



CALIFORNIA ACADEMY OF
FAMILY PHYSICIANS
STRONG MEDICINE FOR CALIFORNIA

Strategies for Coding, Billing and Maximizing Payment 2011 Supplement

New Year, New Changes and New Revenue Opportunities

Every year brings important coding and payment changes for family physicians. Along with new coding changes and Medicare benefits for patients come revenue opportunities for family physicians.

Now is the time for your practice to review these changes, plan for implementation and update your practice management or billing system to ensure all services are billed and revenue is collected.

Medicare Updates/Changes:

The Medicare Part B deductible will increase to \$162, but coinsurance remains at 20 percent. Beginning in 2011, many preventive services for Medicare patients are now exempt from a deductible or coinsurance. To ensure that your practice is collecting the right amount from patients, as well as making the correct adjustments when needed, carefully review the list of exempted services below. Some of the services typically performed in a physician's office that are now exempt from both deductible and coinsurance are:

- Initial Preventive Physical Exam (IPPE)
- Annual Wellness Visits (AWV)
- CV Disease Screenings
- Diabetes Screening Tests
- Medical Nutrition Therapy (MNT)
- Screening Pelvic Exam
- Bone Mass Measurements
- Colorectal Cancer Screening – FOBT, Sigmoidoscopy
- Immunizations – Flu, Pneumonia, Hepatitis B

The 2011 conversion factor that will be used to develop the Medicare fee schedule is \$33.9764. Although Congressional action prevented the 24 percent proposed cut to Medicare physician payments, the conversion factor was modified because of changes

to the Medicare Economic Index (MEI), as outlined in the 2011 final Medicare Physician Fee Schedule. The modifications resulted in increased practice expense and malpractice Relative Value Units (RVUs) and lower work RVUs. The work RVUs, however, were not directly lowered because the Centers for Medicare and Medicaid (CMS) recognized the need for long-term work RVU stability given the use of these RVUs in physician compensation systems. To keep the work RVUs consistent and maintain budget neutrality, the practice expense and malpractice RVUs were increased and the conversion factor was decreased. The result was a budget neutral adjustment, but some practices may see some service payment variations. A number of procedures (non-E/M services) went through the mandatory five-year Relative Value Scale Update Committee (RUC) review of work RVUs this past year. Some work values have been reduced as a result of that review. An example is debridement services for which the pre-and post-service time was removed from the primary service resulting in a decrease in value.

New Preventive Services

Beginning January 1, 2011, Medicare beneficiaries are eligible for an Annual Wellness Visit (AWV) with a Personalized Prevention Plan (PPPS). Two HCPCS Level II codes have been established to report the initial AWV and all subsequent visits. The visits are geared toward initiating and updating the patient's personal prevention plan, as opposed to an actual physical exam. Please make sure your clinical and billing staffs are aware of these services and know how to bill for them.

The requirements for the initial AWV are different from the requirements for subsequent visits. Included in the initial AWV with PPPS are:

- Establishment of an individual's medical/family history – a health history questionnaire is acceptable.
- Establishment of a list of current providers and suppliers that are regularly involved in providing medical care to the individual. You must establish this list so that providers may be added and deleted.
- Measurement of an individual's height, weight, body mass Index (or waist circumference, if appropriate), blood pressure (BP) and other routine measurements as deemed appropriate, based on the beneficiary's medical/family history.
- Detection of any cognitive impairment the individual may have as defined in the Affordable Care Act (ACA).
- Review of the individual's potential (risk factors) for depression, including past or present experiences with depression or other mood disorders. This

evaluation requires the use of an appropriate screening instrument for persons without a current diagnosis of depression, which the health professional may select from various available standardized screening tests designed for this purpose and recognized by national medical professional organizations.

