TIPS FROM OUR CONSULTANT

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Removal of Cerumen - New Coding Option Available in 2016

CPT code 69210, removal impacted cerumen requiring instrumentation, unilateral, is reported when the physician or qualified healthcare provider (QHP), e.g., nurse practitioner, physician assistant, etc., documents the cerumen is clinically impacted and the physician/QHP uses instrumentation (generally under magnification, e.g., otoscope, operating microscopy) to physically remove the cerumen.

Although the description of 69210 includes the term "unilateral," the Centers for Medicare & Medicaid Services (CMS) continues to consider this code as a bilateral service which means it cannot be reported with the bilateral modifier (-50) or using two (2) claim lines with the -RT and -LT modifiers.

Per *CPT Assistant* April 2003, page 9 copyright 2003 American Medical Association (AMA), the physician/QHP must document one of the following considerations to indicate the cerumen was clinically impacted:

- ✓ Visual considerations: Cerumen impairs exam of clinically significant portions of the external auditory canal, tympanic membrane, or middle ear condition.
- ✓ Qualitative considerations: Extremely hard, dry, irritated cerumen causing symptoms such as pain, itching, hearing loss, etc.
- ✓ Inflammatory considerations: Associated with foul odor, infection, or dermatitis.
- ✓ Quantitative considerations: Obstructive, copious cerumen that cannot be removed without magnification and multiple instrumentations requiring physician skills.

Prior to January 1, 2016, physicians/QHPs were instructed to report evaluation and management (E/M) codes when cerumen was not impacted or when the removal did not require instrumentation (e.g., for irrigation only). For 2016, if the cerumen is not clinically impacted, physicians/QHPs will continue to report E/M codes for cerumen removal.

Effective with dates of service on or after January 1, 2016, when impacted cerumen is removed by irrigation, physicians/QHPs should report *CPT* code 69209, removal impacted cerumen using irrigation/lavage, unilateral. Inconsistent with 69210, when the irrigation is performed bilaterally to remove impacted cerumen in each ear, CMS instructs physicians/QHPs to report the service using the -50 modifier. Payment is made at 150 percent of fee schedule.

Observation Care Management Services

In the WPS GHA Medicare eNews dated December 21, 2015, physicians were notified of a change in the WPS-GHA E/M training on observation services. According to the article, in Chapter 12, §30.6.8 of the CMS *Medicare Claims Processing Manual*, initial observation care can be paid **on the date the patient's observation care service began**.

This section goes on to state that the observation discharge management can be paid for the last date of the observation stay. Services provided on any other day by the admitting physician would be submitted using the subsequent observation day procedure codes.

Services performed by physicians/QHPs who are not the admitting physician/QHP must be reported using the Office and Other Outpatient Codes 99201-99215 to bill their visits to patients in observation.

For example, a physician ordered observation care late on Monday but did not see the patient that day. He first saw the patient in observation on Tuesday. The patient was discharged on Wednesday.

In the above example, the physician does not have a service for Monday since he/she did not see the patient on that date of service. Since the physician did not evaluate the patient on Monday, the admitting physician is precluded from reporting one of the *CPT* codes for initial observation care.

The physician can report a medically necessary, appropriately documented subsequent observation care code for the service on Tuesday. The physician can bill a medically necessary, appropriately documented discharge service for Wednesday.

For more information, WPS GHA recommends physicians refer to its Observation Care Q&As available at http://www.wpsmedicare.com/j8macpartb/resources/provider_types/2009_0720_emobservation.shtml

Allergy Injections and "Incident To" Billing to Medicare

The following information was published in the WPS GHA Medicare eNews dated January 18, 2016:

Our nurse provides the allergy injections to our patient. Can we bill under our physician's provider number even though he/she is not treating the allergy?

The CMS MLN Matters article *Special Edition (SE) 0441* available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/se0441.pdf discusses this type of situation. One of the requirements on the incident to billing is that the billing physician is the one treating the patient for that condition or situation.

- ✓ If your physician is treating the patient for the allergy (not just providing the injections), then this could meet the incident to requirements.
- ✓ If your physician is not treating the patient for the allergy, then this does not meet the incident to requirements and therefore, your physician cannot bill for the administration of the injection. You would want to notify your patient of non-coverage.

The above scenario was discussed during a recent meeting of the WPS Provider Outreach and Education Advisory Group (POE-AG) meeting. WPS representatives made it very clear that since the allergist is considered the treating physician in this scenario, the following "incident to" requirements are not met when the injections are administered in another physician's office, e.g., family physician.

To qualify as "incident to," services must be part of your patient's normal course of treatment, during which a physician personally performed an initial service and remains actively involved in the course of treatment. You do not have to be physically present in the patient's treatment room while these services are provided, but you must provide direct supervision, that is, you must be present in the office suite to render assistance, if necessary. The patient record should document the essential requirements for incident to service.

