Meaningful Use Hardship Exceptions: Do You Qualify?

By Laura Kreofsky

The Stage 2 Meaningful Use (MU) Final Rule, published in Fall 2012, describes several hardship exceptions a MU Eligible Professional (EP) or eligible hospital can use to avoid Medicare penalties for not achieving or sustaining MU. For non-hospital based physicians and other providers, these exceptions include:

1. Practicing in an area without sufficient Internet access
2. Newly practicing providers
3. Extreme circumstances making it impossible for the provider to demonstrate MU through no fault of his/her own. (i.e., a practice being closed down; a natural disaster in which an EHR is destroyed; EHR vendor going out of business, etc.)
4. Specialists such as anesthesiologists, radiologists and pathologists who lack both face-to-face interactions with patients and the need to follow up with patients.

In early 2014, CMS posted a FAQ on the CMS website giving more details on the exception process. CMS also added a fifth hardship exception to further accommodate “2014 EHR Vendor Issues.” This exemption could apply if the EHR vendor was unable to obtain or was delayed in obtaining 2014 EHR Certification or the EP was not able to implement or upgrade the EHR in time to meet MU due to EHR certification delays. Given the challenges of vendor EHR certification and the time and resources needed to implement / upgrade an EHR, this added exception may help many EPs avoid Medicare penalties.

In most cases, EPs must complete an application for a hardship exception. However, the following providers do not need to submit an application:

- Providers in their first year of practice
- EPs listed under these specialties in PECOS (ensure your PECOS record is up-to-date!)
  - Diagnostic Radiology (30)
  - Nuclear Medicine (36)
  - Interventional Radiology (94)
  - Anesthesiology (05)
  - Pathology (22)

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“Meaningful Use” Continued...

As with all things Medicare, there is “fine print”, such as: CMS will review each application on a case-by-case basis. Exceptions must be renewed annually except for new EPs who are granted a 2-year exception, and an exception will not be granted for more than 5 years. Additionally, there are fast-approaching application timing deadlines for reporting year 2014.

For providers struggling to meet or sustain MU given any of the reasons noted above, the hardship exception process should be explored; an exception avoids Medicare penalties in 2015 and beyond.

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Understanding Diabetes 2014

By Monique Vanderhoof, CPC

With 5,205 Americans being diagnosed with diabetes each day every day we will likely all be coding diabetes and need to understand the coding guidelines associated with these codes. With several types of diabetes and a multitude of complications and manifestations it can be confusing to say the least. Let’s start to break it down:

Diabetes Type 1 – Otherwise known as insulin dependent diabetes or IDDM. Previously known as juvenile diabetes. However, patients of any age can be diagnosed with type 1 diabetes so age should never be considered a factor in determining the type of diabetes. The pancreas no longer makes insulin to facilitate the blood glucose entering the cells to be used as energy.

Diabetes Type 2 – This is the most common form of diabetes. Otherwise known as non insulin dependent diabetes or NIDDM. Previously known as adult onset diabetes. However, patients of any age can be diagnosed with type 2 diabetes so age should never be considered a factor in determining the type of diabetes. The pancreas doesn’t make enough insulin or the body is unable to use the insulin properly.

Diabetes Type 1.5 - Otherwise known as latent autoimmune diabetes in adults (LADA). This type of diabetes is still under investigation. Some physicians are beginning to classify patients as type 1.5, however, ICD-9-CM does not currently recognize this type of diabetes.

Gestational Diabetes – Pregnant women with higher than normal blood glucose levels are said to have gestational diabetes. Gestational diabetes starts when the body is not able to make enough insulin it needs for the pregnancy.

Secondary Diabetes - Diabetes that is caused by another condition or event (malignant neoplasm of the pancreas, adverse effect of a drug, etc.)

Diabetes Insipidus - Symptoms of frequent urination and excessive thirst caused by a possible defect in the pituitary gland or kidney. In diabetes insipidus glucose levels are normal.

Diabetic manifestations and complications also need to be part of the documentation and coding process. Diabetes codes are broken down into categories based on their associated manifestations and/or complications. For example codes in category 250.40-250.43 are all for diabetes with renal manifestations. Codes is category 250.60-250.63 are all for neurological manifestations. It is important for physicians to understand and document the patients diabetes properly and thoroughly so that coders can begin to determine the correct code selection for the patient condition.