- Review of the individual's functional ability and level of safety based on direct observation, or the use of appropriate screening questions or a screening questionnaire, which the health professional may select from standardized questionnaires designed for this purpose and recognized by national professional medical organizations.
- Establishment of a written screening schedule for the individual, such as a checklist for the next 5-10 years, as appropriate, based on recommendations of the United States Preventive Services Task Force (USPSTF) and the Advisory Committee on Immunization Practices (ACIP), as well as the individual's health status, screening history and age-appropriate preventive services covered by Medicare.
- Furnishing of personalized health advice to the individual and a referral, as appropriate, to health education or preventive counseling services or programs aimed at reducing identified risk factors and improving self-management, or community-based lifestyle interventions to reduce health risk and promote self-management and wellness, including weight loss, physical activity, smoking cessation, fall prevention and nutrition.
- Any other element(s) determined appropriate by the Secretary of Health and Human Services through the National Coverage Determination (NCD) process.

The services to be provided in subsequent AWWs are somewhat different, but are mostly an update of those required for the initial AWW:

- An update of the individual's medical/family history. Provide a mechanism on the initial health history the patient completes for multiple year updates or require the patient to complete a new questionnaire annually, as many practices do.
- An update of the list of current providers and suppliers that are regularly involved in the medical care of the individual, as that list was developed for the first AWW providing PPS.

- Measurement of an individual's weight (or waist circumference), BP and other routine measurements as deemed appropriate, based on the individual's medical/family history.
- Detection of any cognitive impairment that the individual may have as defined in the ACA.
- An update to the written screening schedule that was developed for the individual in the first AWW.
- An update to the list of risk factors and conditions for which primary, secondary or tertiary interventions are recommended or are underway for the individual, as it was developed in the first AWW.
- Furnishing of personalized health advice to the individual and a referral, as appropriate, to health education or preventive counseling services or programs.
- Any other element(s) determined by the Secretary through the NCD process.

Here are some tips for efficiently and effectively providing these new services to the Medicare patients in your practice:

1. Have your non-physician practitioners – NP, PA, or CNS – provide these services.
2. Use your ancillary staff effectively – they can take histories, administer questionnaires, update lists and provide resources.
3. Put your Medicare patients on the practice recall system for these services. It not only reminds patients to make an appointment but also spreads the delivery of the services over the year so that the practice is not bombarded with requests at the beginning of each year.
4. Be cognizant of the time sensitivity of providing these services to the patient. For those patients who become eligible for Medicare throughout the year, remember AWWs must occur subsequently to the patient's IPPE. The Medicare patient should receive the IPPE during his or her first 12 months of eligibility for Medicare and the initial AWW needs to be at least 12 months after the effective date of the patient's Medicare coverage. If a claim for an AWW is submitted within the first 12 months after the effective date of the beneficiary's first Medicare Part B coverage, it will be denied because the beneficiary was eligible for the IPPE or "Welcome to Medicare" physical. The initial AWW is a "once in a lifetime" service. If a patient has had an AWW elsewhere, and a second claim for the service is billed, it will be denied with a remark code indicating the lifetime benefit maximum has been reached.
5. Be aware that the AWW service can be provided on the same day as another E/M service. To report both services as separate and payable, append the -25

modifier to any other illness-related E/M service done on the same date. **Do not put the modifier on the G0438 or G0439 used to report the AWW.**

6. Payment for these services is comparable to Level 4 new patient (99204) and established patient (99214) services. Here is a table for payment for 2011:

Code / Description	Northern CA Areas (Medicare)					
	03	05	06	07	09	99
G0438 Initial AWW	\$182.48	\$195.63	\$195.87	\$184.70	\$188.46	\$166.32
G0439, Sub. AWW	\$124.00	\$133.50	\$133.63	\$125.47	\$128.05	\$112.04

03 = Marin, Napa, Solano Counties 05 = San Francisco County
 06 = San Mateo County 07 = Alameda, Contra Costa Counties
 09 = Santa Clara County 99 = All other Northern California Counties

Code / Description	Southern CA Areas (Medicare)			
	17	18	26	99
G0438, Initial AWW	180.91	179.50	183.38	166.32
G0439, Sub. AWW	122.47	121.25	124.10	112.04

17 = Ventura County, 18 = Los Angeles County, 26 = Orange County
 99 = Imperial, San Diego, Santa Barbara, San Luis Obispo Counties

Tobacco Cessation Counseling Codes

Medicare will now cover counseling to prevent tobacco use in addition to covering smoking and tobacco cessation counseling. Physicians must understand the difference between these two services and bill correctly so proper payment can be received.

