgeon operates while being seated at the system's console. The surgeon is able to view the surgical field through a 3-D eyepiece with his fingers grasping the instrument controls. The controls are below the display. The finger movements are precisely translated in real time to the articulating laparoscopic robotic instruments. The device is not programmable. It is under the surgeon's direct control at all times.

The procedure is known as "laparoscopic robotic-assisted surgery. Many surgical specialties now use this equipment when performing complex procedures. Some of the procedures that may

involve robotic-assistance include: prostatectomy, hysterectomy, sacral colpopexies, nephrectomy, coronary anastomosis, mitral valve repair and Roux-en-y.

To-date, CPT™ does not have a specific procedure code that specifically describes robotic-assisted surgery. The AMA has been discussing adding a new code for this type of procedure since 2004. The primary surgical procedure is laparoscopic. Therefore, the correct CPT™ code to assign for this procedure would be the appropriate laparoscopic code describing the procedure.

If there does not exist a laparoscopic code that describes the actual procedure, you would then need to assign the appropriate unlisted laparoscopic CPT™ code for the anatomical location or an unlisted code for the anatomic location when there is no unlisted laparoscopic code. There is no need for the use of modifier 22 (Increased Procedural Services).

In July 2005, a HCPCS Level II code became available to describe the use of the robotic surgical system. The HCPCS code is S2900 (Surgical techniques requiring use of robotic surgical system) and is to be listed separately in addition to code for primary procedure. Although, most insurers (including Medicare) allow payment for minimally invasive surgical procedures like laparoscopy, you will find they generally will not allow a separate payment for this add-on HCPCS Level II code. Also, Medicare does not ever allow payment for any "S" HCPCS Level II codes.

Example: Laparoscopic radical nerve sparing prostatectomy with robotic assistance, you would assign code 55866 only.

ICD-9 CM Alert

The ICD-9-CM Coordination and Maintenance Committee announced at its regularly scheduled meeting held on Sept. 15, 2010 that it was suspending regular updates to the ICD code sets to ease the healthcare industry's transition to ICD-10 effective on October 1, 2013.

The "Partial Freeze" calendar provided at this meeting:

- **Oct. 1, 2011:** The last annual updates to ICD-9-CM and ICD-10 code sets instituted.
- **Oct. 1, 2012:** Limited code updates to ICD-9 and ICD-10 will be allowed only to capture new technologies and diseases.
- **Oct. 1, 2013:** Limited code updates to ICD-10 will be granted to capture new technologies and diseases.
- **Oct. 1, 2013:** ICD-9 will cease to exist for purposes of reporting.
- **Oct. 1, 2014:** Regular updates to ICD-10 resume.

The update freeze has been called "partial" to allow for the creation of codes needed to capture new technologies and diseases.



Revisions to the U.S. Sentencing Guidelines for Compliance Programs

In April 2010, the U.S. Sentencing Commission voted to amend the Sentencing Guidelines Compliance and Ethics (C & E) Program Provisions in two ways. They also did not adopt an amendment they had been considering.

Respond Appropriately to Criminal Conduct

Commission added a commentary to the seventh element of an effective C & E program that when criminal conduct is detected the company must take "reasonable steps to respond appropriately to the criminal conduct. They also must prevent further similar criminal conduct and make any necessary changes to the organization's C & E program.

Taking "reasonable steps as warranted under the circumstances" could include providing restitution

to identifiable victims, self-reporting and cooperating with the authorities.

Steps taken to act appropriately to prevent further criminal conduction are to be consistent with subsections (b) (5) and (c) which require periodic evaluations of the program and a periodic risk assessment.

Also, the use of an outside professional advisor to ensure adequate assessment and implementation of modifications may also be included. The upside of the second part of the commentary is that a company who has been found to have learned appropriate C & E program lessons from a violation can impact greatly how a prosecutor treats the company.

