

CODING FOR THE OFFICE AND SUPPLIES

Billing as Office

To qualify as an office, the space must be rented or leased at a fair market value, there must be a written agreement for the rental or lease and the agreement must be for at least one year in duration. The staff must be an expense to the practice and can be either employed or leased. If hospital space is rented or leased for an office, this space must be separate and distinct space, not included in the hospital's cost-reporting space. All costs associated with providing a procedure in this space to include the equipment, staff, drugs and supplies must be incurred by the provider to bill as an office based procedure.

Site of Service Differential

The relative value differential was created by CMS to assist physicians providing services in an office with additional funds to cover some overhead of practice expense. When the above conditions are met, the correct place of service for billing purposes is 11- Office. Recognize that some practices may have more than one places of service. For instance, a practice that leases space from a hospital and employs staff solely for Evaluation and Management Services would bill those services as place of service 11- Office. Their procedures may still be performed in the hospital or an Ambulatory Surgery Center where the costs for providing those services is consumed by the other party. In this case, the procedures performed with someone else's equipment, supplies and staff would be then be billed with the place of service 22- Outpatient Hospital or 24- Ambulatory Surgery Center.

Office Based Surgery

Many State Departments of Health have regulations regarding what procedures they consider to be safe and appropriate to be performed in a physician's office. Typically, these regulations have to do with performing procedures that carry a high infection risk and/or with the use of certain levels of anesthesia. This gives the individual State Department of Health jurisdiction over what they allow in their State. The States that have currently adopted standards for office based procedures with certain levels of anesthesia are as follows:

Connecticut, Pennsylvania, Rhode Island, California, Florida, Texas, New Jersey, Arizona, Ohio, Colorado, Washington DC, New York, Oklahoma, South Carolina and Oregon. The regulations vary from the requirement that the office is State Licensed, State Registered and/or Office Based Accredited. State specific summaries on jurisdiction can be found on the Accreditation Association of Health Care website (www.AAAHC.org)

Accreditation For Office Based Practices

The value of accreditation has become a benchmark of quality not only to those involved in health care delivery and management, but to the general public and is a measure of professional achievement and quality of care. In office based settings, even in States that do not require accreditation, this status may prove to expedite third-party payment and favorably influence managed care contract decisions. Accreditation may also favorably influence liability insurance premiums.

Rules for office accreditation include: no more than four surgeons and two operating suites and have been in business for at least six months prior to the accreditation survey. Note: early option is available to satisfy State requirements. The practice must also be a formally organized, legal entity in compliance with applicable federal, state and local regulations and provide medical care under the direction or supervision of a single physician or a group of physicians, dentists, or podiatrists accepting responsibility.

Accreditation is available through American Association of Ambulatory HealthCare (AAHC), The Joint Commission (JCAHO) and American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF). For office based practices they will differ in survey style, but use common guidelines aimed to ensure a high quality of care for patients.

The Accreditation Process

The process begins with an application and pre-survey questionnaire. A manual which describes the Accreditation standards for office based surgery can be purchased and should be used as a self-assessment tool. The manual includes topics for policies and procedures, emergency equipment, appropriate staffing, evaluation of quality and risk management. An on-site survey is then conducted by survey team experienced in both the clinical and administrative aspects of ambulatory health care. Following survey the team makes an accreditation recommendation which is then reviewed by the Accreditation Committee, who makes the final decision. Accreditation may be awarded for six months, one year, or three years. The accreditation decision could be deferred or denied as well.

Procedure Billing in the Office

When billing for procedures done in the office setting, it is important to understand the payment rules of different payors. In fact, it is a given that only Medicare recognizes the site of service rule; commercial payors' that allow a higher payment for office services vary by region. Step one in this process is to ascertain the fee schedule for all the practice's payors. If the payor does not recognize a site of service differential, negotiations should include some form of added reimbursement for procedures performed in the office. In addition to payment for the procedure, whether it has a site of service "enhancement" or not, ensure that payment will be made for both the professional and technical components (global) on the use of the C' arm for needle localization under fluoroscopic guidance or for the provision of supervision and interpretation study as applicable. Medicare and other payors will reimburse for this global as well as injected drugs. Although Medicare considers payment for the procedure inclusive of supplies, other payors may pay a supply or tray fee for office based procedures.

