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The Insider News

January 2011

Volume 3, Number 2

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Snapshot of 2011 Coding Changes

The following is a list of coding changes that have occurred for 2011. The list is not all-inclusive but it does contain those codes that may be most relevant to your practice. For a complete list of updates, refer to your 2011 CPT book.

Many of the changes involve revised code descriptions that may have a bearing on how certain services are reported. Please make sure your computer system is updated with the 2011 code changes, including new codes, revised codes, and deletions.

Wound Care Codes

The concept of debridement/wound care coding is changed to focus more on the depth of the wound and the size of the repair.

The descriptions for code 11010-11012 have been revised to more clearly state that they are used for excisional debridement at the site of an open fracture or open dislocation.

Codes 10040-10041 have been deleted. For debridement of skin to the epidermis or dermis only, report from the code series 97597- 97598.

Codes 11042, 11043, 11044 have been revised so that both the depth of the debridement and the size of the debridement are considered. These codes are all used to report the first 20 sq cms or less.

Codes 11045, 11046 and 11047 are new add-on codes created to report each additional 20 sq cms, or part thereof. The correct code depends on the depth of debridement: 11045 is an add-on to 11042; 11046 is an add-on to 11043; 11047 is an add-on to 11044.

The description for code 97597 has been revised. The add-on code 97598 is revised to state: *"each additional 20 sq cm, or part thereof"*

The edit between the 11040-47 series and 97597-97598 has been changed as well. So long as applicable to different wounds, and supported by applicable modifier, both series can now be used within the same encounter.

Musculoskeletal Codes

- 20000 -Incision of soft tissue abscess (eg, secondary to osteomyelitis); superficial, **was deleted** (For incision and drainage procedures, cutaneous/subcutaneous, see 10060,10061)
- Arthrodesis procedures that include discectomy, osteophyctectomy and spinal cord decompression are to be reported with two new bundled codes to replace reporting of 63075 + 22554
 - 22551 Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophyctectomy and decompression of spinal cord and/or nerve roots; cervical below C2
 - +22552 each additional interspace (List separately in addition to code for separate procedure)

- New guidelines for 22554:
 - Do not report 22554 in conjunction with 63075, even if performed by separate providers. To report anterior cervical discectomy and interbody fusion at the same level during the same session, use 22551
 - If two physicians are performing discectomy and arthrodesis, they must bill 22551 with the 62 modifier, 63075 and 22554 cannot be billed, even separately.

New Descriptions

- 27070: "Partial excision, wing of ilium, symphysis pubis, or greater trochanter of femur, (craterization, saucerization) (eg, osteomyelitis or bone abscess); superficial"
- 27071: "Partial excision, wing of ilium, symphysis pubis, or greater trochanter of femur, (craterization, saucerization) (eg, osteomyelitis or bone abscess); deep (subfascial or intramuscular)"

New Codes for Hip Arthroscopy

- 29914 Arthroscopy, hip, surgical; with femoroplasty (ie, treatment of cam lesion)
- 29915 Arthroscopy, hip, surgical; with acetabuloplasty (ie, treatment of pincer lesion)
- 29916 Arthroscopy, hip, surgical; with labral repair

Transforaminal Epidural Injection

- Imaging guidance (fluoroscopy or CT) and any injection of contrast are inclusive components of 64479-64484. Image guidance and localization are required for the performance of 64479-64484).
- For transforaminal epidural injection under ultrasound guidance, use 0228T-0231T.
- For transforaminal epidural injection at the T12-L1 level, use 64479

Paravertebral Spinal Nerves and Branches

- Imaging guidance (fluoroscopy CT) and any injection of contrast are inclusive components of 64490-64495. Imaging guidance and localization are required for the performance of paravertebral facet joint injections described by 64490-64495. **If imaging is not used, report 20552-20553.** If ultrasound guidance is used, report 0213T-0218T.
- For paravertebral facet injection of T12-L1 joint, or nerves innervating that joint, use 64490.
- Do not report 77003 in conjunction with 64479-64484, 64490-64495. Fluoroscopic guidance is now bundled into the injection code.

Modifiers

- Modifier 50: The term "operative" has been deleted from the description
- Modifiers 76, 77, 78: "Other Qualified Health Care Professional" was added to the description

Submitting Claims for Compound Medications for Pump Refills to Medicare

- Whether a single agent or a combination of agents is used, the compounded medication must be submitted with HCPCS code J3490, even though the compound is similar to or includes a drug with a specific HCPCS code (e.g., HCPCS code J2275 for preservative free morphine).
- Use HCPCS code J3490 on a single claim line with '1' unit
- Enter the name and total dose (in mg or mcg) of each drug of the refill in Box 19 of the HCFA 1500 or the appropriate comment loop of electronic claims
Example: Unit of 1 J3490 claim line detail: Entered in Box 19/4010a comment field 'Morphine Sulfate XX mg + Fentanyl YY mcg + Clonidine ZZ mcg'
- To compute the price for J3490, multiplying the price per mcg or mg in the table below by the total number of mcg or mg of each drug used to refill the pump then add a pharmacy compounding fee of \$60 per refill.

Medication Price	Per mg or mcg	Medication Price	Per mg or mcg
Morphine Sulfate	\$0.050/mg	Droperidol	\$0.0013/mcg
Hydromorphone	\$0.130/mg	Ketamine	\$0.0048/mcg
Bupivacaine	\$0.040/mg	Baclofen	\$0.003/mcg
Tetracaine	\$0.040/mg	Clonidine	\$0.001/mcg
Fentanyl PF	\$0.0072/mcg	Sufentanyl	\$0.090/mcg
		Prialt*	\$7.900/mcg

Coding Reminder: Using Modifiers 24 & 25

- Report modifier 24 for an E/M service that occurs during the global period for an unrelated problem (i.e., patient in global for hip fracture, now presents with wrist pain).
- Report modifier 25 for an E/M service that is a significant separately identifiable service occurring on the same day as a minor procedure.

Coding Reminder: Place of Service

The OIG has announced that a review of Place of Service Coding for physician services for calendar year 2007 reveals that 90% of claims sampled were coded incorrectly by using non-facility place of service codes for services that were actually performed in hospital outpatient departments or ASCs.

Make sure that the POS is correct and that there is a proper documentation.

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For coding questions, contact Gladys Ross, CPC, CCS-P, ACS-EM at gross@grmed.com

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