Smoking cessation counseling is covered for individuals who:

1. Use tobacco and have been diagnosed with a recognized tobacco-related disease; or,
2. Use tobacco and exhibit symptoms consistent with tobacco-related disease.

Use CPT codes 99406 (intermediate) and 99407 (intensive) to report this service.

Counseling to prevent tobacco use is for outpatient and hospitalized Medicare beneficiaries who:

1. Use tobacco (but do not show signs or symptoms of tobacco-related disease);
2. Are competent and alert at the time counseling is provided; and
3. Undergo counseling furnished by a qualified physician or other Medicare-recognized practitioner.

The diagnosis codes that should be reported for these individuals are ICD-9 code 305.1 (non-dependent tobacco use disorder), or ICD-9 code V15.82 (history of tobacco use).

Two individual tobacco cessation counseling attempts per year are allowed for these beneficiaries, just as they are for symptomatic individuals. Each attempt may include a maximum of four intermediate or intensive sessions, with a total benefit covering up to eight sessions each year per Medicare beneficiary. The practitioner and the patient have the flexibility to choose between intermediate (more than three minutes up to 10 minutes) and intensive (more than 10 minutes) cessation counseling sessions for each attempt. HCPCS codes have been established to report the two different types of counseling (intermediate vs. intensive).

Several other Medicare changes that family physicians should be aware of will be enforced:

1. Timely filing limitations have changed. Medicare has been fairly lenient with billing timeframes for services, sometimes allowing nearly two years for a claim to be filed. Beginning with services provided on or after January 1, 2010, the timely filing limitations for claims have been reduced to within one year of the date of service. Do not be caught off-guard. Keep up with filing your claims in a timely manner.
2. Effective January 1, 2011, a new Medicare home health law goes into effect that affirms the role of the physician as the person who orders home health care based on personal examination of the patient. Effective as of that date, a physician who certifies a patient as eligible for Medicare home health services must have seen the patient. The law allows the requirement to be satisfied if a non-physician practitioner (NPP) sees the patient when the NPP is working for or in collaboration with a physician.

As part of the certification form itself or an addendum to it, the physician must document that he or she or a NPP saw the patient and documented the clinical condition that supports a patient's homebound status and need for skilled services. The face-to-face encounter must occur at most 90 days prior to the start of home health care or 30 days after the start of care.

3. Medicare has made a change to the reporting requirement for services provided to Medicare beneficiaries in Place of Service (POS) Home. While there is no change to payment policy, physicians are required to document the address (including the Zip Code) where services were performed on claims for anesthesia and every service payable under the Medicare

Physician Fee Schedule for services provided in all places of service, including home.

This change will be effective for all claims processed by Medicare that are submitted on the 5010 version of the ANSI x12N 837 P electronic form and on the paper form CMS=1500 on or after January 1, 2011.

Claims submitted on the 4010A1 electronic form are not affected by this change, but billing staff need to be aware of it. It is especially important to be aware of this change because during 2011, many software vendors will be updating practice management systems to the 5010 version of the ANSI x12N 837 P electronic form in preparation for ICD-10 implementation. To avoid having your home visit claims denied because a form has not been completed properly, call your software vendor now to find out how to enter the patient's home address in field 32 or the corresponding electronic function in your software.

CPT Code Changes:

There are two new codes in the Evaluation and Management section of CPT that allow physicians to report subsequent observation care for a patient under observation who has not yet been admitted to the hospital as an inpatient. Since its inception, observation care service codes (initial care and discharge care) have been problematic for physicians to report and receive appropriate payment when the patient is under observation care for more than two days (one day of initial care and another day of discharge care). There was no choice for the physician to report the "in between" day or days of care for anything other than an office/other outpatient service (CPT 99211 – 99215). This was problematic from an insurance benefits standpoint because the patient often incurred office visit copayments for these services. As it became apparent that patients occasionally spent more than two days under observation before going home or being admitted as an inpatient, it was clear there was a need to report subsequent observation care as a service of its own. The new codes have structure and value that are close to subsequent hospital inpatient service codes, and typical times have been established for the subsequent observation care codes. The codes are:

- **99224 subsequent observation care**, per day, for the evaluation and management of a patient requires at least two of these three key components:
 - Problem-focused interval history
 - Problem-focused examination
 - Medical decision-making that is straightforward or of low complexity

Usually, the patient is stable, recovering or improving. Physicians typically spend **15 minutes** at the bedside and on the patient's hospital floor or unit.

