



ED Coding and Reimbursement Alert

Your practical adviser for ethically optimizing coding, payment, and efficiency in emergency medicine

• Documentation • Compliance • Reimbursement

February 2012, Vol. 15, No. 2 (Pages 9-16)

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CCI 18.0 Update

Watch for These Two Codes, Bundled into Dozens of Procedures

You need to know these edits if you report 20527 or 29582

New codes aren't the only things that affect your ED coding in 2012 –Correct Coding Initiative (CCI) edits version 18.0 went into effect Jan. 1, 2012, with 15,530 new edit pairs, says **Michael A. Granovsky, MD, FACEP, CPC**, President of LogixHealth, a medical coding and billing company in Bedford, MA.

Although few of the new edits are focused on frequently used emergency medicine services, you should review the list for bundled code pairs if you report 29582 (*Application of multi-layer compression system; thigh and leg, including ankle and foot, when performed*) or 20527 (*Injection, enzyme [e.g., collagenase], palmar fascial cord [i.e., Dupuytren's contracture]*). These two CPT® codes are now paired with hundreds of codes from the surgical section; especially those related to trigger point injections, fracture and dislocation services.

Trigger Point Injections Are Targets

If your ED group administers trigger point, joint, or tendon injections, don't miss the CCI edits involving those procedures:

- » Trigger point injection codes 20552 through 20553 are the Column 1 codes with new codes 29582 and 29584 (... *upper arm, forearm, hand, and fingers*).
- » Joint injection codes 20600, 20605, and 20610 are the Column 1 codes with new procedures 20527, 29582, 29583 (*Application of multi-layer compression system; upper arm and forearm*), and 29584.

Reminder: When CCI edits pair two codes together, you'll typically report the Column 1 code instead of the Column 2 code. The Column 1 code either represents a procedure that includes the services of the Column 2 code, or represents a procedure that "outweighs" the Column 2 code and should be reported alone.

Note This Crucial Timing Change

CMS Transmittal 2370, effective Dec. 16, 2011 outlines Integrated Outpatient Code Editor (I/OCE) instructions and specifications for the I/OCE that will be utilized under the OPSS and Non-OPSS for hospital outpatient departments, including the ED.

The I/OCE routes all institutional outpatient claims (which includes non-OPSS hospital claims) through a single integrated OCE which eliminates the need to update, install, and maintain two separate OCE software packages on a quarterly basis.

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Facility coders, take notice: In the past, the CCI edits have been one quarter behind. Effective for Jan. 1, 2012, the current quarter (Version 18.0) of the CCI edits will be implemented. Facility coders in particular should be aware that there is no longer a one quarter lag between the CCI edits and integration into the OCE logic. This will create greater consistency but may require updating your systems more quickly with each new publication of the CCI edits, says Granovsky.

Resource: Visit the CMS website <https://www.cms.gov/MLN MattersArticles/downloads/MM7616.pdf> for a complete look at Version 18.0 CCI edit changes. □

Coding Strategies

Wake Up To These Deep Sedation Insider Tips

You could be coding more deep sedation services this year in the ED, thanks to recent changes. Your claims' accuracy will depend on careful documentation of the duration and level of consciousness achieved. Read on for expert advice on modifier use and payer regulations dealing with anesthesia.

What's driving the trend: The advent of newer sedation drugs, particularly propofol, have led to greater sedation effectiveness and less recovery time for the patient after deep sedation, thus making the services a better fit in the ED. Increased residency training in deep sedation protocols have also contributed to the increase.

Green light from CMS: CMS issued a policy clarification in January 2011 that clearly recognized that it is acceptable to CMS for emergency physicians to provide all levels of sedation. CMS stated that "Emergency Medicine-trained physicians are uniquely qualified to provide all levels of analgesia/sedation and anesthesia (moderate to deep to general)."

Take This Definition Refresher

CPT® clearly defines what Moderate Sedation is and what it is not, says **Stacie Norris, MBA, CPC, CCS-P**, Director of Coding Quality Assurance for Medical Management Professionals in Durham, NC. From CPT®, "Moderate (conscious) sedation is a drug induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained. Moderate sedation does not include minimal sedation (anxiolysis), deep sedation or monitored anesthesia care (00100-01999)."

Coding tip: To accurately bill these services, you'll need ED providers to document the patient's level of consciousness throughout all anesthesia services, says Norris. CPT® directs coders to the Anesthesia Section of CPT® to code deep anesthesia or monitored anesthesia care.

