

# AcSel Advisor

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## CMS 2012 PHYSICIAN PAY CUT EXTENDED UNTIL MARCH 1

CMS has posted the 2012 Medicare Physician Fee Schedule (MPFS) on their website November 1, 2011. All payment and policies were to be effective January 1, 2012.

CMS estimated that the statutory formula used to determine the physician update (\$24.6712) will result in a negative (27.4%) physician fee schedule update. The overall fee schedule reduction could only be prevented by an Act of the US Congress.

On December 23, 2011 the House and Senate approved a two-month payroll tax cut extension package that included a two-month pay freeze for physicians. Providers will be paid at the 2011 rates for Medicare services they provide through the end of February 2012.



CMS may instruct Medicare Administrative Contractors (MACs) to hold claims if it appears that Congress will miss the March 1, 2012 deadline. According to CMS, this hold should have a minimal effect on provider cash flow because, under law, clean electronic claims are not paid sooner than 14 days after receipt.

For the complete story go to: [www.ama-assn.org](http://www.ama-assn.org)

## CMS - OBESITY SCREENING AND COUNSELING COVERAGE

CMS has added coverage for preventative services to reduce obesity. For patients who screen positive for obesity (BMI  $\geq 30$  kg/m<sup>2</sup>), the benefit would cover one face-to-face counseling visit per week for one month and one face-to-face counseling visit every other week for an additional five months. The patient may receive one face-to-face counseling visit every month for an additional six months if they have achieved a weight reduction of at least 6.6 pounds (or 3 kg) during the first six months of counseling. However, the services must be rendered by the primary care physician. For more information, go to <http://www.cms.gov>.



## 2012 CPT ADDITIONS, DELETIONS, AND MODIFICATIONS

### CPT - 2012 Radiation Oncology

#### NEW CODES:

- **77424** – Intraoperative Radiation Treatment delivery, x-ray, single treatment session
- **77425** – Intraoperative Radiation Treatment delivery, electrons, single treatment session
- **77469** – Intraoperative Radiation Treatment management (includes 77290, 77334, 77431 and 77470)

#### MODIFIED CODES

- **77470** – amended to exclude 77469

### CPT – 2012 Pathology

The major changes in CPT-2012 are the new Tier 1 and Tier 2 molecular pathology codes and instructions; cytopathology 88107 has been deleted, and descriptors and instructions for special stain codes 88312-88319 have been modified.

Tier 1 and Tier 2 Molecular Pathology procedures have been added in CPT 2012, however CMS has not yet recognized these new codes and have not approved these codes for payment in 2012.

**88107** – Smears and simple filter preparation with interpretation have been deleted in 2012. To report smears and simple filter preparation, see 88104 and 88106 (do not report 88106 in conjunction with 88104).

**88312 – 88313** Special Stains. The special instructions state to report one unit for each special stain, on each surgical pathology block, cytologic specimen or hematologic smear.

**88318** – Determinative histochemistry to identify chemical components (copper, zinc) has been deleted.

### CPT – 2012 Surgery/Integumentary System

Regardless of the type of skin substitute the providers uses, allograft, acellar dermal allograft, tissue cultured allogeneic dermal substitute skin substitute, tissue cultured allogeneic dermal substitute, xenograft, or acellular xenograft implant, the skin substitute should be reported using the new Skin Substitute Graft section in the CPT 2012. Skin substitute grafts will be reported based only on the wound site and size.

**15170- 15176** – Acellular Dermal Replacement have been deleted; to report see 15271-15278.

#### **15271- 15278—New Codes to report Skin Substitute Grafts**

Per CPT “the supply of skin substitute graft(s) should be reported separately in conjunction with 15271-15278. For biologic implant for soft tissue reinforcement, use 15777 in conjunction with the code for the primary procedure.”

**15300 – 15366 – Allograft/Tissue Cultured Allogeneic Skin Substitute** has been deleted (to report see, 15271-15278).

**15400- 15431 - Xenograft** has been deleted (to report see, 15271-15278).

### CPT 2012 Initial Observations Time Guidelines

CPT 2012 has updated the initial observation care codes (**99218- 99220**), adding the typical time a provider spends with the patient on the hospital floor or unit.