Work RVU = 0.54

- **99225 subsequent observation care**, per day, for the evaluation and management of a patient requires at least two of these three key components:
 - Expanded problem-focused interval history
 - Expanded problem-focused examination
 - Medical decision-making of high complexity

Usually, the patient is responding inadequately to therapy or has developed a minor complication. Physicians typically spend **25 minutes** at the bedside and on the patient’s hospital floor or unit.

Work RVU = 0.96

- **99226 subsequent observation care**, per day, for the evaluation and management of a patient requires at least two of these three key components:
 - Detailed interval history
 - Detailed examination
 - Medical decision-making of high complexity

Usually, the patient is unstable or has developed a significant complication or a significant new problem. Physicians typically spend **35 minutes** at the bedside and on the patient’s hospital floor or unit

Work RVU = 1.44

Here is a comparison of these service codes and their element requirements with the subsequent inpatient hospital care services.

Observation Services (OBS)	Key components (2/3) Time	HOSPITAL	Key components (2/3) Time
99224	PF/PF/SF-L 15	99231	PF/PF/SF-L 15
99225	EPF/EPF/M 25	99232	EPF/EPF/M 25
99226	D/D/H 35	99233	D/D/H 35

Things to remember about Subsequent Observation Care:

- Subsequent observation care begins after the initial observation care date of service.

- Subsequent observation care cannot be reported on the same date as initial observation care.
- Observation care discharge services and subsequent observation cannot be reported on the same day.
- Observation services cannot be reported on the same day as office or emergency department services.

Immunization Administration for Vaccines/Toxoids Codes

CPT for 2011 has two new codes for Immunization Administration for Vaccines/Toxoids. Codes 90465, 90466, 90467 and 90468 were deleted and replaced with new immunization administration codes 90460 and 90461 for patients ages 18 and younger who receive counseling from physicians or non-physician practitioners (NPP). The descriptions for these codes are:

- **90460** Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional, first vaccine/toxoid component.
- **90461** Each additional vaccine/toxoid component (list separately in addition to code for primary procedure).

Things to remember about Immunization Administration for Vaccines/Toxoids codes:

- Age range was changed to birth through 18 years of age.
- Encompasses all routes of administration.
- Uses a Building Block Approach. Code according to number of Vaccine/Toxoid Components administered.
- A component refers to each antigen in a vaccine that prevents disease(s) caused by one organism. Combination vaccines are those vaccines that contain multiple vaccine components. (e.g., MMR = three components).

To differentiate between CPT 90460 and 90461 (counseling) and 90472-90474 (without counseling **or** older than age 18):

- Use 90460 for each vaccine administered.

For vaccines with multiple components (combination vaccines), report 90460 in conjunction with 90461 for *each* additional component in a given vaccine. The rationale is that each component requires specific counseling and the CPT panel did not want to have disincentives for the use of combination vaccines. Counseling does not apply to 90471-90474; they remain per vaccine and by route of administration.

Potential Future Pandemic Formulation Codes

A series of codes was added to CPT 2011 for potential future pandemic formulations (vaccines). These codes can be recognized in the CPT manual by the lightning bolt

symbol (✓), indicating the codes are in place to be used when US Food and Drug Administration (FDA) approval is received. These codes are:

- **90664** Influenza virus, vaccine, pandemic formulation for intranasal use.
- **90666** Influenza virus vaccine, pandemic formulation, split virus, preservative-free for intramuscular use.
- **90667** Influenza virus vaccine, pandemic formulation, split virus, adjuvanted, for intramuscular use.
- **90668** Influenza virus vaccine, pandemic formulation, split virus, for intramuscular use.

These codes *should not* be used for the H1N1 Vaccine. The H1N1 products developed for the 2009 pandemic have expired and should not be administered. The reformulated seasonal flu vaccines, which incorporated the H1N1 and related viruses, should be reported with the seasonal influenza vaccine codes (90655 et al.) and vaccine administration codes 90460, 90461 and 90471-90474.

