Coding for Ancillary Services and Providers

Joanne Mehmert, CPC
Joanne Mehmert & Associates, LLC
816-436-4271
fmeh@aol.com

Today’s Discussion Points

- Billing/payment for supplies
- New and revised HCPCS codes
- Radiological procedures
- New EMG & stimulation codes for chemodenervation
- Incident To billing
- Coding/billing for drugs
Office or Clinic Payment

- Professional payments – POS 11
- Medicare and a number of commercial payers pay a higher rate for procedures performed in a physician owned office or clinic. This is called a “site of service” differential (SOS)

2006 HCPCS Changes

- Moved and Added: Spinal code stimulator implants have been moved from the DME “E” section to the Orthotics/Prosthetic “L” section in the Healthcare Common Procedure Coding System (HCPCS) Level II Manual- New and revised codes- see table included in this material
  - Effective 1/1/06
- Low Osmolar Contrast codes A4644-A4646 expired 12/31/05
  - Replaced by a series of Q codes – See table included in this material
2006 HCPCS (cont.)

- Deleted: 12/31/05 A4656 Needle, any size each
  - See A4215 Needles only, sterile, any size, each

- Added: Ziconotide (Prialt) J2278 per 1 microgram
  - Intrathecal only
  - Used in implantable pumps – non-narcotic
  - Effective date 1/1/06
  - S0118 per 1mcg (eff. 7/1/05 expired 12/31/05) Not a valid Medicare code
  - C9226 per 5 mcg – (eff: 10/05 expired 12/31/05)
  - Pass through for hospital outpatient only

LOCM Medicare Payment Table

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
<th>Dosage</th>
<th>Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q9945</td>
<td>LOCM&lt;=149mg/ml iodine 1 ml - Report contrast per ml</td>
<td>1ML</td>
<td>$0.24</td>
</tr>
<tr>
<td>Q9946</td>
<td>LOCM 150-199mg/ml</td>
<td>1ML</td>
<td>$1.79</td>
</tr>
<tr>
<td>Q9947</td>
<td>LOCM 200-249mg/ml</td>
<td>1ML</td>
<td>$1.30</td>
</tr>
<tr>
<td>Q9948</td>
<td>LOCM 250-299mg/ml</td>
<td>1ML</td>
<td>$0.30</td>
</tr>
<tr>
<td>Q9949</td>
<td>LOCM 300-349mg/ml</td>
<td>1ML</td>
<td>$0.34</td>
</tr>
<tr>
<td>Q9950</td>
<td>LOCM 350-399mg/ml</td>
<td>1ML</td>
<td>$0.23</td>
</tr>
<tr>
<td>2005 Code</td>
<td>2006 Code</td>
<td>HCPCS Descriptor</td>
<td></td>
</tr>
<tr>
<td>-----------</td>
<td>-----------</td>
<td>------------------</td>
<td></td>
</tr>
<tr>
<td>E0752</td>
<td>L8680</td>
<td>Implantable neurostimulator electrode, each</td>
<td></td>
</tr>
<tr>
<td>E0754</td>
<td>L8681</td>
<td>Patient programmer (ext) w/implantable neurostimulator RF receiver</td>
<td></td>
</tr>
<tr>
<td>E0757</td>
<td>L8682</td>
<td>Implantable neurostim. RF receiver</td>
<td></td>
</tr>
<tr>
<td>E0758</td>
<td>L8683</td>
<td>RF transmitter (ext) use w/implantable neurostimulator RF receiver</td>
<td></td>
</tr>
<tr>
<td>See E0756</td>
<td>L8685</td>
<td>Implantable neurostimulator pulse generator, single array, rechargeable, includes extension</td>
<td></td>
</tr>
<tr>
<td>See E0756</td>
<td>L8686</td>
<td>Implantable neurostimulator pulse generator, dual array, <em>non rechargeable</em>, includes extension</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2005 Code</th>
<th>2006 Code</th>
<th>HCPCS Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>See 0756</td>
<td>L8687</td>
<td>Implantable neurostimulator pulse generator, dual array, rechargeable, includes extension</td>
</tr>
<tr>
<td>See 0756</td>
<td>L8688</td>
<td>Implantable neurostimulator pulse generator, dual array, <em>non rechargeable</em>, includes extension</td>
</tr>
<tr>
<td>See 0756</td>
<td>L8689</td>
<td>External recharging system for implanted neurostimulator, replacement only</td>
</tr>
</tbody>
</table>
Physician’s Office or Clinic