ED Coding and Reimbursement Alert (USPS 019-206) (ISSN 1523-4835 for print; ISSN 1947-8747 for online) is published monthly 12 times per year by The Coding Institute, LLC 2222 Sedwick Drive, Durham, NC 27713. ©2012 The Coding Institute. All rights reserved. Subscription price is \$249. Periodicals postage is paid at Durham, NC 27705 and additional entry offices.

POSTMASTER: Send address changes to *ED Coding and Reimbursement Alert*, The Coding Institute, LLC 2222 Sedwick Drive, Durham, NC 27713

The CPT® Anesthesia section guidelines state that the Anesthesia codes include the usual preoperative and postoperative visits, the anesthesia care during the procedure, the administration of fluids and/or blood and the usual monitoring services such as EKG, temperature, blood pressure, pulse oximetry, capnography and mass spectrometry.

Modifier 47 alert: When coding regional or general anesthesia services provided by the same physician performing the service for which the anesthesia is administered, CPT® directs the use of modifier 47 (*Anesthesia by Surgeon*), to be appended to the basic service. Norris adds that you should check with individual payers for their policy on the use of this modifier.

Heed Time, Patient Status: Careful reporting of anesthesia time is critical to the coding and documentation of these services. Per CPT®, anesthesia time begins when the physician begins to prepare the patient for the induction of anesthesia and ends when the physician is no longer in personal attendance.

If more than one surgical procedure is done during the same sedation episode, the anesthesia code for the most complex procedure is coded and the combined total time for all procedures would be used, says Norris.

CPT® also instructs to use both the anesthesia code itself and a physical status modifier. These modifiers contain the letter “P” and a number from 1 to 6:

- » P1: A normal healthy patient
- » P2: A patient with mild systemic disease
- » P3: A patient with severe systemic disease
- » P4: A patient with severe systemic disease that is a constant threat to life
- » P5: A moribund patient who is not expected to survive without the operation
- » P6: A declared brain-dead patient whose organs are being removed for donor purposes.

Coding example: For a patient with mild systemic disease receiving deep sedation services for a bronchoscopy, the anesthesia portion would be reported as: 00520-P2.

Qualifying circumstances are add-on codes to represent specific situations where anesthesia services are particularly difficult. They are coded in addition to the primary anesthesia code. For example, qualifying circumstances code 99100 is defined by CPT® as, “Anesthesia for patient of extreme age, younger than 1 year or older than 70.”

There is also a qualifying circumstances code for anesthesia complicated by emergency conditions, +99140 (*Anesthesia complicated by emergency conditions [specify] [List separately in addition to code for primary anesthesia procedure]*) An emergency condition is defined as one

where “a delay in the treatment of the patient would lead to a significant increase in the threat to life or body part”, such as a significant crush injury to an extremity or gunshot wound to the head. Providers should document if such an emergency condition exists.

Work Closely With Payers

Norris adds, there are numerous billing related issues that should be addressed and understood before undertaking the coding and billing of anesthesia codes.

For those payers that utilize the CCI edits, which includes Medicare, the ED evaluation and management levels 99281-99285 are bundled into the anesthesia codes, with no modifier allowed to override this edit. Critical Care services (99291-99292) are separately billable.

And facility required credentialing to provide anesthesia services should be addressed with the physician practice; this is something that the physicians will have to discuss with their hospital, advises Norris.

Brush Up on Medicare Anesthesia Rules

Payor contracts may have to be modified for reimbursement to the ED physician for anesthesia services. Individual payer

(Continued on next page)

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policies on anesthesia services should be researched, says Norris.

Medicare has specific anesthesia billing guidelines that you'll need to apply to accurately code ED anesthesia services.

First of all, there is a separate Anesthesia Conversion Factor ("CF") that is updated annually. At the time of publication, payments for 2012 Medicare fee schedule were still uncertain. For 2011 the National Anesthesia CF is \$21.0515. CMS adjudicates anesthesia claims using a geographically adjusted CF. For example in 2011, the Anesthesia CF for North Carolina is \$20.31.

Medicare calculates anesthesia payment by using [(Base + Time) x Geographically Adjusted Anesthesia CF]. The base units assigned to each anesthesia procedure can be found on the CMS website and this file is updated annually.

The time units are calculated by Medicare in 15 minute units; the actual Anesthesia time (defined by Medicare as the period that the anesthesia practitioner is present with the patient) should be reported on the claim.

Watch the clock: Anesthesia time starts when the anesthesia practitioner begins to prepare the patient for anesthesia services and ends when the anesthesia practitioner is no longer furnishing anesthesia services, (i.e., when the patient may be placed safely under postoperative care).