With Commercial and Workers Compensation payors, it is important to recognize that some office based practices may be able to negotiate a global fee to include the professional fee and all incidentals for the use of the procedure room. Bear in mind, however, that this is not a facility fee. Local and state law as well as third party payor policies including, Commercial and Workers Compensation, typically require the facility to be licensed and Certified in order for facility fees to be paid. Although there is no law prohibiting a practice from billing facility fees (Medicare excepted), prosecutors could use the mail fraud or wire fraud statutes to allege a general "scheme to defraud" and allege that the MD billed as if he were a facility when the industry standard is that a facility must be licensed as such.

Many Workers Compensation plans publish their fee schedule and billing rules on the internet.
<http://www.comp.state.nc.us/ncic/pages/all50.htm>

The following are some important items to clarify with the payors because they often impact reimbursement significantly:

I. Fee Schedule

- Medicare regulations do not bar providers from sometimes collecting payment rates lower than Medicare rates. The regulations from OIG do however, bar providers from charging Medicare rates that are substantially in excess of the provider's usual charges. It may be appropriate to accept less than Medicare rates if you have other contracts that reimburse you at rates equal to or greater than Medicare allowables.

II. Insurance Coverage Verification

- What co-pays or co-insurance pertain to the services?
- What is an effective date of coverage?
- Are there any special rules for surgical services?
- Are there procedures that may not be done in the office?

III. Pre-Certification

- Does the payor require preauthorization for any of the procedures performed in the office?
- If so, what must be done to obtain pre-certification?
- What must be included when the claim is filed?

IV. Medical Review Policies

- Does the payor have any policies based on the frequency of treatment, the number of injections, special conditions supporting medical necessity; or any other special rules?
- Are you permitted to bill the patient for these non-covered services or services considered not medically necessary?
- If so, are you required to use an Advanced Beneficiary Notice (or any other notice) and any modifier at time of claim filing?

V. Bilateral Procedures

- How does the payor handle bilateral services? Are you to use the 50 modifier on one line of the CMS 1500 or with the 50 modifier and use two lines, or are you to use RT/LT?
- Are there any procedures that when done bilaterally are not reimbursed at all?
- Are the bilateral services subject to a multiple procedure reduction?

VI. Multiple Levels

- How does the payor reimburse for services rendered at multiple levels on the same day?
- Will these services be subject to the multiple procedure reduction?
- Will they be bundled if done with other certain services?

VII. Correct Coding Initiative

- Does the payor follow CCI (Correct Coding Initiative) rules or do they have their own rules and/or “black-box” edits?
- If they have their own, what are the rules?
- Can you bill the patient for any of the bundled services if patient is notified in advance or are you prohibited from billing the patient?

VIII. Modifiers

- What modifiers does the payor recognize and how do these modifiers affect payment? Under what circumstances a modifier should be used?

IV. Global Surgery Rules

- Does the payor have global surgery rules for any of the services rendered in the office? If so, what are they and what services are considered to be part of the global surgical package?

Note: Lysis of epidural adhesions and radio frequency/chemodenervation procedures have a 10 day global period. The majority of nerve block and injection procedures do not have global days.

Once you have a clear understanding of the rules for each of the primary payors of the practice, it is important to establish office policies to address the various situations that are likely to arise. These policies should identify:

- 1) When to use the Advanced Beneficiary Notice and/or Notice of Exclusion from Medicare Benefits
- 2) What may be billed to the patient and what are the collection rules at time of service?
- 3) What is the self pay payment rule for patients without insurance?
- 4) Will the practice accept payment plans and if so what is the minimum payment and maximum repayment direction that is acceptable?
- 5) When and how will the patient be dismissed from the practice for non- payment?