- To qualify as an “office” – place of service (POS) 11, the physician/group must bear all of the operating expenses including but not limited to:
  - Rent and utilities
  - Supplies
  - Administrative and clinical staff

Medicare Payment - Supplies

- Medicare does not allow additional payment for any of the supplies used to perform the usual interventional procedures such as epidural injections, nerve blocks and/or radiofrequency procedures
- Supplies bundled into payment for the procedure include but are not limited to:
  - Surgical trays, needles, syringes, catheters, equipment used for procedure, gloves and dressings
  - Refill kit for intrathecal pump refills
Non-Medicare Payers

- Commercial payers that have a SOS differential usually bundle supplies;
- No specific standard seems to exist among commercial payers;
- Commercial payers may bundle some supplies and pay for others. Example:
  - Needles and syringes used for injections may be bundled; however a commercial payer may pay separately for some items such as the refill kit used for the implantable infusion pump (A4220).

Non-Medicare (cont.)

- Contracted fee schedules and payer policies should be carefully reviewed to determine whether supplies are included in the professional payment;
- It may be possible to carve out selected equipment such as needles used for Radiofrequency procedures or when procedures such as Nucleoplasty or IDET are covered, the disposable portion of the equipment.
Worker’s Compensation

- Worker’s Compensation Service Center is a web site from which you can access your state guidelines and/or department contact information
  
  www.workerscompensation.com

- A number of W/C payers allow additional payment for a supply tray
  
  - Create your own tray for procedures such as a trigger point injection when you do not use a purchased tray

Radiological Guidance
Office vs Facility

- CMS pays the global fee which includes both the technical (TC) and professional (26) component when the physician performs the procedure in place of service 11 (office) where h/she owns/leases the equipment and bears all of the expense;
  - Report radiology codes **without a modifier**, i.e. 76005
- When a procedure is performed in a facility, outpatient hospital (22) or an ASC (24), the facility payment includes the technical component
  - Report with a -26 modifier, i.e., 76005-26

Fluoroscopy Codes

- **CPT 76005** Needle placement for:
  - 27096 SI joint injection
  - 62273 Epidural Blood Patch
  - 62280-62282 Injection neurolytic substance
  - 62310-62319 Epidural injections and catheter placement
  - 64470-64475 Facet injections
  - 64479-64484 Transforaminal epidural
  - 64622-64627 Radiofrequency procedures facet nerves
Fluoroscopy Codes

- Code **76003**, Fluoroscopic guidance for needle placement for all other nerve blocks and injections:
  - 62287
  - 64400-64450
  - 64505-64530
  - 64600-64614
  - 64630-64640

Other Means of Radiological Guidance

- Magnetic resonance guidance (MRI) or computed tomography (CT) guidance may be used for needle placement
  - **Code 76360** CT
  - **Code 76393** MRI

- MRI and CT equipment are not commonly found in the office of a small group practice that specializes in chronic pain
Supervision and Interpretation

- Supervision and interpretation codes (S&I) are reported when the physician performs a radiological study for diagnostic purposes.

- A copy of the film and the report should be in the patient’s chart for future reference.

- The use of fluoroscopy is included in the S&I codes. Codes 76000, 76003, and 76005 should not be separately reported.

Guidance for Other Disc Procedures

- IDET - 0062T and 0063T
  - Codes include fluoroscopic guidance – do not report separately.
  - MRI (76393) and CT (76360) are not inclusive and may be separately billed.
  - Nucleoplasty -62287 per CPT or (64999 See carrier policies) – Nucleoplasty
    - 76004 – Fluoroscopic guidance.
Epidurogram

Code 72275:
An epidurogram report evaluates the epidural space around the target nerve roots or spinal nerves. Visualization of free flow or lack of flow of contrast in the epidural space assists in identifying focal scarring, areas of moderately severe narrowing and/or swelling in the diameter or other parts of the nerve/nerve root; may also describe shape and size of target nerves. CPT requires that images be documented.