New Vaccine Product Code

Finally, one new vaccine product code has been added to CPT for 2011. It is a vaccine awaiting FDA approval and can be used upon approval. The code is:

- **90644** Meningococcal conjugate vaccine, serogroups C and Y and Hemophilus influenza B vaccine, tetanus toxoid conjugate (HIB-MenCY-TT), four-dose schedule, when administered to children two to 15-months of age for intramuscular use.

New CPT Modifier for Preventive Services (33)

The implementation of health care reform regulations has begun with a significant change involving preventive services. The Patient Protection and Affordable Care Act (PPACA) requires all new health care insurance plans to begin covering preventive services and immunizations without any cost-sharing, i.e., they must provide first-dollar-coverage for specified preventive services. The regulation becomes effective on January 1, 2011 but the timing of implementation depends on when health insurance plans renew or change, since they do not all offer or renew at the same time each year. The regulations specify that plans cannot impose cost-sharing requirements, such as co-pays, coinsurance or deductibles with respect to specified preventive services, when preventive services are billed separately. When these services are part of an office visit, the visit may not require cost-sharing if the *primary* reason for the visit is to receive preventive services. Cost-sharing is permitted when the office visit and covered preventive services are billed separately and the primary purpose of the visit is *not* delivery of the covered preventive services, however.

In addition, insurance plans are permitted to impose cost-sharing (or choose not to provide coverage) for recommended preventive services if they are provided out-of-network. Not all services that some clinicians consider preventive are included in the

law. For preventive services not covered in the statute and regulations, plans may require cost-sharing. The new mandate may also affect payer coverage or payment policies for services listed in the Counseling Risk Factor Reduction and Behavior Change Intervention section of CPT (99401-99429).

For a comprehensive list of recommendations and guidelines covered by the final regulations, please visit www.healthcare.gov/center/regulations/prevention/recommendations.html.

In response to the PPACA requirement that plans cover preventive services without any cost-sharing, CPT Modifier 33 was created to allow providers to notify insurance payers that the service was preventive under applicable laws and patient cost-sharing does not apply. The modifier assists in the identification of preventive services in payer-processing systems. It indicates when it is appropriate to waive the deductible associated with copay/coinsurance and may be used when a service was initiated as a preventive service, but then was converted to a therapeutic service.

The complete description for Modifier 33 is:

Modifier 33, Preventive Service: When the primary purpose of the service is the delivery of an evidence-based service in accordance with a US Preventive Services Task Force A or B rating in effect and other preventive services identified in preventive services mandates (legislative or regulatory), the service may be identified by appending Modifier 33 to the service. For separately reported services specifically identified as preventive, the modifier should not be used.

CPT Modifier 33 is applicable for the identification of preventive services without cost-sharing in four categories. For an explanation of those categories, please read this American Medical Association article.

Using CPT Modifier 33 will be an important function for all family physicians as they provide preventive services to patients and collect (or do not collect) copayments, coinsurance and deductibles from patients.

HCPCS Code Changes for 2011:

CMS has developed two new Level II HCPCS codes for reporting Smoking and Tobacco Cessation Counseling Visits for the Asymptomatic Patient. These are considered preventive services for the Medicare patient. The codes are:

- **G0436** Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than three minutes, up to 10 minutes.
- **G0437** Smoking and tobacco cessation counseling visit for the asymptomatic patient; intensive, greater than 10 minutes.

Two new HCPCS codes have been developed to report the new Annual Wellness Visits (AWV) benefit available to Medicare patients beginning January 1, 2011. Those codes are:

- **G0438** Annual Wellness Visit, includes a personalized prevention plan of service (PPS), initial visit.
- **G0439** Annual Wellness Visit, includes a personalized prevention plan of service (PPS), subsequent visit.

CMS has also developed a new modifier for 2011 that allows a service that begins as a screening service to be converted to a therapeutic surgical procedure on the same date as the diagnostic service. Example: a diagnostic sigmoidoscopy or colonoscopy turns into a therapeutic procedure because of a removed polyp or tumor). The use of a modifier on the therapeutic procedure will allow all surgical services done on the same date as the screening or diagnostic to have the deductible and coinsurance waived. The modifier is:

- **PT** Colorectal cancer screening test; converted to diagnostic test or other procedure.

