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IMBS, Inc.

# Billing Bits

## AMA Working to Stop ICD-10 Implementation

The American Medical Association (AMA) has decided to make every effort to stop the implementation of the new code set, ICD-10, which is due to take effect on October 1, 2013.

According to the AMA president, Peter W. Carmel, MD, the implementation will create considerable time and financial burdens on practices with no direct benefit to individual patient care. He said in a statement, "At a time when we are working to get the best value possible for our healthcare dollar, this massive and expensive undertaking will add administrative expense and create unnecessary workflow disruptions".

One reason the AMA is working so hard to stop, or at least delay this change is because it is coming at a time when physicians are already working so hard to implement their Electronic Health Records (EHR). This will only add to their operational and financial frustrations.

Physicians are under a lot of pressure to meet Medicare's timeline of adopting an EHR by 2015, so they are not financially penalized.


Another concern is that payers will use this new coding system to require documentation of minor subcategories to determine payment, This will result in delays in payment, or no payment at all, for many claims.

A study done by the MGMA in 2008 indicated that it would cost a typical 10-doctor practice about $285,000 to convert to ICD-10. The software costs are a minimal percentage of that figure, The biggest costs would be from an increase in claims queries, reductions in cash flow, and increased documentation time.

The AMA board of trustees chairman, Robert Way, MD, states, "We don't understand how adding a five-fold increase in codes, going from 13,000 codes to 68,000 codes, is going to help a patient in my office". He points out that many of the codes have nothing to do with diagnosing patients. One of his examples is a code that would specify whether a patient received a head injury from a baseball bat or a hockey stick.

Way and the AMA are hoping that the Centers for Medicare and Medicaid Services will at least be open to talking about delaying the ICD-10 implementation and reducing the number of codes in the set.

**Meaningful Use Guide**

https://www.cms.gov/EHRIncentive programs/Downloads/Beginners_guide.pdf

The centers for Medicare and Medicaid services released a tool to help guide physicians and other eligible professionals through all phases of the Medicare EHR incentive payment program. It includes chapters on program basics, eligibility, and registration and provides a description of all stage 1 meaningful use criteria. It also advises practitioners on how to choose the optional measures they will use as part of attestation phase of the Program.

# 2012 Evaluation & Management Updates

Evaluation and Management (E/M) guidelines have been updated in the 2012 CPT book, to clarify the meaning of "new" vs. "established" patients, as has the code use in several categories.

**Three-year rule applies to Same Group, Same Subspecialty**

The CPT now states, "A new patient is one who has not received any professional services from the physician or another physician of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years." This statement is not very different than the "three-year rule" used currently, However, it allows a physician to bill new patient services if the patient has been seen in their group, but not with the specific specialty. The E/M Services Guidelines also states, "Solely for the purpose of distinguishing between new and established patients, processional services are those face to face services rendered by a physician and reported by a specific CPT code(s)." Even if the physician interpreted test results for the patient earlier, but had no face-to-face services with the patient, the patient would still be considered new.

Life is not merely to be alive, but to be well.

~Marcus Valerius Martial

**Initial Observation Care can be Time Based**

For 2012, reference times have now been added to initial observation care codes.

| CPT | New Description added to Code |
|---|---|
| 99218 | Physician typically spend 30 minutes at the bedside and on the patient's hospital floor or unit |
| 99219 | Physician typically spend 50 minutes at the bedside and on the patient's hospital floor or unit |
| 99220 | Physician typically spend 70 minutes at the bedside and on the patient's hospital floor or unit |

Time associated to the service must be face-to-face with patient and/or decision makers, or may include unit/floor time in the hospital or nursing facility. The addition of time reference to these codes also permits the use of prolonged services codes in addition to the initial observation care.

**Revamped Prolonged Services**

CPT 2012 added important new text indicating correct use of prolonged services codes 99354-99357. Direct patient contact is defined as "face-to-face", but "additional non face-to-face services on the patient's floor or unit of the hospital or nursing facility during the same session" counts as well. All codes report the total time duration of care, and are add-ons to other E/M services that include reference times.

## 2012 Updates Continued

The term "face-to-face" has been omitted from the code descriptors to allow unit/floor time to count in the inpatient setting; and the codes no longer apply specifically to physicians, but to physicians and other qualified health care professionals.

More Services are included in Neonatal/Pediatric Critical Care

CPT 2012 includes some new language in the guidelines directing use of inpatient neonatal and pediatric critical care (99468-99472) intensive services (99475-99476) codes , and for initial and continuing intensive care services (99477).

This year, car seat evaluation (reported with new codes 94780-94781) has been added to the list of procedures bundled with critical care.

New instructions have also been added to clarify billing when a critically ill neonate or pediatric patient is transferred to lower-level care. CPT® specifies "the transferring physician does not report a per day critical care service." Instead, either 99231-99233 (subsequent hospital care) or 99291-99293 (critical care) is reported. The receiving physician reports "subsequent intensive care (99478-99480) or subsequent hospital care (99231-99233), as appropriate based upon the condition of the neonate or child."

**The greatest wealth is health.**

**~Virgil**

Similarly, when a neonate is transferred from intensive care (99477) to a lower-level care, the transferring physician should report subsequent hospital care (99231-99233). If the neonate or infant must be transferred to critical care on a day when initial or subsequent intensive care services have been performed, the transferring physician may report either the critical care (99291-99292) or the intensive care (99477), but not both. The receiving physician may report subsequent inpatient neonatal or pediatric critical care (99469 or 99472).

## Patient Statements: Something to Think About

Take a look at the statements going out to patients in your practice. Chances are they have 30, 60, 90 and 120 days past due columns on them. It has been suggested that showing those columns on the patient statements lets them know how long you are willing to carry their balance. Some patients will assume that the payment is not really late until it gets into that 120 days past due column, so until then, they ignore the bill.

Think about other bills they might receive throughout the month. Their cable bill doesn't give them a breakdown of their outstanding balance. These types of statements expect payment in full, immediately, or there would be consequences. They get the bill; it says to pay right now, so they pay it.

If your Practice changed the way the statements went out, it might change the way your patients view their bills. Think about omitting the outstanding balance columns and just have a "Balance Due". Or, have a "Balance Due" for the current balance and an "Outstanding Balance" for any past due amount so they know their payment is late. These small changes could have a considerable effect on your bottom line.

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