Consult the current year CPT™ manual for the name of the procedure or service that accurately identifies the service. A provider should not select a CPT code that merely approximates the service. If there is no CPT™ code, AMA/CPT directs coders to report the service using the appropriate unlisted procedure or service code (CPT changes 2001: An Insider’s View, page 5).

Drugs

Medicare will reimburse for injectible drugs e.g., drugs that cannot be self-administered. Bear in mind however, that Medicare does not reimburse for anesthetics even if used in an injection, as they consider the drug to be a topical or local that is bundled into the procedure. Reimbursement is based on the average

sales price of the drug. Currently, the majority of payors accept “J” codes; however, some commercial payors may request National Drug Codes (“NDC”) codes. NDC codes are specific to manufacturer and dosage; they are listed on the invoice or label.

Consult a current year HCPCS book to find the appropriate “J” code. Each J code also includes a specific dosage by which the J code is measured. A drug is billed in units and each unit represents the dosage specified by the code. To determine the number of units to bill, calculate as follows:

$$\frac{\text{(Fill Volume) x (Concentration of drug)}}{\text{Dosage of J code}} = \text{\# units to place in box 24G of the HCFA1500 claim form}$$

HCPCS Code J3490 is the unlisted drug code and is used for any drug that does not have a specific J code.

Medications are sometimes prepared from reconstituted powder. This can be done either in the office or by a compounding pharmacist. An example of a drug that is often compounded is morphine, (sometimes mixed with other drugs), used in implantable infusion pumps for severe pain conditions. The cost of compounded medications is significantly lower than that of commercially prepared medication. A compounded drug should generally not be billed with the J codes for the commercially prepared, preservative free medications.

Most experts recommend that the unlisted code, J3490 be utilized to bill compounded drugs. The number of units to report for an unlisted drug will always be “1”. The name of the drug(s) and dosage administered must be written on the claim form. Some carriers also require a copy of the invoice. Medicare carriers’ policies vary; it is important to monitor the billing and reimbursement of the drugs closely.

Medicare does not pay for drugs that are considered experimental or not proven effective. Medicare publishes the drug fee schedule on a quarterly basis and the approved drugs are listed. The approved fee listed in the fee schedule represents a per unit fee based on the dosage specified for each J code.

Other third party payors may or may not reimburse the office for drugs separately from the service rendered. This should be clarified at contract negotiation time. Third party payors may want drugs submitted using the miscellaneous expense code of 99070 or may bundle the drugs into the fee for the service. When 99070 is used it is important to specify the drug name, dosage and concentration. This is an important item to negotiate with a payor. It is not unusual for a payor to reimburse separately for the drugs and it is important to clarify the basis by which they calculate their reimbursement. If they bundle drugs, be sure to identify the more expensive drugs and “carve out” these drugs so they are not bundled.

Supplies

As stated previously, Medicare does not reimburse separately for supplies for the majority of procedures performed in an office, and this includes pain management procedures. Medicare considers supplies to be bundled into the fee for the service rendered, i.e., part of the “global surgical package”. Ominipaque (Low Osmolar Contrast Material (LOCM) is a good example of this. Most Medicare carriers only cover this for intravenous, intraarterial and intrathecal injections for diagnostic purposes. See **Related Change Request (CR) #: 3748 Medlearn Matters Number: MM3748 - Related CR Release Date: March 11, 2005**

Related CR Transmittal #: 502

Effective Date: April 1, 2005

Implementation Date: April 4, 2005

New Contrast Agents Healthcare Common Procedure Coding System (HCPCS) Codes

HCPCS codes Q9945 – Q9951 replaced codes A4644 – A4646; and

HCPCS codes Q9952 – Q9954 replaced codes A4643 and A4647

Other third party payors may reimburse for supplies typically by using the CPT code 99070. Some payors will reimburse for the epidural tray as supplies using the code A4550. At contract negotiation it should be clarified as to what supplies are reimbursed separately and how to bill these supplies: line itemized with the

contents of the tray (A4550) (or purchased separately), or one line item with 99070. Additional supplies may include Omnipaque (Low Osmolar Contrast Material), although payment for this depends on the carrier. **Providers need to be extremely aware as to what supplies are already included in a tray and not list those separately again in a line item or as part of the miscellaneous 99070.**

Should the payor require an itemized list, the contents of the epidural tray can found as a sticker on the back of the tray. Consider also using a procedure charge list attached to the charge ticket for check-off by the clinical staff.