Bonus Programs for Physicians – a Source of Additional Revenue!

There are several bonus incentive programs that physicians may qualify for or elect to participate in during 2011. Many of them are favorable to family physicians.

- Primary Care Incentive Program (PCIP) - PPACA makes a 10 percent bonus available to qualifying primary care physicians. A physician's eligibility to receive the bonus in 2011 is based on services provided in 2009 or, for new physicians who were not enrolled in Medicare in 2009, the year prior to the year immediately prior to the PCIP payment year. Primary care services are defined as:
 - CPT 99201 – 99215 for new and established patient office or other outpatient E/M visits.
 - CPT 99304 – 99340 for initial, subsequent, discharge and other nursing facility E/M services, new and established patient domiciliary, rest home (e.g., boarding home) or custodial care E/M Services and homecare plan oversight services.
 - CPT 99341 – 99350 for new and established patient home E/M visits.

Eligibility for the PCIP bonus is based on a historical percentage of allowed charges as primary care services that equal or exceed a 60 percent threshold. The bonus will be paid on a quarterly basis.

- The Physician Quality Reporting Initiative (PQRI) will be known as Physician Quality Reporting (PQR) beginning in 2011. The bonus is one percent of Medicare allowed

charges. The threshold for claims-based reporting of individual measures has been lowered from 80 to 50 percent, so more physicians will be able successfully to report and qualify for incentive payments.

- The Medicare E-prescribing (eRx) bonus is reduced to one percent for 2011, but beginning in 2012, the Centers for Medicare and Medicaid Services will penalize providers who fail to e-prescribe. The bonus is based on Medicare Part B allowed charges and paid as a one-time payment. To qualify to be a successful e-prescriber for 2011, eligible physicians need to report the e-prescribing measure for at least 25 visits during the year. Note that Medicare providers cannot earn incentive payments under the e-Prescribing and Electronic Health Record (EHR) Incentive Programs at the same time.

Participating in any or all of these bonus programs provides potential for added revenue to all family practices.

Other Important Items for 2011

Registration for the Medicare and/or Medicaid EHR incentive programs begins in 2011. Physicians should consider registering for one of the incentive programs even if they are uncertain whether they will participate once the programs are under way. CAFP developed a web-based tool designed to help you determine if your practice qualifies for the Medicare and/or Medicaid incentive programs. [Click here to use this tool.](#) Additional information about the incentive programs is available on [CAFP's HIT Toolkit.](#)

To qualify for incentive payments up to \$44,000 under the Medicare EHR incentive program, and up to \$63,750 under the Medicaid EHR incentive program, eligible professionals must register for the program. [Registration for the incentive programs is available here.](#) Additional registration is required for the Medi-Cal program starting March 1. That registration is [available here.](#) Eligible professionals can determine at the attestation phase whether they will participate.

To participate, all eligible professionals must have:

- A National Provider Identifier (NPI)
- An enrollment record in the Provider Enrollment, Chain, and Ownership System (PECOS)

CMS and the National Coordinator for Health Information Technology made registration for the Medicare program available on January 3, 2011. It is expected that registration in the Medicaid EHR incentive program will become available on March 1, 2011.

Keep on top of these incentive programs and other issues in [health information technology at CAFP's website.](#)

Here is a calendar of key dates for 2011:

- January 3, 2011 – Registration for the Medicare EHR incentive program begins.
- January 3, 2011 – States that are ready may launch their incentive programs for Medicaid providers. *California is not among these states. Registration for the Medi-Cal program is expected to open on March 1, 2011.*
- April 2011 – Attestation for the Medicare EHR incentive program begins.
- May 2011 – Issuing of Medicare EHR incentive payments expected to begin.
- October 3, 2011 – Last day for eligible professionals to begin their 90-day reporting period for calendar year 2011 to demonstrate meaningful use for the Medicare EHR incentive program.

- December 31, 2011 – Calendar 2011 payment year ends for eligible professionals.