WPS GHA Issues Local Coverage Decision Covering Allergy Immunotherapy (L36408)

Local Coverage Decision (LCD) for Allergy Immunotherapy is effective with dates of service on or after 03/18/2016 and is available at https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=36408 The following excerpts have been taken from the LCD:

The medical record must document the elements of the medical and immunologic history including but not limited to correlation of symptoms; occurrence of symptoms; exposure profile; documentation of allergic sensitization by accepted means and where attempts at avoidance have proven unsuccessful (or the impracticality of avoidance exists); and a copy of the sensitivity results; along with the physical examination. Testing results and treatment need to justify the diagnosis and code on each claim form. The clinical condition that is claimed to justify this treatment must be clearly documented in the record.

Note: A payable diagnosis alone does not support medical necessity of ANY service. The interpretation of the test results and how the results of the test was used in the patient's plan of care for treatment and the management of the patient's medical condition (s) must be documented. The treating physician must clearly document the medical necessity to initiate allergen immunotherapy and the continued need thereof. This plan of care needs to include the dosage regimen.

Progress notes that document physician management during the course of the allergic disease, anticipated length of treatment, and explanation of any deviations from normal treatment frequency should be included. The record should be prepared so that the data regarding injection and responses can be appreciated in a logical and sequential sense.

WPS representatives indicated that for another physician to be considered a treating physician, the physician must review the allergist's recommendations, evaluate the patient, and document the medical necessity for immunotherapy as well as the schedule and dosing.

Antigens must be administered in accordance with the plan of treatment and by a doctor of medicine or osteopathy or by a properly instructed person (who could be the patient) under the supervision of the doctor. Supervision must be direct which does not mean that the physician must be in the same room when the staff person administrates the antigens. The physician must be present in the office suite and immediately available to provide direction and assistance through the time the staff person is performing the service. The supervising physician should be documented in the medical record.

In addition to providing indications and documentation requirements, the LCD includes the following statement:

According to 42 CFR 410.68 – antigens: scope and condition, (b)(2)(ii), antigens can be administered by a doctor of medicine or osteopathy or by a properly instructed person under the supervision of a doctor of medicine or osteopathy. Therefore, a non-physician practitioner (NPP) cannot provide the direct supervision.

Drug Screening Laboratory Tests - CERT Denials

The following information was published in the WPS GHA Medicare eNews dated 02/15/2016:

Recent claim reviews performed by the Comprehensive Error Rate Testing (CERT) contractor have noted significant error findings for qualitative drug tests and quantitation of drugs screened (therapeutic drug assays and certain chemistry tests). In most cases, the independent laboratories that performed and billed the services did not submit sufficient documentation to support the medical necessity of the tests in accordance with Medicare regulations.

Documentation reminders:

- ✓ Medicare requires a signed treating physician order or authenticated progress note identifying all tests to be performed (i.e. simply stating "urine drug screen" is not acceptable)
- ✓ An unsigned requisition does not support physician intent and will not be considered in a Medicare claim review
- ✓ Progress notes to support the medically necessity for ordering each test must be maintained in the patient's medical record and submitted upon request for a Medicare claim review

If you find documentation issues exist with your referring providers, we recommend educating these practitioners about these CERT review findings and applicable Medicare regulations. For more information, refer to §80.6.1 - Requirements for Ordering and Following Orders for Diagnostic Tests in Chapter 15 of the Medicare Benefits Policy Manual. You can also find additional information in the CMS publication "Complying with Documentation Requirements for Laboratory Services," ICN 909221, available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ProviderComplianceLabServices-Fact-Sheet-ICN909221.pdf

Screening for Colorectal Cancer Using Cologuard™ - A Multitarget Stool DNA Test

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9115.pdf

2016 Coding Change

G0464, Colorectal cancer screening; stool-based DNA and fecal occult hemoglobin (for example, KRAS, NDRG4 and BMP3) was used to report Cologuard tests for dates of service from October 9, 2014, through December 31, 2015.

Effective with dates of service on and after January 1, 2016, *CPT* code 81528 replaces G0464.

Coverage

Effective for dates of service on or after October 9, 2014, Medicare Part B will cover the Cologuard™ test once every three (3) years for Medicare beneficiaries that meet all of the following criteria:

- ✓ Age 50 to 85 years;
- ✓ Asymptomatic (no signs or symptoms of colorectal disease including but not limited to lower gastrointestinal pain, blood in stool, positive guaiac fecal occult blood test or fecal immunochemical test); and
- ✓ At average risk of developing colorectal cancer (no personal history of adenomatous polyps, colorectal cancer, or inflammatory bowel disease, including Crohn's Disease and ulcerative colitis; no family history of colorectal cancers or adenomatous polyps, familial adenomatous polyposis, or hereditary nonpolyposis colorectal cancer).