Monique Vanderhoof, CPC joined RMC in September 2011 as Manager of Coding Services, focusing on HCC coding audits and client education. With over 15 years experience as a Clinic Manager, Monique has a extensive experience working in both outpatient and inpatient physician billing with emphasis in cardiology. Her skills also include EHR implementation, HIPAA, eRx and Meaningful Use readiness and attestation.
The 2014 CPT update brought additions, deletions and guideline updates in breast procedures. Following the trend of recent years, the 2014 CPT update includes new codes that combine breast procedure codes with imaging-guidance codes, which were frequently found to be reported together. Codes are now based on the type of imaging modality as well as the number of lesions treated.

Introduction guidelines were revised to include instructions for coding breast biopsies without imaging-guidance; breast biopsies with image guidance; and image-guided placement of localization devices without image-guided biopsy procedures. The guidelines also clarify when add-on codes should be used and how to code multiple biopsies using different imaging modalities. Parenthetical notes have been added to instruct users in reporting these new codes.

No changes were seen for breast biopsies performed without imaging-guidance. CPT code 19100 is used to report percutaneous breast biopsies not using imaging guidance; CPT 19101 is used to report open, incisional breast biopsies without imaging guidance. The documented approach is the controlling factor when coding breast biopsies without image guidance.

Image-guided breast biopsies, including the placement of localization devices when performed, are reported using 6 new bundled codes 19081-19086. Add-on codes were created and should be used for each additional biopsy performed using the same imaging modality. When additional biopsies are performed using different imaging modalities, an additional primary code should be reported for each modality utilized. An exclusionary parenthetical note has been added following code 19086 restricting the use of breast biopsy with imaging codes 19081-19086 in addition to the placement of breast localization device codes 19281-19288 and imaging codes 76098, 76942, 77002, and 77021 for the same lesion. Image-guided breast biopsy codes are chosen based on the type of imaging modality documented and add-on codes are utilized for each additional lesion.

CPT 2014 also established eight new bundled codes, 19281-19288, to report the image-guided placement of localization devices without biopsy. Coders should report an add-on code for each additional localization device placed using the same imaging modality. When additional localization devices are placed using different imaging modalities, an additional primary code should be reported for each modality utilized. When an open incisional biopsy is performed after image-guided placement of a localization device, code 19101 is reported along with the appropriate image-guided localization device placement code. An exclusionary parenthetical note has been added following 19288 restricting the use of the placement of the breast biopsy localization device codes 19281-19288 in addition to the breast biopsy with imaging codes 19081-19086 and the imaging codes 76942, 77002, and 77021 for the same lesion. To ensure the correct code(s) for image-guided placement of localization device(s) is used, coders should determine the type of imaging modality as documented by the provider.

The guidelines further clarify that open excisions of breast lesions without specific attention to adequate surgical margins, with or without the preoperative placement of radiological markers, are reported using codes 19110-19126. Examples would include lesions of the breast duct, cyst, benign malignant tumors. Open excisions of breast tissue with specific attention to adequate surgical margins are coded as partial mastectomy procedures (e.g. lumpectomy, tylectomy, quadrantectomy, or segmentectomy). For partial mastectomy codes 19301 or 19302, documentation includes attention to the removal of adequate surgical margins surrounding the breast mass or lesion.

No changes were seen in the total mastectomy codes 19303-19307. Total mastectomy procedures include simple mastectomy, subcutaneous mastectomy, modified radical mastectomy, radical mastectomy, and more extended procedures, for example, an Urban-type operation.

As with all medical coding, provider documentation is critical and should be referenced before assigning any CPT or ICD-9 code. If information isn’t documented, it cannot be assumed and must be coded based on the documentation provided.

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The National Correct Coding Initiative (NCCI) was developed by the Centers for Medicare & Medicaid Services (CMS) to prevent inappropriate payment of services when incorrect code combinations are reported, i.e., codes that should not be billed by the same provider for the same patient on the same date of service. NCCI edits are used by Medicare carriers and other payers in adjudicating claims and can be found on the CMS Web site at: http://www.cms.gov/NationalCorrectCodInitEd/01_overview.asp#TopOfPage.