Discography

- Report each disc injected (62290 or 62291) and each film interpretation (72285 [cervical] or 72295 [lumbar]) separately.
- No modifier required for injection 1st disc; append –51 to codes 62290 or 62291 for each additional disc injected.
- No modifier required for interpretation film #1; append 59 modifier to 72285 or 72295 for additional films (CPT Assistant November 1999).
Discography

A discography report is a diagnostic report that will describe disc appearance, such as annular tears, scarring, disc bulges and changes in the nucleus of the disc. The report will also describe the patient’s pain responses and volume injected.

Hard copies of the films will be in the patient’s record.

Discography (cont.)

*CPT Assistant Q&A, April 2003:*

“Also, code 72295, *Discography, lumbar, radiological supervision and interpretation*, may be reported four times for the radiological supervision and interpretation as this code can be reported for each lumbar level.

If the physician performed only the professional component of the diskography, then modifier -26 *Professional component*, should be appended to code 72295 to indicate this circumstance.”
SI Joint Arthrography

- **Code 73542** - Radiological examination, SI joint arthrography, supervision and interpretation

- This is distinguished from guidance for needle placement
  - Documentation should include the reason that the diagnostic study is being performed
  - Results of the study are documented and the treatment plan will be based on the results

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Example of Arthrography Report

<table>
<thead>
<tr>
<th>Normal</th>
<th>The joint structures are in the correct position and appear normal in size and shape</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abnormal</td>
<td>The cartilage inside the joint appears damaged or torn; the sac surrounding the joint (joint capsule is enlarged or leaking; An abnormal growth or cyst is present</td>
</tr>
</tbody>
</table>
Radiological Guidance for Kyphoplasty- Vertebroplasty

Radiology (cont)

- 76012 – Radiological supervision and interpretation, percutaneous vertebroplasty or vertebral augmentation (*Kyphoplasty*) including cavity creation, per vertebral body; under fluoroscopic guidance
  - 76013 Under CT guidance
- Report guidance for each vertebral body for which vertebroplasty or kyphoplasty is performed
Needle Guidance for Chemodenervation – New 2006

- Established to report needle EMG guidance with chemodenervation. It is sometimes necessary to perform a precise localization for needle placement before injecting the chemical (commonly Botox A or B (Myobloc)) (CPT bundles 95873 & 95874)
  - 95873 – Electrical stimulation for guidance in conjunction with chemodenervation
  - 95874 – Needle electromyography for guidance in conjunction with chemodenervation

Total facility & non-fac RVU: Global .77; TC .22; -26 .55

- 95874 – Needle electromyography for guidance in conjunction with chemodenervation

Total facility & non-fac RVU: Global .78; TC: .22; -26 .56

Non-Physician Providers

- Nurse Practitioner (NP)
- Physicians’ Assistants (PA)
- Clinical Nurse Specialists (CNP)- More frequently working in facility setting than physician’s office
Non Physician Practitioners

- Medicare reimburses services permitted under State license;
- Medicare requires NPP-s to take assignment;
- NPP’s may bill “incident to”;
- NPP’s may bill under their own provider number;
- Commercial carriers have varying policies – usually not published, often vague
  - Clarify coverage and billing guidelines with your major payers
  - What happens when the doctor is not in the office?

“Incident To”- Medicare Definition

- An integral, although incidental part of the physician’s professional service
- Commonly rendered without charge or included in the physician’s bill
- Furnished under the physician’s direct personal supervision
- Furnished by the physician or by an individual who qualifies as an employee of the physician
  - Registered Nurse or other qualified employee
  - State Law may require certain services to be provided by R.N.
“Incident To” – Billing Medicare

"Incident to"
- Physician’s name & provider number on bill
- Carrier unable to distinguish provider of service, i.e., Doctor, NP, CNA, PA
- Physician must be in office suite
- Physician must conduct initial exam for the condition
- Physician sees patient periodically as appropriate

Medicare Clarification 2004
- Effective May 24, 2004
  - Changes for billing NPP when the supervising physician is different from the doctor that originated the plan of care
  - The doctor that initiated the treatment plan is listed as the “referring physician”
  - The service is reported using the doctor’s name and PIN that is in the office

CMS Transmittal 148, dated April 23, 2004
Non-Medicare Payers

- Billing rules vary from payer to payer
- Providers should review participating agreements and State Laws
- A number of payers allow equal payment for physicians and physician extenders
- States and/or payers may allow physicians to use their discretion to delegate treatment authority to licensed NPP’s without requiring on premises supervision
- When non-par or payer policy is not known, Medicare rules are best bet

