2013 CPT CODE CHANGES

According to the AMA there are significant changes to the 2013 Current Procedural Terminology (CPT) code set. The 2013 CPT code set has added 186 new codes, deleted 119 codes and revised 263 codes. The new codes consist of 116 for molecular pathology, as well as codes that reflect technological changes in cardiology, neurological testing and psychiatry.

2013 NEW INTERVENTIONAL CARDIOLOGY CODES

There are many new codes for interventional cardiology, including 13 new codes describing PCI procedures (92920-92944). There are also new codes to describe transcatheter aortic valve repair (TAVR) from an endovascular approach (33361-33369) and four new codes to describe insertion, repositioning, and removal of percutaneous ventricular assisted devices (pVADs) (33990-33993).

According to a recent article by The Society for Cardiovascular Angiography and Interventions (September 07, 2012) the new family of PCI codes greatly differ from the existing coding conventions for these services.

- CPT 92920-92944 codes support reporting revascularization for each major coronary artery and branch treated. All revascularization procedures performed in all segments (proximal, mid, distal) of a single major coronary artery through the native coronary circulation are reported with one code.
- CPT 92927-92944 describe these same services when provided to patients who have had coronary artery bypass graft(s) (CABG), active ST-elevated myocardial infarction (STEMI), or chronic total coronary artery occlusion.

2013 NEW & REVISED CODES FOR RADIATION THERAPY

CPT 32701 – Thoracic target(s) delineation for stereotactic body radiation therapy (SBRT), (photon or particle beam), entire course of treatment

- is a new code for target delineation for stereotactic radiotherapy (SBRT). This code will not be billed by the radiation oncologist.
- The code may be reported once per course of treatment by the pulmonary specialist who actively participates in computer planning for thoracic SBRT.

CPT 20665 – Removal of tongs or halo applied by another physician

- has been revised for 2013 to reflect removal by another “individual” rather than another physician.

2013 NEW & REVISED CODES FOR PAIN MANAGEMENT

In the nervous system section, derervation subsection, there are two revised codes and one new code. CPT has revised codes 64612 and 64613 and added CPT 64615 for bilateral chemodenervation of muscles innervated by the facial, trigeminal, cervical spinal and accessory nerves. CPT 64615 can only be reported once per session. Do not report 64610 in conjunction with 64612, 64615, or 64613.

2013 NEW & E&M CODES FOR CARE COORDINATION

There are three new codes for 2013 to describe Complex Chronic Care Coordination Services for patients with complicated, ongoing health issues. Codes 99487-99489 were created for providers to report time that is not necessarily face-to-face but spent connecting patients to community services and preventing readmissions. According to the AMA, a typical patient will have one or more chronic continuous or episodic health conditions that commonly require coordination of a number of specialties and services.

Codes 99487-99489 are reported only once per calendar month and include non-face-to-face complex chronic care coordination services and non- or one face-to-face office or other outpatient, home, or domiciliary visit. These codes can only be reported by the single provider who assumes the care coordination role. If the physician personally performs the clinical staff activities, their time may be counted toward the required clinical staff time to meet the elements of the code.

Note: Time of care coordination with the emergency department is reportable using 99487-99489, but time spent while the patient is inpatient or admitted as observation is not.

AcSel Is Going Paperless!

We are asking our clients to help us with this endeavor by not using staples to attach your documents. If you feel documents need to be attached, please use a paper clip. Thank you for your cooperation in helping us achieve our goal.

CMS: Begins Audits of Meaningful Use Bonus Recipients

CMS has begun the audit of EHRR bonus recipients. In 2011 and 2012, more than 55,000 physicians received incentive payments. If during the post-payment audit a physician is found ineligible for incentive payment, the bonus payment must be returned. If the provider has supporting documentation and reports to demonstrate meaningful use, they will not have to refund the bonus.

Providers must reply within 2 weeks of receiving the letter. The letter will request the provider to submit:
- Proof that the EHR system is certified to meet the meaningful use requirements
- Supporting documentation proving that 15 core objectives were met to achieve Stage 1 meaningful use.
- Documentation supporting that meaningful use of five of the 10 menu objectives in Stage 1 were met.