PROCEDURE SUPPLY LIST
CPT CODE 99070
TOTAL: _____

Patient: _____
Date of Service: _____

SUPPLIES/EQUIPMENT/MEDICATIONS

- | | |
|--|---|
| ___ RF SMK Needle | ___ Versed 1 mg (J2250) |
| ___ RF RFK Needle | ___ Lidocaine 1% 1mg |
| ___ RF Grounding Pad | ___ Propofol 200mg |
| ___ RF Sluyter-Mehta Kit | ___ Sodium Bicarbonate |
| ___ Braun Epidural Kit | ___ Ketrolac 15mg (J1885) |
| ___ Caudal Racz Kit | ___ Marcaine 25mg (S0020) |
| ___ LOR Syringe | ___ Sodium BiCarbonate 50ml |
| ___ Syringe 1cc (A4206) | ___ Depo-Medrol 80mg (J1040) |
| ___ Syringe 3cc (A4208) | ___ Depo-Medrol 40mg (J1030) |
| ___ Syringe 5cc or greater (A4209) | ___ Ephinephrine 1mg (J0170) |
| ___ Syringe 20cc | ___ Calcium Chloride 1g |
| ___ Needles only, any size (A4215) | ___ Naloxone 1mg (J0150) |
| ___ Discogram Needle Set | ___ Adenocard 6mg (J0150) |
| ___ 22 x 3.5 Quinke (18336) | ___ Atrophine Sulfate up to 0.3mg (J0460) |
| ___ 20 x 6 Quinke (183140) | ___ Cefazolin 500mg (J0690) |
| ___ 20 x 3.5 Quinke (18335) | ___ Zofran 4mg (J2405) |
| ___ 17 x 6 Tuohy (18323) | ___ Phenergan 50mg (J2550) |
| ___ 18 x 3.5 Tuohy | ___ Benadryl 50mg (J1200) |
| ___ 25 x 3.5 Quinke | ___ Solu-Medrol 125mg (J2390) |
| ___ Nerve Root Kit | ___ Dexamethasone 1mg (J1100) |
| ___ IV Fluids/Bag | ___ Morphine 10mg (J2275) |
| ___ IV Tubing | ___ Pump Refill Kit (A4220) |
| ___ Jelco | ___ Atrophine Syringe 1mg |
| ___ IV Extension | ___ Fentanyl 2ml (J3010) |
| ___ IV Kit | ___ Demerol 100mg (J2175) |
| ___ Stopcock 3 Way | ___ Sterile Towels |
| ___ Suture Removal Kit | ___ Sterile Drapes |
| ___ Propaq | ___ Sterile Lap. Drapes |
| ___ Pulse Ox | ___ Sterile C-Arm Cover |
| ___ EKG Monitor | ___ Sterile Gown |
| ___ O2 | ___ Sterile Gloves |
| ___ O2 Nasal Tubing | ___ Skin Marker |
| ___ IDET Catheter | ___ 4 x 4 Pack |
| ___ IDET Needle Introducer | ___ Bayer Elite XL Blood Glucose |
| ___ Dopamine 40mg | ___ Romazicon 1mg |
| ___ Ephedrine Sulphate 50mg (CPT: 82962) | ___ Trandate 5mg |
| ___ Universal Tray | ___ Trandate 5mg |

Moderate Sedation

In 2006, the CPT added new codes for moderate (conscious sedation). These are CPT codes 99143 to 99150. Moderate sedation is a drug induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. Moderate sedation does not include minimal sedation, deep sedation or monitored anesthesia care.

Codes 99143 to 99145 describe moderate sedation provided by the same physician performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status. Codes 99148 to 99150 describe moderate sedation provided by a physician other than the health care professional performing the diagnostic or therapeutic service that the sedation supports. The physician can bill the conscious sedation code as long as the procedure with which it is billed is not listed in Appendix G of CPT.