## CAREFIRST—Revised Policy for Reporting Modifier 62, Two Surgeons

Effective Jan. 1, 2012, providers will no longer be required to submit operative reports or other clinical records to be reimbursed for claim lines containing only modifier 62. Each surgeon will be reimbursed at 50 percent of the allowed amount for the procedure after all other reductions have been applied.

For more information, go to <https://provider.carefirst.com>.



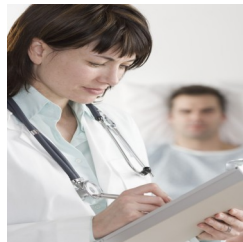
## AETNA—In the December 2011 issue of Aetna OfficeLink Updates, Aetna outlines several new and updated coding and policy changes.

### Precertification Requirements for Polysomnography

Effective March 1, 2012 all Aetna markets will require precertification for Polysomnography (PSG). This precertification will support a comprehensive, end-to-end Obstructive Sleep Apnea (OSA) program.

Precertification will be required for the following codes:

- 95807
- 95805
- 95810
- 98511



### Multiple Procedure Reductions for CT Scans, MRIs or Ultrasounds

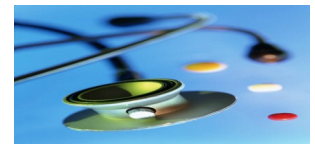
Effective for dates of service on or after February 1, 2012, the multiple procedure reduction policy for certain imaging services will change. The initial CT scan, MRI or ultrasound will be allowed at 100 percent and subsequent scans performed on the same day will be allowed at 50 percent. The reduction will apply to scans performed on contiguous body areas, and technical and global charges.

For more information go to: <http://www.aetna.com/healthcare-professionals>

## UnitedHealthcare Medicare Name Change

Effective January 1, 2012 UHC is changing the name of its Medicare Solutions Medicare Advantage plans. These plans include products such as SecureHorizons, AARP Medicare Complete from SecureHorizons, and Evercare. AARP's program will now be AARP MedicareComplete from UnitedHealthcare and SecureHorizons and Evercare will be called UnitedHealthcare.

For more information, go to [www.unitedhealthcareonline.com](http://www.unitedhealthcareonline.com).



## ANTHEM – Authorization Requirement Changes for HealthKeepers and HealthKeepers Plus Members

Effective January 1, 2012, authorization requirements will change for physical, occupational and speech therapies, supplies and medical equipment for HealthKeepers and HealthKeepers Plus members.

For Healthkeeper members, physical and occupational therapy authorization will no longer be required when an in-network provider is used. In addition, for Healthkeepers Plus authorization will no longer be required for members over the age of 3, for physical, occupational or speech therapy when an in-network provider is used.

For more detailed information, go to, [www.anthem.com](http://www.anthem.com).

## CMS- Post-Kidney Transplant Donor Complications Covered

Effective April 1, 2012 Post-kidney transplant expenses that are incurred for complications that “arise with respect to the donor” are covered and separately billable if they are directly attributable to the donor surgery.

## 2012 HCPCS II Changes

Effect January 1, 2012 New HCPCS II codes go into effect. There are over 400 changes, 285 code additions, 48 revisions, and 75 deletions.

## CMS – Medicare Part B Deductibles for 2012

The Medicare Part B deductible for 2012 is \$140/year.



## Can You Code It ...??

What new CPT code for 2012 would you use to identify the application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body are of infants and children?

- A. 15271
- B. 15273
- C. 15330
- D. 15360

**LAST ISSUE'S ANSWER:** 173.62

## MODIFIER 59 –

### DISTINCT PROCEDURAL SERVICE

#### Guidelines/Instructions:

The CPT manual defines Modifier 59 as: "Distinct Procedural Service: Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances."

## MODIFIER CORNER



Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries).

Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service see modifier -25.

When another modifier is appropriate, it should be used rather than modifier 59. Modifier 59 should only be used if there is no other descriptive modifier is available.

#### Example:

Patient presents with benign lesion on the forearm which is excised, and a separate benign lesion on the upper arm, which is destroyed via cryosurgery.

**11400** – Excision, benign lesion including margins, except skin tag (unless listed elsewhere) trunk, arms or legs, excised diameter 0.5 cm or less.

**17000** – Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic ketatoses); first lesion.

Modifier -59 would be appropriate because the procedures were performed on separate lesions.

For more information go to: <https://www.cms.gov/NationalCorrectCodInitEd/Downloads/modifier59.pdf>