Jan 2019 Volume 8 Issue 1

Happy New Year – Are you ready for 2019??

Updates and Issues for 2019

CPT Coding Issues

There are two new codes related to consultations

- 99451 - Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a written report to the patient's treating/requesting physician or other qualified health care professional, 5 minutes or more of medical consultative time
- 99452 - Interprofessional telephone/Internet/electronic health record referral service(s) provided by a treating/requesting physician or other qualified health care professional, 30 minutes

CPT code 99451 would be reported by the CONSULTANT whereas code 99452 is reported by the REQUESTING provider.

Some issues to reporting of these codes:

- The consultation requested may either be a new patient to the consultant or an established patient with a new problem or an exacerbation of an existing problem. However, the consultant should not have seen the patient in a face-to-face encounter within the last 14 days.
- When the consultation leads to a transfer of care or other face-to-face service (eg, a surgery, a hospital visit, or a scheduled office evaluation of the patient) within the next 14 days or next available appointment date of the consultant, these codes are NOT reported.

You will want to read more on these two codes and their guidelines in the CPT manual.

New FNA and biopsy codes and guidelines

Pay close attention to the new biopsy section guidelines and codes. The selection is made based on the type of biopsy and the imaging being used.

New Allograft CPT Codes

20932 - Allograft, includes templating, cutting, placement and internal fixation, when performed; osteoarticular, including articular surface and contiguous bone (List separately in addition to code for primary procedure)

- Do not report 20932 with 20933, 20934, 23200, 24152, 27078, 27090 27091, 27448, 27646, 27647, 27648

20933 - Allograft, includes templating, cutting, placement and internal fixation, when performed; hemicortical intercalary, partial (ie, hemicylindrical) (List separately in addition to code for primary procedure)

- Do not report 20933 with 20932, 20934, 23200, 24152, 27078, 27090 27091, 27448, 27646, 27647, 27648

20934 - Allograft, includes templating, cutting, placement and internal fixation, when performed; intercalary, complete (ie, cylindrical) (List separately in addition to code for primary procedure)

- Do not report 20934 with 20932, 20933, 20955-20957, 20962, 23146, 23156, 23200, 24116, 24126, 24152, 25126, 25136, 27078, 27090, 27091, 27130, 27132, 27134, 27138, 27236, 27244, 27356, 27448, 27638, 27646-27648, 28103, 28107

Make sure to read the subsection guidelines and the requirements needed to report these codes.

Radiological Documentation

CPT has finally placed in the CPT Manual guidelines that they have had in several CPT Assistants regarding the documentation needed to support an 'official interpretation'. And even went a step further. The Section guidelines state:

- "Written Report – With regard to CPT description for imaging services, "images" must contain anatomic information unique to the patient for which the imaging service is provided. "Images" refer to those acquired in either an analog (ie, film) or digital (ie, electronic) manner."

Two new Category III codes

- 0512T – Extracorporeal shock wave for integumentary wound healing, high energy, including topical application and dressing care; initial wound
- 0513T – Extracorporeal shock wave for integumentary wound healing, high energy, including topical application and dressing care; each additional wound (List separately in addition to code for primary procedure)

NCCI Updates 2019

You will notice in **chapter one** of the guidelines they have changed the wording regarding intra-operative biopsies. Prior to Jan 2019 the section read that you could report a biopsy during another procedure IF you were waiting for the results of that biopsy to determine what the next procedure should be. This portion has now been removed and it now reads:

- "5. A biopsy performed at the time of another more extensive procedure (e.g., excision, destruction, removal) is separately reportable under specific circumstances.

- If the biopsy is performed on a separate lesion, it is separately reportable. This situation may be reported with anatomic modifiers or modifier 59.
- The biopsy is not separately reportable if *utilized* for the purpose of assessing margins of resection or verifying resectability.
- If a biopsy is performed and submitted for pathologic evaluation that will be completed after the more extensive procedure is performed, the biopsy is not separately reportable with the more extensive procedure. "

Chapter three added clarification regarding adjacent tissue transfer, rearrangement vs. complex repair.

- 2. *Undermining of adjacent tissue to achieve closure of a wound or defect constitutes complex repair, not tissue transfer and rearrangement. Tissue transfer and rearrangement requires that adjacent tissue be incised and carried over to close a wound or defect.*

Chapter four had many updates relating to spinal procedures and when more than one primary CPT code can be reported in a family of codes. It reads "If multiple procedures from one of these families of codes are performed ***through separate skin incisions*** at multiple vertebral levels that are not contiguous and in different regions of the spine, the physician may report one primary code for each non-contiguous region."