Appendix G, *Summary of CPT Codes That Include Moderate (Conscious) Sedation*, lists those procedures for which conscious sedation is an inherent part of the procedure itself. CPT describes the interrelationship between the appendix and the conscious sedation codes.

CPT coding guidelines instruct practices not to report Codes 99143 to 99145 in conjunction with codes listed in Appendix G. The National Correct Coding Initiative added edits in April 2006 that bundled CPT codes 99143 and 99144 into the procedures listed in Appendix G. (There are no edits for code 99145; it is an add-on-code and it is not paid if the primary code is not paid.)

In the unusual event when a second physician other than the health care professional performing the diagnostic or therapeutic services provides moderate sedation in the facility setting for the procedures listed in Appendix G, the second physician can bill 99148 to 99150. However, when these services are performed by the second physician in the non-facility setting, codes 99148 to 99150 are not to be reported. Since 2006, the conscious sedation codes have been assigned a status indicator of "C" under the physician fee schedule designating that these services are carrier priced. CMS has not established relative value units for these services.

The new policy is as follows:

If the physician performing the procedure also provides moderate sedation for the procedure, then payment may be made for conscious sedation consistent with CPT guidelines.

If the physician performing the procedure also provides local or minimal sedation for the procedure, then no separate payment is made for the local or minimal sedation service.

Other commercial and/or Worker's Compensation carriers should a reasonable charge for moderate sedation administered during a nerve block or an injection procedure. Documentation in the patient's record should convey the medical necessity of sedation. The office/clinic also must be in compliance with any State Regulations required by that Individual Department of Health.

Fluoro Billing In The Office

Fluoroscopic guidance for needle placement is separately reimbursed **in addition** to most injection procedures. Bill only once per anatomical region.

77003 **without a modifier**: Indicates use of C' arm for fluoroscopic guidance for needle placement on spinal injection procedures in an office where the provider owns or leases the equipment.

77002 **without a modifier**: Indicates fluoro for non-spinal injection procedure (nerve blocks).

Supervision and Interpretation Studies such as:

Epidurogram 72275*, Arthrogram 73542 and Discogram 72285 (cervical) and 72295 (lumbar) all require a formal radiological report. The provider bills for the injection and the interpretation report. Epidurogram* and Arthrogram are billed only once, however, the discogram report is billed per level.

- *When billing for an Epidurogram, it is imperative that there is a distinct, diagnostic reason **and a result** with the appropriate documentation to support the medical necessity for billing an Epidurogram as a separate procedure. The Epidurogram is bundled with the majority of pain management procedures and can only be billed with the modifier -59 **IF** the above guidelines are met.

Remember that when billing for an interpretation study, fluoroscopic guidance for needle localization is bundled and cannot be billed separately.

“Incident To” Services

In the physician’s office or clinic, Place of Service (“POS”)11, the physician may bill Medicare for the services provided “incident to” his/her professional services provided these services are commonly provided in physician offices and are either commonly rendered with or without charge or included in the physician’s bills. “Incident to” services include drugs, supplies and personnel employed by the physician including non-physician practitioners, clinical social workers and nursing staff. Any charge submitted under the physician’s name and provider number that is not personally performed is an “incident to” service.

Physician Assistants, Nurse Practitioners and Clinical Nurse Specialists are among those providers eligible to receive reimbursement for services provided to Medicare beneficiaries. If the physician is present in the office or clinic and participates in the treatment planning, the services of non physician practitioners, (“NPP’s”) may be billed as “incident to”. Incident to services are reimbursed at 100% of the physician’s fee schedule “Incident to” services must also be furnished in the course of treatment where a physician performs an initial service and subsequent services of a frequency that reflects the physician’s active participation in, and management of a course of treatment.

Services provided by NPP’s in a hospital or ASC setting cannot be billed to Medicare using the physician employer’s provider number. An NPP must bill under his/her own name and provider number for service provided outside of the office.

