Why You Can’t Get An Annual Medicare Physical

In 2011, the Centers for Medicare and Medicaid (CMS) unveiled a new benefit to address the need for annual care for seniors. It was widely hailed as a wonderful thing for Medicare patients who previously had no preventive care unless they paid out-of-pocket for a “complete physical.” What some people overlook is that the new Medicare benefit includes no actual physical examination of any kind.

The “physical” terminology is what trips most people up. The American Medical Association (AMA) owns Current Procedural Terminology (CPT) which is part of the Medicare’s Healthcare Common Procedure Coding System (HCPCS). Neither CPT nor HCPCS lists an “annual physical” or a “complete physical,” with the exception of the preventive visit codes which include an “age-appropriate examination.” The traditional expectation for an annual physical is complete review of all physical systems with reporting of any issues, a complete head to toe physical examination, and any needed tests to confirm/promote wellness or to ascertain illness.

According to CPT/HCPCS, confirming/promoting wellness and ascertaining illness are not both parts of one code, but are addressed in two different types of codes – the well visit codes and the sick visit codes. The question on everyone’s mind is “What if you ascertain and address illness (a new problem) during a well visit?”

I don’t think there is a good answer to this question. There’s the right answer for billing, according to Medicare and there’s the right answer in the minds of most physicians I know, but there is not a single answer that works for billing and what patients want.

Because of this confusion, there is great frustration on the part of physicians and patients. If the office doesn't understand what the patient wants, or the patient doesn't understand their Medicare benefits, there is either a surprise in the exam room, or a surprise at the check-out desk, and no one enjoys that kind of surprise.

The only answer is to help patients understand what Medicare will and will not pay for and to try to match their benefits, their needs and what they are willing to pay for.

Here are the service choices defined by CMS/Medicare:

NAME: Welcome to Medicare Visit

WHEN: Available to all Medicare patients during the first 12 months of Medicare Part B eligibility

WHAT HAPPENS: Review of patient's medical history, risk factors, functional abilities and referrals for education or counseling. Could include an EKG or referral for an EKG. Could include screening for an
abdominal aortic aneurysm (AAA). **Does not include a physical exam.**

WHO PAYS: This visit has no deductible and no co-insurance, unless the patient has a screening EKG. The EKG does have the deductible and co-insurance applied.

NAME: Annual Wellness Visit

WHEN: Available 12 months after the Welcome to Medicare Visit and every 12 months thereafter
Does not include a physical exam.

WHAT HAPPENS: Review of your medical history, risk factors, functional abilities, a depression screening and a written screening schedule.

WHO PAYS WHAT: This visit has no deductible and no co-insurance.

NAME: Sick Visit (standard office visit)

WHEN: No restrictions on how often as long as there is a documented need for the visit.

WHAT HAPPENS: This is a regular office visit for an illness, injury or new problem or for monitoring of an existing problem. The three parts of a standard office visit are the HISTORY, the PHYSICAL EXAM, and the ASSESSMENT/PLAN.

WHO PAYS WHAT: This visit will apply to the deductible ($147 for 2013) if the patient's deductible has not been met, and co-insurance will apply.

SPECIAL NOTE: Patients can have a wellness visit and a sick visit at the same appointment and will not owe anything for the wellness visit but will owe the deductible/co-insurance for the sick visit.

NAME: Preventive Visit (most like the old "annual physical")

WHEN: Annually.

WHAT HAPPENS: This is a visit where the physician will review your medical history and perform an exam, order routine lab

tests and talk to you about risk factor reduction.

WHO PAYS: Medicare does not pay for this service at all and the patient is responsible for 100% of the cost of the visit.

Medical Coding Expert Doug Palmer Talks About the Future: Computer-Assisted Coding, and ICD-10

Doug Palmer is a practice management, billing and coding and revenue cycle consultant with over 17 years of experience in the industry. He was nice enough to answer some questions for our readers about his experiences and where he sees coding going in the future.

MMP: How did you get started in coding?

Doug: I started in the industry as a medical biller with a billing company in NY City. In a rather short period of time, I became familiar with the coding systems (COT, ICD-9, and HCPCS) and began to want to know more. I also wanted to know more about the overall Revenue Cycle Process. That starting point in billing led me to coding for several reasons. Aside from personal and professional development, I realized that I would be more marketable with that skill set. I was right. As I learned more and more about coding…more and more opportunities seemed to come my way.

MMP: What type of coding education and certification do you have?