This infers that they are looking for different regions, cervical, thoracic or lumbar AND not contiguous. For example, if you did a posterior thoracic fusion at T3-4 and then a separate posterior fusion with a separate incision for lumber fusion at L4-L5 – you will be able to report both 22610-59 and 22612. Whereas, prior to Jan 1st, 2019, it would have been reported as 22612 and 22614. The example given in chapter four relates to the vertebroplasty/kyphoplasty codes.

Also, in **Chapter four** you will find clarification of the lumbar posterior fusion codes and which add on codes are allowed with which primaries. Here are some examples based on the new wording in chapter four.

If a physician performs arthrodesis across multiple interspaces using the same technique in the same spinal region, the physician shall report a primary code for the first interspace and an add-on code for each additional interspace.

- **Example – Posterior fusion L1-L5 = one primary – 22612; and the rest add on – 22614x3**

- **Example – Posterior fusion C2-C6 = one primary 22600; and the rest add on – 22614x3**

If the interspaces span **two different spinal regions** through **the same skin incision**, the physician shall report a primary code for the first interspace and an add-on code for each additional interspace.

- **Example – Posterior fusion T10-L3 (thoracic and lumbar regions)- Same skin incision – one primary – 22612; the rest add on code 22614x4**
- **Example – Posterior fusion C4-T2 (cervical and thoracic regions) – Same skin incision – one primary – 22600; the rest add on code 22614x4**

If the interspaces span two different spinal regions through different skin incisions, the physician may report a primary code for the first interspace through each skin incision and an add-on code for each additional interspace through the same skin incision.

- **Example – Double fusion at L4/5 and L5/S1 (Lumbar region-separate incision) with posterior fusion at T9-T10 (thoracic region – separate incision) – 22633; 22634 (lumbar region); 22610-59 (thoracic region)**
- **Example – Anterior fusion with discectomy C4-C6 and posterior cervical fusion C5-T3 – Two different spinal regions – two separate incisions – Anterior 22551, 22552; Posterior 22600; 22614x4**
- **Example – Anterior fusion with discectomy C2-C3 (cervical region – separate incision) and T1-T3 anterior fusion – (cervical region- thoracic region – separate incision) C2-C3 = 22551; T1-T3 = 22554; 22585**

If you do spinal procedures, you will want to read through chapter four changes and also have your surgeons read through it.

HCPCS codes

Two new codes 2019:

- J7318 Hyaluronan or derivative, durolane, for intra-articular injection, 1 mg
- J7329 Hyaluronan or derivative, trivisc, for intra-articular injection, 1 mg.

Medicare Physician Fee Schedule 2019 - https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1693-F.html

Hopefully by now you have read through or at least looked at the first 1000+ pages to find out what you need to be aware of regarding changes to the Medicare Physician Fee Schedule.

The biggest issue is your EM documentation and what you can start doing now in 2019 vs. the changes for 2020-2022. As of Jan 1st, 2019, the documentation for the history component has greatly changed. The fee schedule says:

"For CY 2019 and CY 2020, **CMS will continue the current coding and payment structure** for E/M office/outpatient visits and practitioners **should continue to use either the 1995 or 1997 E/M documentation guidelines to document E/M office/outpatient visits billed to Medicare**.

For CY 2019 and beyond, CMS is finalizing the following policies:

- Elimination of the requirement to document the medical necessity of a home visit in lieu of an office visit;
- For established patient office/outpatient visits, when relevant information is already contained in the medical record, practitioners may choose to focus their documentation on what has changed since the last visit, or on pertinent items that have not changed, and need not re-record the defined list of required elements if there is evidence that the practitioner reviewed the previous information and updated it as needed. Practitioners should still review prior data, update as necessary, and indicate in the medical record that they have done so;
- Additionally, we are clarifying that for E/M office/outpatient visits, for new and established patients for visits, practitioners need not re-enter in the medical record information on the patient's chief complaint and history that has already been entered by ancillary staff or the beneficiary. The practitioner may simply indicate in the medical record that he or she reviewed and verified this information; and
- Removal of potentially duplicative requirements for notations in medical records that may have previously been included in the medical records by residents or other members of the medical team for E/M visits furnished by teaching physicians.

This infers that the HPI elements as well as the ROS elements can be obtained by someone other than the billing provider. However, remember that this is what CMS is saying, you will have to check with your private contracted payers to see if they will follow the same changes.