Drugs Used in the Office

- Who should bill for the drugs?
  - Entity that paid…whose name is on the invoice
  - Provider Group……..Practice bills
  - Facility…………..Facility bills
  - “Brown Bagging” – Patient brings drugs purchased at the pharmacy out of pocket or pharmacy bills insurance…………..Provider does not bill
- Samples………..Provider does not bill
Payment Methodology for Drugs

- Medicare
  - Prior to Dec 2003
    - 95% Average Wholesale Price (AWP)
  - 2004 - Medicare Modernization Act (MMA)
    - 85% Average Wholesale Price (AWP) with some exceptions
  - 2005 - MMA
    - Covered drugs reimbursed at 106% Average Sales Price (ASP)

Drugs (Cont.)

- Effective 2006 – MMA: ASP versus CAP
  - Competitive Acquisition Program for certain Part B drugs
  - Drugs used in a typical chronic pain practice may not be included when program begins
    - Questionable advantage to pain as it stands now-future may bring more advantages
  - The goal is to remove financial risk for reimbursement from provider and have a cost benefit for Medicare
  - Current, expected implementation date 7/1/06
Commercial Payment - Drugs

- Commercial
  - Varies with individual payer
  - May be similar to old Medicare – AWP
  - May be similar to new Medicare - ASP
  - May be based on Invoice or “cost + handling”

- Workers’ Compensation
  - Varies per governing entity

How to Code / Bill Compliantly?

- J codes – Drugs administered Other than Oral Method
  - J0000 – J8999
  - HCPCS Level II codes
  - Locating the correct J code from the documentation
    - Index – Generic names
    - Appendix 3 –Table of Drugs – Trade / Brand names
J Code Tips

- Locate correct drug name
- Check for drug concentration for 1 unit of HCPCS code billed
  - J0585 Botulinum type A, *per unit*
  - J0587 Botulinum type B, *per 100 units*
- Calculate number of units to bill
  - List in Box 24G or equivalent electronic field

Charge ticket / Superbill

Good Communication / Continuity of Drug Dosage Listing

- Coding / Billing calculate units billed
  - List as described by HCPCS code amount injected
    - J3302 Aristocort Forte per 5mg, amount injected 40 mg
    - or
  - Provider calculate and list units billed
    - J3302 Aristocort Forte per 5mg, bill 8 units
Drug Mixtures

- Different from compounds
- Combination of two or more “off-the-shelf” medications
- Each medication has its own:
  - NDC #
  - AWP/ASP established
  - J code that compliantly describes drug and strength

Drug Mixtures and/or Compounds

- Calculate J code units accurately
- Dosage set for specific HCPCS Level II codes are based on smaller doses that would be used for a single injection administered in the office, typically not for continuous infusion via a pump
- Check payer preference for coding / billing
  - Many OK to use J codes
  - Some mandate J3490, always ___ for all medications for infusion pumps
- Medicare Carrier policies vary – stay informed of your carrier’s current policy
National Drug Code (NDC)

- Use not mandated by HIPAA
- Some payers prefer this additional information to assist in processing
  - Box 19 CMS 1500 form (58281-562-01)
    - 10 digits
  - 1st segment = Drug Manufacturer / Distributor
  - 2nd segment = Drug Dosage / Strength
  - 3rd segment = Package Size
  - Found on drug label and/or packaging

National Drug Code Directory:

Compounded Medications

- Frequently powdered form of 2 or more drugs blended together and then diluted to prescribed strength/volume
- Most payers require use of J3490 Unclassified drug
  - Include notation in box 19 of CMS 1500 form
  - Some carriers may require copy of invoice showing cost to provider
  - May allow addition of x% for preparation & handling
When your quest for payment starts to get you down, think of these words from Harper Lee:

“True courage is when you know you’re licked before you begin, but you begin anyway.”

Summary of Drug Questions

- Ask and answer these questions when making billing decisions for drugs:
  - Are the drugs an expense to the practice?
  - Did the provider/pharmacist mix or combine two or more pure “off the shelf” drugs?
  - Were drugs compounded to create an individual preparation?
  - Is there a J code that accurately describes the drug(s)?
  - How much was given- what is the dosage described by the J code?
  - Is there a Local Medicare billing policy relative to the drug?
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