Test Your Knowledge: Review this E D Medicare anesthesia coding example from Norris:

The scenario: A 60 year old otherwise healthy patient presents to the ED with a Colles fracture requiring manipulation to reduce the fracture. The patient's pain is severe and the emergency physician makes the treatment decision to provide deep anesthesia to the patient for the reduction. Another EP from the physician group provides the anesthesia while the primary EP reduces the fracture. The EP documents 15 minutes of deep sedation.

First step: Looking in the CPT® index under the main heading "Anesthesia" and then under the subheading "forearm" (00400, 01810-01820, 01830-01860) or "wrist" (00400, 01810-01860), you will find a range of anesthesia codes to check.

The answer: After reviewing these code ranges, you can see that the best choice is CPT® 01820 (*Anesthesia for all closed procedures on radius, ulna, wrist or hand bones*). The AA Medicare Anesthesia modifier P1 physical status modifier should be appended to the anesthesia code.

Utilizing the 2011 Anesthesia Base Unit file on the CMS website, the base units assigned for CPT® 01820 are 3 base units. The 2011 North Carolina Medicare allowable for this service is calculated as: [(3 Base Units x 1 15 minute time unit) x \$20.13] = \$60.93.

Editor's note: Please see "Anesthesia Coder" on SuperCoder.com for additional anesthesia coding resources. □

Coding Tips

Splinting or Strapping? These Tips Help You Decide

Hint: Look to materials to narrow down your selection.

When a patient reports to the ED with an injury that requires a splint or strap, coders must know the difference between the two in order to assign the correct procedure code.

Review these rules to make sure your code choice is secure.

Use 2 Scenarios As Guides CPT® includes a special section on application of casts, strapping and splints arranged by body area (i.e. body and upper extremity or lower extremity). Use those codes, 29000-29799, to report any splinting and strapping services. The preamble to that section offers two scenarios for coding the application of splints and strapping:

- » the service is a replacement procedure used during or after the period of follow up care (whether or not the physician provided restorative treatment [fracture care] to the patient); or
- » the service is an initial service performed without restorative treatment or procedures(s) to stabilize or

protect a fracture, injury, or dislocation and/or to afford comfort to a patient .

The second scenario is most common in the ED setting, says **Betty Ann Price BSN, RN**, President and CEO of PRCS, Inc. in Palmetto Florida. However, don't overlook the instructions concerning whether the ED physician provided at least partial restorative care. If restorative care is provided, report the appropriate fracture/dislocation code instead of the splint or strapping code.

If that is the case, remember to attach modifier 54 (*Surgical care only*) when the patient is being referred for follow up care. CPT® specifically states in this preamble that the application of an initial splint or strap may be reported with an additional E/M code if appropriately documented as separately identifiable. CPT® is also clear that restorative treatment by another physician after the application of the

initial splint or strapping may be reported with a treatment of fracture or dislocation code.

Once you decide the encounter has met splinting or strapping parameters, you'll next select a code from the 27000-27999 series in CPT®. But in order to finalize your selection, you'll need to know which applications payers will consider a splint and what they'll consider a strap, says Price.

Heed These Strapping Application Pointers

Strapping definition: Payers generally consider strapping the application of adhesive tape, one overlapping the other, to provide support and/or restriction of movement of ligament structures by exerting pressure upon the extremity or other area of the body. Strapping requires specialized skill and knowledge of the anatomical structures as well as application technique.

A specific method of strapping is the application of an Unna boot (CPT® 29580). An Unna boot is a paste bandage which consists of gauze that has typically been impregnated with zinc oxide, and may contain other emollients. The bandage is applied to the leg from the toe to the knee by overlapping wraps of impregnated gauze. The Unna boot bandage restricts the volume of the distal lower extremity, controls edema, and promotes venous blood return. The Unna boot is particularly useful for venous stasis ulcers or ankle sprain with severe swelling.

Another example of strapping is buddy tape or “buddy splint” (CPT® 29280, 29550). This strapping application typically involves wrapping tape around both an injured digit and an adjoining digit to treat a finger sprain or toe fracture. While it may be referred to as “buddy splint,” this procedure is appropriately coded as strapping.

You Be the Coder

Consider this example

Question:

A 67-year-old female presents to the ED after falling off a three-step ladder. After a level 3 E/M service and review of radiographs, the physician determines that the patient sustained a non-displaced fracture of the distal left ulna. Due to the swelling, the physician applies a plaster molded splint for immobilization and protection of the fracture. The patient is then referred to an orthopedic clinic for follow-up treatment and casting in two days

Answer: See page 15. □

Rule of Thumb: A strap is something used to bind surfaces together or to give support or compress a body part (e.g., wrapping tape around a sprained ankle).