Payment reductions for EMs are not scheduled until 2021. It appears that CMS is delaying this change in hopes that third party payers will also follow suit. If your private payers don't follow CMS, you may then have to develop two different situations of documentation for EM services.

Radiology Assistants

"CMS is revising the physician supervision requirements so that diagnostic tests performed by a Radiologist Assistant (RA) that meets certain requirements, that would otherwise require a personal level of physician supervision as specified in our regulations, **may be furnished under a direct level of physician supervision to the extent permitted by state law and state scope of practice regulations**. This is in response to stakeholder comments that the current requirement of personal supervision that applies to some diagnostic tests is overly restrictive when the test is performed by an RA and does not allow for radiologists to make full use of RAs, and that reducing the required level of supervision will improve efficiency of care." Check your State Scope of Practice for your RAs and how the direct supervision needs to be set up in your group.

Physical Therapy/Occupation Therapy

Yeah as of Jan 1st, 2019, you no longer have to report the functional status HCPCS codes. In the final MFPS released they stated that we will no longer be required to report the functional status codes. CMS was going to delete the codes effective the 1st of Jan, but since some third-party payers were using, they will give a year for those payers to figure out what they will be doing once the codes are deleted.

Also, for PT/OT will now have a new modifier for when PTA/OTAs are providing therapy services to Medicare beneficiaries. The final fee schedule stated:

"The Bipartisan Budget Act of 2018 requires payment for services furnished in whole or in part by a **therapy assistant at 85 percent of the applicable Part B payment amount for the service effective January 1, 2022**. In order to implement this payment reduction, the law **requires us to establish a new modifier by January 1, 2019** and CMS details our plans to accomplish this in the final rule."

They established the new modifiers by 2019 which are - Modifiers CQ = PTA and CO =OTA. Must use starting Jan 1, 2020 and they are considered payment modifiers. Discounted payments won't start until 2022. If you have PTA/OTAs working in your therapy departments and you provide therapy services to Medicare beneficiaries, you will want to read through this section so that your office will be ready for these changes.

Global Surgical Postop days

Remember if you live in any of these 9 states you are required to report the postop data – The states are – Florida, Kentucky, Louisiana, Nevada, New Jersey, North Dakota, Ohio, Oregon and Rhode Island.

Make sure that you access all of the official sources for these changes and get the information to the correct departments/people in your group.

Past and current newsletters can now be obtained at www.margievaught.com scroll to the bottom and click on past newsletters.
The newsletters will now start coming out quarterly and if there is 'breaking' updates that need to come out sooner, then special editions will be sent.

If you have issues or concerns that you would like further input on, please feel free to send emails to info@margievaught.com. If you would like to schedule any audios or live presentations, please feel free to contact me.

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Check out below for upcoming Audios and Live Presentations

Upcoming Audios and Workshops 2019

Jan 11th, 2019 – Florida Bones - 2019 FOS & BSOF Coding & Reimbursement Conference - Orlando - for details - https://www.floridaorthopediccommunity.com/event/2019Coding

Jan 15th, 2019 – Audio **- PT-OT coding and documentation** - Sponsored by audioeducator- https://www.audioeducator.com/orthopedics/physical-therapy-coding-updates.html

Feb 7th, 2019 – Audio- **Spinal Procedures** - Sponsored by audioeducator.com - https://www.audioeducator.com/orthopedics/spinal-coding-updates.html

Feb 21st, 2019 – Alabama BONES – Birmingham, AL - Alabama bones workshop in Birmingham, AL - contact person Bethany Sweatt - BSweatt@orthosportsmail.com

Feb 26th, 2019 – Audio – **Big Spinal Changes for 2019** – Are you Ready - Sponsored by DH - http://www.codingbooks.com/ympda022619

March 12th, 2019 – Audio – **Shoulder Procedures** – sponsored by www.audioeducator.com

March 22nd, 2019 – Wisconsin BONES – Green Bay, WI – Full day of Orthopedic Surgical coding

March 26th, 2019 – Audio – **Imaging documentation and billing for the Orthopedic office** – sponsored by DH at www.codingbooks.com

April 16th, 2019 – Audio – **Ankle-Feet-Toe procedures** – sponsored by www.audioeducator.com

April 23rd, 2019 – Audio – **2019 updated PT/OT coding and documentation issues** – sponsored by DH – www.codingbooks.com

May 3-7th, 2019 – National AAOE conference – Nashville, TN - https://s4.goeshow.com/aaoe/annual/2019/

Oct 6-9th, 2019 – Advanced Orthopedic Symposium 2019 – San Antonio, TX – sponsored by DH – www.codingbooks.com