ICD-10 Next Steps Toolkit

CMS released the "*ICD-10* Next Steps Toolkit" available at https://www.cms.gov/Medicare/Coding/ICD10/Downloads/ICD10NextStepsToolkit20160226.pdf to help physicians/QHPs track and improve *ICD-10* progress with information and resources on how to:

- ✓ Assess *ICD-10* progress using key performance indicators to identify potential productivity or cash flow issues
- ✓ Address opportunities for improvement
- ✓ Maintain progress and keep up-to-date on *ICD-10*

Visit the *ICD-10* websites https://www.cms.gov/Medicare/Coding/ICD10/index.html?redirect=/ICD10 and http://www.roadto10.org/ for the latest news and official resources, including the *ICD-10* Quick Start Guide, and a contact list for provider Medicare and Medicaid questions.

***ICD-10* - Regular Coding Updates to Begin 10/01/2016**

The *ICD* Coordination and Maintenance Committee implemented a partial freeze of the *ICD-10* codes prior to the implementation of *ICD-10*. On October 1, 2016, regular updates to *ICD-10* will begin.

Tips to Avoid Improper Payment(s) Due to Insufficient Documentation

According to the CMS Medicare Fee-For-Service (MFFS) 2014 Improper Payments Report, the most common cause of improper payments (accounting for 60.1 percent of total improper payments) was lack of documentation to support the services or supplies billed to Medicare.

Claims are determined to have insufficient documentation errors when the medical documentation submitted is inadequate to support payment for the services billed (that is, the reviewer could not conclude that some of the allowed services were actually provided, were provided at the level billed, and/or were medically necessary). Claims are also placed into this category when a specific documentation element that is required as a condition of payment is missing, such as a physician signature on an order, or a form that is required to be completed in its entirety.

The national improper payment rate attributed for insufficient documentation increased from 6.1% reported for the 2013 report period to 8.2% for the 2014 report period. Insufficient documentation accounted for the greatest proportion of improper payments, projected at $29.49 billion, for claims reviewed for the 2014 report period. The 2014 report, available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/Downloads/MedicareFeeforService2014ImproperPaymentsReport.pdf, includes tables that

illustrate the projected improper payments (dollars in billions) by type of error and clinical setting, the top 10 states with projected improper payments, improper payment rates and amounts by state, and other information.

CMS and its contractors have established corrective actions to target insufficient documentation and providers and staff should also consider doing so. In addition to documenting completely and appropriately, here are some tips that providers and staff may consider:

- Make sure that both sides of double sided documents are submitted
- Ensure the documentation has legible signatures and dates
- Ensure the correct CPT/HCPCS code is used
- Ensure dates are correct and consistent with the documentation
- Ensure the provider on the documentation is consistent with the provider on the claim
- Ensure that the physician orders include an actual order or the progress note that supports the intent that the service(s) be performed as this documentation is used by the review entity to determine medical necessity
- When referring to a previous encounter in the patient's chart, include and send that documentation also
- Include test results and lab results, if applicable
- Make certain the copy sent to the review contractor is legible; consider using a signature log
- Make certain to read the entire request for records to determine that all needed information is being sent
- For other than orders, consider sending an attestation statement when the records are not signed by the author of the medical record entry
- Include a list of acronyms if using uncommon acronyms
- Number the pages before making a copy, so it will be easy to see if one of the pages are missing
- When responding to requests for documentation, become familiar with Local Coverage Determinations or CMS Internet-Only Manual instructions that may govern the service(s) in order to return all required documentation to the requestor
- Consider establishing a point person (i.e., a Manager or Administrator) who is responsible for oversight of the collection, review, and return of records and communicate within the organization the responsibilities of this individual
  - This individual will log, document, and ensure proper processing to adhere to timeliness standards
- Use a checklist to ensure that all of the essential pieces are included in the record (the Additional Documentation Request (ADR) letter from Medicare will list the items that are necessary)
- Recognize that a rendering physician may need to obtain documentation from the ordering physician in order to send needed documentation to a CMS review entity
  - If necessary, check with the review entity as to how to document refusal of the ordering provider to provide the documentation
- Remember, it is the billing provider's responsibility to obtain the necessary information required for the record review, regardless of the location of the documentation
- Establish a line of communication between all office staff in order to determine expectations/responsibilities for timely provision of records
- Ensure complete and timely entry of documentation into the medical record
- Be aware of documentation maintenance requirements
  - CMS has published Medicare Learning Network Matters Number MM9112 that describes this. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM9112.pdf
- For CMS Secure Net Access Portal (C-SNAP) users, review information available on C-SNAP to determine records previously sent and only send additional documentation