Adopt group policy after review of relevant payer rules

Payers and clinical conventions support the use of strapping when the physician has stabilized a joint with non-rigid materials allowing the patient to retain some range of motion, such as tape, web rolls and possibly an elastic (e.g. ACE) bandage. But the sole use of elastic bandages as strapping may be controversial among certain payers.

Coders can approach this issue by doing a little research with payers and creating a practice policy specifying which materials are appropriate to use for strapping.

Policies regarding reimbursement for strapping and taping by health care professionals vary greatly from state to state. Review payer policies to determine which codes apply and work best for your practice.

If the payer does not accept an elastic bandage wrap as strapping, then you will likely be limited to coding the appropriate level evaluation and management (E/M) code.

Clinical coding example: A patient reports to the ED after stumbling, falling, and hyperextending his ankle while walking his dog. During a Level 3 ED evaluation and management (E/M) service, the physician diagnoses a sprained ankle. The physician applies layers of web roll followed by adhesive tape to stabilize the ankle followed by application of an elastic bandage to the patient's ankle and foot.

You should use a strapping code in this scenario. On the claim, report the following codes:

- » 99283 (*Emergency department visit for the evaluation and management of a patient, which requires these three key components: an expanded problem focused history; an expanded problem focused examination; medical decision making of moderate complexity*) to evaluate the injury, rule out additional injuries and manage pain as needed.
- » Attach modifier 25 (*Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service*) to 99283 to show the E/M and strapping were separate services.
- » 29540 (*Strapping; ankle or foot*). Modifier LT or RT may be applied as appropriate to indicate the affected limb.
- » ICD-9 code 845.00 (*Sprains and strains of ankle; unspecified site*) linked to 29540 and 99283-25.

(Continued on next page)

- » ICD-9 code E885.9 (*Accidental fall on same level from other slipping, tripping, or stumbling*) linked to 99283-25.

Look For Rigid Materials With Splint

Whereas straps are typically combinations of tape, bandages or some other flexible material, splints are made of harder stock. “Splinting is the application of a device made of rigid material including metal, plastic, fiberglass or plaster. Splints are used for stabilization, protection, and patient comfort for an injury such as a sprain, fracture, or dislocation, says Price.

Static versus Dynamic Splints

A static splint has no moving parts, protecting, immobilizing and providing stability for an acute injury. The static splint is most frequently utilized in the Emergency Department. Dynamic splints have moving parts (e.g. hinges, springs) that allow for limited movement and/or resistance during rehabilitation.

Rule of Thumb: Splinting is an application of an appliance used for the fixation, union, or protection of an injured body part; it may be movable or immovable.

Remember: According to Medicare rules, in order to report splinting or strapping codes, documentation must support that the physician or NPP directly participated in the application process, Price adds. CMS directs ED providers to bill for splints only if the splint is personally applied by the physician or NPP, when the NPP is a member of the ED physician group.

CMS Carriers referenced the fact that “incident to” rules do not apply in the hospital setting under Medicare Part B and referred to Chapter 15, Section 60-0B and Section 60.1B (B-3 2050.1) of the Medicare Benefit Policy Manual, which states that a physician may not bill for the services of a hospital employee “incident to” the physician service.

Bottom Line: Provider documentation is the key to determine whether a strapping or splint application code is appropriate. When in doubt, the best coding practice is to ask the provider for clarification, says Price. □

Reader Questions

Distinguish Open From Closed Fracture Treatment

Question:

What is the difference between an open and closed fracture treatment?

California Subscriber

Answer:

You’ll need to know the difference between the two, because your CPT® code choice is based on whether the physician performed open or closed repair.

Closed definition: When the physician performs closed fracture treatment, it means that she did not have to surgically open the fracture site in order to repair the break. So if the operative report indicates that the physician performed closed treatment of a patient’s broken rib, you’d report 21800 (*Closed treatment of rib fracture, uncomplicated, each*) for the repair.

Open definition: When the physician performs open fracture treatment, she either: surgically opens the fracture site and performs internal fixation; or exposes the fracture site remotely and inserts an intermedullary nail. However, due to the equipment needed for the procedure and the high risk of infection, open fractures are typically fixed in the operating room, not the ED.

So if the thoracic surgeon performs an open repair on a patient’s sternum, you’d report 21825 (*Open treatment of sternum fracture with or without skeletal fixation*) for the repair.

