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The Insider News

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In This Issue

- Nerve Block vs. Nerve Destruction
- OIG 2009 Work Plan: Physician Services
- Health Care and the Economy

Nerve Block vs. Nerve Destruction

To avoid potential errors, providers should be aware of the guidelines for counting and properly documenting nerves vs. joints when performing/coding for facet joint injections vs. nerve destruction.

A single level for paravertebral facet joint injections [64470-64476] refers to the interspace between two vertebrae. For example, if you perform a diagnostic nerve blocks of the C3 and C4 medial branches, that represents only one level and you should only report 64470. When you perform a more extensive nerve destruction [64626-64623], you will count the actual number of nerves destroyed by a neurolytic agent. For example, if you document "C5-C6 facet joint nerve radio frequency destruction", you would report procedure code 64626 for the first level and procedure code 64627 for the additional level. In both circumstances, fluoroscopy guidance-procedure code 77003-is to be reported separately.

Proper documentation is crucial and the solution is rather simple: You should carefully document the location of each and every injection, including the level(s) injected, the total number of injections per level, and the side of the spine the injection(s) took place. You should always document the reason why the injections are administered and make sure your diagnosis is consistent with the procedure. Check the diagnosis crosswalk before submitting your claims.

OIG Work Plan for 2009: Physician Services

Each year, the OIG Develops a work plan that encompasses all avenues of medical care (physician services, hospitals, nursing home, etc.), and identifies what services within each category they will evaluate for coding appropriateness.

The following is a list of some of the physician services that the OIG will be scrutinizing:

- **Place of Service Errors** – review of ASC and hospital outpatient department claims for appropriate place of service identification to assure that payment levels are appropriate based on facility versus non-facility payment levels
- **E/M Services During Global Surgery Periods** – review number of E/M encounters occurring during the global period to see if industry standards for services supplied during global period have changed since the inception of the global surgery concept in 1992
- **Outpatient Physical Therapy Services Provided by Independent Therapists** – evaluation of outpatient physician therapy services to assure they are in compliance with Medicare guidelines
- **Physicians' Medicare Services Performed by Non-Physicians** – evaluation of "incident-to" services for potential over-utilization and to validate that persons performing these services are qualified to do so

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- **Medicare Payment for Unlisted Codes** – *evaluation for the volume and types of services performed that are not described by existing CPT/HCPCS codes*
- **Medicare Billings with Modifier GY** – *review the appropriateness of provider use of the modifier "GY" on claims not covered by Medicare; examine the patterns and trends for use of the "GY" modifier*

Health Care and the Economy

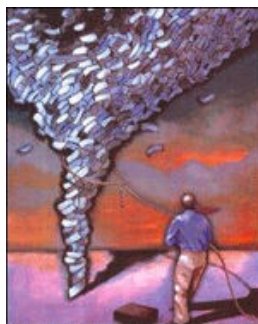
There's no avoiding news on the economy these days. The most common prediction for the medical community is that utilization may decline because so many people are facing lay-offs and finding it difficult to maintain insurance premiums. Certainly there are cautions about practices investing income wisely and re-thinking capital expenditures. Most economists do believe the health care field will be less impacted by the economic down-turn than other industries.

There is a general "belt-tightening" philosophy throughout the nation right now, So, in that spirit, what are some steps that can be within the medical office on a daily basis to protect and maintain practice revenue?

Here's some considerations:

- **Don't neglect to collect the co-pay** - *If your patient is insured, and their plan requires that they pay a co-pay at time of service, make every effort to collect it at time of service. You cannot waive the co-pay or you will be in violation of your agreement with the carrier. Sending the patient a statement just for co-pay collection is not cost-effective.*
- **Watch your AR** - *It's a well-known fact that a claim that is over 120 days is much more difficult to collect, and thus, more costly to the practice. Don't wait until claims are 90 days old to work the accounts.*
- **Verify eligibility** - *With so much job instability occurring, don't assume the patient who had insurance last month has insurance this month. Verify eligibility at each patient encounter. If you are a surgical practice and you see Mrs. Jones in January but plan to do her surgery in February, verify she still has benefits in February.*
- **Review your claim denials** - *Don't leave money on the table. If you have claim denials and don't know why, investigate. If there is a problem on the practice side (i.e., necessary modifiers never attached), fix it. If it's something that the carrier should have paid, appeal it. This sounds like a no-brainer, but many practices never review EOB's for lost revenue.*

Industry News



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