For more information, go to: http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html

Can You Code It ??.... Does a non-physician practitioner (NPP) visit affect a patients “new vs. established” status?

Last Issue’s Answer: 284.11

CIGNA - MedSolutions, Inc and Medicare Primary Radiology Claims

In the October 2012 Cigna Network News Letter, Cigna advises as of June 1, 2012, all health care professionals that are contracted with MedSolutions, Inc (MSI) should send all Medicare primary radiology claims directly to Cigna. Cigna will process the claims and forward the explanation of payment (EOP) to the health care provider. If a Medicare primary claim is sent to MSI, the claim will not be accepted, and the provider will be instructed to bill Cigna. All other claims for radiology services should be sent directly to MSI.

Medicare - Revalidation Phase 2

CMS is now in Phase 2 of the provider revalidation process. Providers who enrolled in Medicare prior to March 25, 2011 will be required to revalidate their enrollment information when notified by CMS. Providers will receive a yellow envelope from CMS with revalidation instructions. The Internet-based PECOS system has been updated to allow providers to edit information online, upload supporting documents and electronically sign the application.

Health Net Federal Services, LLC – VA Repricing Program

Effective August 3, 2012 Health Net has been notified that the VA Repricing Program will no longer be using the contract you have with Health Net for the VA Repricing Program. Existing provider contracts with Health Net, including the VA Program Attachment, will remain and have not been terminated. Health Net will release additional information on their website as it becomes available. Visit www.hnfs.com for more information.

In incident-to-guiding

Cigna requires services meet incident-to-guidelines when performed by a qualified non-physician practitioner (NPP).

Requirements for "Incident-to":
- The NPP must be licensed or certified to provide professional health care services in the state where the physician practice is located.
- The services are commonly furnished in a physician’s office.
- The physician must have initially seen the patient.
- There is direct supervision by the physician of NPP, regardless of whether the individual is an employee, leased employee or independent contractor of the physician.
- The physician is an active part in the ongoing care of the patient.
- The physician must be present in the office suite and immediately available to provide assistance.

Incident-to rules apply to Medicare payers specifically. Commercial payers may have their own rules, be sure to know the individual payer rules.

Reminder: This list is not a complete list and will not contain all potential payer guidelines. This list was prepared to assist in the initial understanding of potential payer guidelines. For additional information, please contact the provider’s contracts, regulations, or other payer materials. For additional potential guidance, please see the provider’s website. It is always best to check the specific payer’s site for all information or guidance. For more information to review the specific payer guidelines, regulations and other requirements visit the site that is relevant to the situation in question.
On September 12, 2012, CMS approved the Medicare Region C RAC audits of coding for E&M services in physician offices, specifically for CPT codes 99214 and 99215. The audit will include claims with dates of service after October 2007. The following states are affected: Alabama, Arkansas, Colorado, Florida, Georgia, Louisiana, Mississippi, New Mexico, North Carolina, Oklahoma, Puerto Rico, South Carolina, Tennessee, Texas, Virgin Islands, Virginia, and West Virginia. For more information go to http://www.connolly.com/healthcare/pages/ApprovedIssues.aspx.

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ICD-10 – Tip: The letters I and O are not used in ICD-10 procedure codes to avoid confusion with the numbers 1 (one) and 0 (zero), respectively.

NUMBER OF RAC AUDITS INCREASED IN 2012

According to a recent American Hospital Association (AHA) survey, the number of RAC-related denials in the second quarter of 2012 was up 24 percent and the number of medical records requests was up 22 percent compared to the first quarter of 2012.

The total aggregated dollar amount averaged $224.8 million per the four geographical regions the AHA tracked during the second quarter. This is more than double as compared to $185.2 million during the first quarter and $110.9 million during the fourth quarter of 2011.

The AHA suggests that providers track requests for records, coding and documentation along with performing self-audits to help mitigate RAC activity.

For the complete article, go to: www.AHAnews.com

Disclaimer: This article was prepared as a service and is not intended to grant rights or impose obligations. This article may contain references to links to other policy materials. The information provided was intended to be a general summary. It is not intended to take the place of either the written law or regulations. Readers are urged to review the specific statutes, regulations and other important materials for a full and accurate statement of their contents.