Modifier 54 alert: Nearly all ED fracture care claims include modifier 54 (*Surgical care only*), because the ED physician is only treating the acute fracture, not providing the follow-up care. CPT® reports that you must append modifier 54 to your fracture care claims unless the ED

You Be the Coder

Consider this example

(Question on page 13)

Answer:

You should code this scenario as a splinting procedure. On the claim:

- » Report 99283 (*Emergency department visit for the evaluation and management of an established patient, which requires these three key components: an expanded problem focused history; an expanded problem focused examination; medical decision making of moderate complexity*) for the E/M.
- » Attach modifier 25 to 99283 to show the E/M and splinting were separate services.
- » Report 29125 (*Application of short arm splint [forearm to hand]; static*) for the splinting.
- » Attach ICD-9 code 813.43 (*Fracture of distal end of ulna [alone] closed*) to represent the fracture.
- » Link ICD-9 code E881.0 (*Accidental fall from ladder*) to represent the cause of the injury. □

physician performs all of the follow up services during the global period which is typically 90 days. □

Can You Report an ED E/M And Critical Care on the Same Day?

Question:

Is there official documentation where both critical care and an ED level can be billed on the same date of service? I understand it is rare (most patients come in critical) and requires additional work to get reimbursement and that not all payers will reimburse for both on the same day, but it is a possible billing situation, correct or incorrect? And is there any official documentation to support this situation?

Mississippi Subscriber

Answer:

CPT® specifically states that critical care and other E/M services may be provided to the same patient on the same day by the same physician. In fact, that is a direct quote, but Medicare does not allow both services to be reported in the emergency department setting.

CMS describes the criteria in which they will pay for both a regular E/M and a critical care code in. In Pub 100-4, Chapter 12, Section 30.6.12 (H), the text is as follows:

H. Critical Care Services and Other Evaluation and Management Services Provided on Same Day

“When critical care services are required upon the patient’s presentation to the hospital emergency department, only critical care codes 99291-99292 may be reported. An emergency department visit code may not also be reported.

When critical care services are provided on a date where an inpatient hospital or office/outpatient evaluation and management service was furnished earlier on the same date at which time the patient did not require critical care, both the critical care and the previous evaluation and management service may be paid. Hospital emergency department services are not payable for the same calendar date as critical care services when provided by the same physician to the same patient.

Historically, Medicare would allow both services only if the ED E/M occurred first and then was followed by a significant decline in the patient’s condition to the extent that became critically ill, but the underlined sentence indicates that policy has changed. □

Tread Carefully When Dealing with Tarsal Fractures

Question:

My physician saw a patient for a non-displaced tarsal bone fracture, which did not require manipulation. Rather than

applying a cast, the physician placed a prefabricated short leg removable cast. I spoke with my physician and the patient will not require much in the way of additional treatment. She was instructed to follow up with the orthopedist in 2 weeks. Can this be reported as fracture care?

Wisconsin subscriber

Answer:

Yes, this would be reported using code, 28450 (*Treatment of tarsal bone fracture [except talus and calcaneus]; without manipulation, each*). In this case, the physician has determined that there is a fracture, decided on the appropriate course of treatment, so he is meeting the requirements for reporting the fracture care code.

However, unless they are providing the associated follow-up fracture care included in the global surgical package, be sure to append the 54 modifier to indicate you are reporting the procedure only. □

The CMS Shared Services Documentation Exemption Only Applies to E/M Services

Question:

If an emergency physician sees a patient and performs an ED E/M service, but has a Non Physician Provider come in to perform a laceration repair and both provider’s properly document in the chart, and sign the chart, do the E/M and procedure get billed under the physician, or does the E/M get billed under the physician and the procedure under the Non Physician Provider? Also, does it make a difference depending on the payers the bill is being sent too?

Texas Subscriber

Answer:

The physician can’t bill for a procedure performed by the NPP. The changes from Transmittal 1776 and the rules regarding shared services only apply to E&M services. There is no mechanism for a procedure to be reported as a shared service. Procedures performed by an MLP should be billed under their ID number and paid at 85% of the Medicare allowable.

The resident rules for procedures do not would apply to NPP services. Most private insurers require that the bill for services provided by NPP be filed under the physician’s name and provider number. A few private insurers want the claim to be filed under the NPP name, specifically Aetna and some BCBS have stated that they will be following Medicare policy for documentation and performance requirements as well as applying the 15% discount. □

— Reader Questions and You Be the Coder reviewed by **Michael A. Granovsky, MD, FACEP**, president of Logix Health, a medical coding and billing company in Bedford, Mass.

Emergency Medicine

C O D I N G A L E R T

We would love to hear from you. Please send your comments, questions, tips, cases, and suggestions for articles related to *Emergency Medicine coding and reimbursement* to the Editor indicated below.

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