Reporting to the Board

The second amendment concerns the obligation and authority of the person with operational responsibility for the C & E program to report to the highest governing authority of the organization. The Sentencing Guidelines specify a reduction in the organization's culpability score and therefore its criminal fine is not to be granted when the organization unreasonably delays reporting the offense and an individual within high-level personnel of the organization participated in, condoned or was willingly ignorant of the offense. The amendment allows the culpability score and fine reduction to occur despite the involvement of high-level personnel as long as the following conditions are met:

- The individual with operational responsibility for the C & E program have direct reporting obligations to the governing board (authority) or an appropriate subgroup of it such as the audit committee. Person has direct reporting obligations to the governing authority when the individual has express authority to communicate personally no less than annually on the implementation and effectiveness of the program.
- The C & E program detected the offense before discovery outside of the organization or before discovery was reasonably likely.
- The Organization acted promptly to report the offense.

- No individual with any operational responsibility for the C & E program participated in, condoned or was willfully ignorant of the offense.

The Commission added an application note about reporting annually to the Board on program implementation and effectiveness by the individual with operational responsibility for the C & E. This has been more of a suggestion in the Guidelines and now with the amendment language is not a requirement to qualify for this exception.

"Express Authority" would appear to require a written program and/or board document setting forth the authority and obligations with operational responsibility to report to the board.

Noteworthy is that NOT found in the new Commission advice was a provision that would have raised the document retention to a presumptive high risk area for organizations.

Congress has until November 1, 2010 to take action regarding these amendments to the Sentencing Guidelines. It is considered highly unlikely they will do so. Therefore, without Congressional action, these new amendments will be effective November 1, 2010.

Monthly Quiz



Coding Mini-Quiz

- Evaluation and Management

1. A patient encounter is focused entirely on counseling of a medical problem. Time spent is 15 minutes. The physician should code:

- a. 99401
- b. 99078
- c. 96152
- d. 99213

2. Physician A provides 90 minutes of critical care to a patient age 18 months

in the ED. Physician B (different group) provides 3 hours of inpatient critical care to the same patient on the same date. You would code for the physician services in this scenario:

- a. Physician A: 99291, 99292
Physician B: 99471
- b. Physician A: 99471 Physician B: 99472
- c. Physician A and B: 99471 only once
- d. Physician A: 99285 Physician B: 99471

3. Physician B covers for another physician of the same specialty in the same group practice. Physician B has never provided professional services to the patient who had seen Dr. A previously. This should be coded as an established visit.

- a. True
- b. False

4. With a brief HPI, a problem-pertinent review of systems and a complete PFSH, the level of history documented is:

- a. Detailed
- b. Problem Focused
- c. Comprehensive
- d. Expanded Problem Focused

5. Which of the following is the first step when selecting a level of E/M?

- a. Determine the extent of history
- b. Review the level of E/M service descriptors
- c. Determine the level of examination
- d. Identify the category and subcategory of service

For answers go to:

www.codingtrainer.com/answers100110.pdf



CodingTrainer.com provides central Maryland's premier training for coders who want any of nine certifications. We have a fulltime training facility in Catonsville Maryland, one half mile from the beltway.

Our next class dates are as follows:

- Coding certification class for *nine different certifications* –November 20, 2010
- Certification class for previously certified coders to become CCS-Ps – October 7, 2010
- 11th Annual Breakfast With Debbie (CPT,ICD-9) update Seminar – December 2010
- ICD-10 Seminar – January 2011
- CCS Certification course – January 2011
- Our next Saturday Class is soon.
- Call us to set up a class for you and your providers at your facility.



Medical Reimbursement Resources is our sister company that provides auditing and compliance services to the medical community.

MRR also provides the following services;

- Compliance Plans**
- Compliance Audits**
- Baseline Audits**
- Medical Record Reviews**
- Fraud Audits**
- Educational Audits**
- Practice Management Assessments**
- RAC Audits**
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