Other third party payors may or may not allow reimbursement for NPP’s and/or “incident to” billing. This issue should be addressed in the provider’s contractual agreement. Questions including but not limited to NPP credentialing, how charges should be submitted (e.g., in physician’s name or NPP), does the carrier model after the Medicare “incident to” guidelines should be answered for all of the practice’s major payors.

Medicare carriers are mandated to edit claims for “unbundling”. “Unbundling” is defined as, “ billing multiple procedure codes for a group of procedures that are covered by a single comprehensive code”. Attempting to bill separately for these already bundled charges will constitute a claim for unbundled codes.

AdminiStar Federal entered into a contract with CMS, then HCFA, to identify code combinations which, if billed together, constituted “unbundling”. This project resulted in a manual, termed the Correct Coding Initiative (“CCI”), The CCI is not used exclusively by Medicare Carriers; it is often used by some commercial payors. Commercial payors may also have their own enhanced version of “CCI,” sometimes referred to as “black box edits,” that are not published.

Each chapter in the Manual is divided into two sections:

1. Mutually exclusive procedures are those which cannot be performed during the same operative or patient session;
2. Comprehensive and Compound procedure code combinations, which are divided into Column 1 and Column 2 procedures. The Component procedure (column 2) will not be reimbursed, when it is rendered by the same provider on the same date. There are circumstances where a modifier is allowed that further explains the service, in which case the service may pass the system edit and reimbursement will be allowed.

The CCI is updated every quarter and often have changes that affect pain management procedures. Everyone that assigns CPT codes and/or bills physicians’ services should have a current subscription to the

CCI. A subscription to this quarterly publication can be obtained from several sources one of which is: CMS Correct Coding Initiative, AdminiStar Federal, P.O. Box 50469, Indianapolis, IN, 46250-0469.

Diagnosis

The condition for which the patient received service is communicated to a third party payor through the assignment of a diagnosis code commonly referred to as an ICD9 code. Assignment of an accurate diagnosis is a key element for reimbursement because this is what determines medical necessity.

Each visit or service should fully document the patient's chief complaint and the physician must document his/her assessment of the patient's condition. This assessment conveys the medical necessity for the service rendered and gives the coding/billing person information to complete a claim..

The diagnosis(es) billed for the services rendered should only be for conditions addressed at the time the service is rendered, Historical conditions should only be billed if they influence or impact the treatment of the patient.

The diagnosis code selected should always be specific. Some ICD-9 codes require additional digits to further clarify the condition. It is important that the physician be as specific as possible.

If for any reason the patient presents with additional problems, other than the original reason for the service, it is important that the physician specify the diagnosis for each of the services rendered and link the appropriate diagnosis to the appropriate services.

Medicare carriers develop Local Coverage Decisions. LCDs are based on utilization of CPT codes. These policies define the treatment or service and the condition(s) for which Medicare will reimburse those services. LCD policies may vary from carrier to carrier for the same condition and treatment; each carrier has an advisory committee ("CAC") that reviews treatments and services through extensive research. The CAC is comprised of physicians; it is to the advantage of the Pain Management specialist to serve on his/her Medicare CAC to ensure that procedures and treatments specific to the practice of pain medicine are fairly assessed.

Local Medicare web sites are a provider's best resource for published policies. A provider can also write to "Freedom of Information" ("FOIA") at the local carrier address. Questions addressed to FOIA should have complete information for the reviewer to answer the question. It may be necessary to send a dictated report or product information to explain the procedure.

There are some services and procedures that are non-covered due to National policy decisions such as acupuncture and prolotherapy. CMS publishes a Coverage Issues Manual that has all National Coverage Decisions (NCD). Local carriers also publish these decisions in Local Coverage Bulletins Notices. A library should be kept in the office or clinic that has NCD, LCD, and articles pertaining to the specialist's practice. These policies should not be limited to Medicare. It is of equal importance to adhere to policies of any third party payor that provides information. If no policy information is available, services should be billed in accordance with AMA/CPT standards and guidelines.

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