NCCI includes three types of edits:

- NCCI Procedure-to-Procedure (PTP) edits are those that prevent inappropriate payment of services that should not be reported together. Each edit has a column one and column two HCPCS code. If a provider reports the two codes of an edit pair for the same patient on the same date of service, the column one code is eligible for payment. The column two code will be denied unless an appropriate NCCI-associated modifier is also reported. These PTP “bundling” edits have been around for many years.

- Medically Unlikely Edits (MUEs) prevent payment for an inappropriate quantity of the same service on a single day. An MUE for a given HCPCS code is the maximum number of units of service that may be reported by the same provider for the same patient on the same date of service. CMS publishes most MUE values on its Web site, but other values are confidential and remain unpublished in an effort to deter fraud and abuse.

- Add-on Code Edits are codes that are eligible for payment if and only if one of their primary codes is also eligible for payment. Listings of such HCPCS add-on codes with their respective primary codes may be found in CMS Transmittal 2636, CR 7501 or for 2014 can be downloaded from CMS at: http://www.cms.gov/apps/ama/license.asp?file=/NationalCorrectCodInitEd/downloads/Complete-Add-on-Code-Edits-Report.zip. These edits are fairly new in comparison to their counterparts.

Changes in the NCCI Policy Manual 2014 can be downloaded from http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/Downloads/NCCI_Policy_Manual.zip and have been noted in red italicized font. The zipped file contains a Table of Contents, an Introduction, a general coding policies chapter and twelve additional chapters based upon HCPCS ranges. Chapter 1 includes instructions on reporting modifiers to bypass bundling edits. According to CMS, there are 40 modifiers that can be used, when appropriate, to bypass bundling guidelines. As always, documentation in the medical record is necessary to support any NCCI-associated modifier used. NCCI version 20.2 will become effective on July 1, 2014.

NCCI changes for 2014 include bundling of mammograms to verify clip placement into breast localization when performed under mammographic guidance (PTP example); limiting the units of service (UOS) to one for Tier 1 molecular pathology procedure codes for each distinct source of a specimen (MUE example); and changes to the codes and situations with which drug infusion for stimulation and pacing may be reported (Add-on code example). While you may have software that checks these edits for you, it is advisable to download the latest files and take a look for yourself. Then review the specific NCCI Policy Manual chapter for the timeframe of the code(s) in question, as often, the guidance clearly indicates how to report, i.e., what modifier to use, etc., and even sometimes how the place of service can impact reporting and modifier usage. Dealing with NCCI edits can be challenging but life can be made easier with a little “whatnot” knowledge!

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Examples:

#1
S: 30 year-old male here for follow-up of sinusitis. Pt uses Rhinocort currently for allergic rhinitis. He has been diagnosed with sinusitis 6 times in the last year. Treatment has been with Zithromax, but most recent episode has not cleared.
O: Vital signs normal. A maxillary sinus culture was taken and came back positive for H. influenzae. He complains of loss of sense of smell. Exam otherwise normal.
A: Recurrent acute infection of the maxillary sinus due to H. influenzae. Allergic rhinitis.
P: Continue antibiotic treatment. RTC 2 weeks.

#2
S: 48 year-old male here for preventative exam. Feels well and has no complaints. Chronic problems include tobacco dependence in remission, and varicose veins of the legs.
P: Doing well. Continue regimen and RTC 1 yr or as problems arise.

#3
S: 78 year-old male brought in by caregiver with new onset speech difficulties and confusion. Pt carries dx of cerebral amyloid angiopathy for which he takes Tegretol. His seizures are well controlled.
O: Vital signs: stable. Pt is oriented to person but not place. He has had no falls or injuries to the head. Had flu like symptoms with vomiting yesterday but feels better today. STAT labs and head CT ordered.
A: CT of the brain revealed a small cerebellar hemorrhage.
P: Admit to neurology and get MRI.

Answers:

#1
J01.81 Other acute recurrent sinusitis
B96.3 Hemophilus influenzae as the cause of disease classified elsewhere
J30.9 Allergic rhinitis

#2
Z00.00 Encounter for general adult medical exam without abnormal findings
I83.93 Asymptomatic varicose veins of bilateral lower extremities
F17.201 Nicotine dependence, unspecified, in remission

#3
I61.4 Nontraumatic intracerebral hemorrhage in cerebellum
E85.4 Organ-limited amyloidosis
I68.0 Cerebral amyloid angiopathy

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