Doug: I have gotten most of my education in coding "on the job". I have attended many seminars, CEU courses, internal education opportunities with employers, etc., however, I have never matriculated into any formal or long term courses of study in coding other than a BS in Health Administration which did not specifically focus on coding. At the same time, with my CCS-P Certification through AHIMA, I have taught coding and related courses both in a formal classroom environment in several adult education schools as well as providing on site education as well as web based instruction to other coders as well as medical providers across the country.

MMP: What was your first coding consultant position and how did it come about?

Doug: After a very bad employment experience where I had to stand up for being compliant against a manager that had no regard for regulations nor the impact it had on the organization we worked for, I sought a different environment. A company based in California contacted me about a travel consulting position and it felt right and seemed to be just what I needed, and indeed it was. I have been consulting ever since. It has afforded me growth I do not think possible remaining in one environment. It has exposed me to countless organizations giving me the opportunity to see what works well, what doesn't, and has made me a better coder, manager, and consultant.

MMP: What tools do you use to assist you in your day-to-day coding?

Doug: Of course, the basics are the CPT, ICD-9, and HCPCS publications which are the cornerstone of coding. There are a wide variety of resources out there that help you think outside of the your environment and open up a more global

perspective. Some examples are Coding Alerts from The Coding Institute which are published in a number of specialties, Coding Clinic, and Medicare NCDs and LCDs. These resources provide great insight, clarification, and education on a broad range of coding scenarios.

MMP: What do you find interesting about coding?

Doug: This is a tough question to answer only because there are so many fascinating aspects to coding. To be a part of the health field and know that coding goes beyond mere reimbursement, is one of the elements that I find both intriguing and satisfying. When a news report states a statistic such as a higher or lower incidence of a particular condition in a particular area, I know that those statistics are captured in large part from the coding that goes on.

MMP: What have you seen change about coding over the years?

Doug: I began in healthcare at a time when E&M Codes were assigned by the provider in essentially an arbitrary fashion based on what they believed the services they rendered were worth on an ascending scale. Largely, government programs such as Medicare and Medicaid with their dual role as payor and regulator of health services have led the way in changing, shaping, defining, and standardizing coding. E&M codes in particular, at least on the professional services side, have become much more standardized and in theory are more equitably assigned then they were prior to the 1990’s. Payment methodologies such as fee-for-service, DRG (Diagnosis Related Groups), capitation, HCC (Hierarchical Condition Categories), and CRG (clinical risk groups) all influence or depend on the core of coding and thus depend on complete and accurate coding to be optimal.

MMP: Would you encourage people to go into medical coding as a career? Why or why not?

Doug: Well, as an educator in this field, I would encourage

people to explore it and find out enough about it to make a sound decision for them. While I find this field fascinating, rewarding, fulfilling, and have made a successful career of it, it may not be for everyone. There can be long arduous hours in front of a computer screen, with the requirement to think critically and analytically. This may not appeal to everyone. Reading some records may make some people squeamish or depressed. The many rules, which change regularly, may not necessarily be for everyone to digest. However, for those that are looking for not just a job, but a career with so many opportunities, a career where one can feel that they play a valuable role in a process and can learn so much, I would highly encourage coding as a possibility. It really is a wonderful field to work in.

MMP: Do you think computer-assisted coding (CAC) will ever take the place of coders?

Doug: Absolutely not. At least not as long as the coding methodology is as it is now. I have actually worked with a number of these systems, and there are too many areas where context is involved and these systems are yet to be able to accurately and reliably handle context. If that hurdle is ever solved, then perhaps. But, until then, I can not envision this being nearly as reliable as the human element.

MMP: Do you think the change to ICD-10 is being underrated as a healthcare-wide change in the US, or do you think people are making more fuss over it than is really necessary?

Doug: I view the transition to ICD-10 as a positive step forward. It offers a much more accurate and precise means of reporting conditions, circumstances, anatomical locations, and other important and relevant information. Of course, change is always disruptive and polarizing. The issue is still being deliberated at many different levels and lobbied by many different organizations based on so many different agendas. I think that is to be expected when a change of this magnitude

is proposed and initiated.

MMP: What has been the most interesting or unusual coding job you've ever had?

Doug: I have been so many places, performed so many functions in such a wide variety of roles and specialties, this is difficult to choose only one. However, I believe that a project for a large health organization in Northern California would have to be the one I choose. In this capacity, I supported the transition to physicians, PAs, and NPs being responsible for assigning their own Evaluation and Management codes. This was all new to these providers and a task that they did not wish to be responsible for. It was a great challenge to go in and not only teach them a topic that they were not embracing, but to accomplish this in a very short period of time, and ALSO to achieve proficiency while changing a mind set. I got to do this over and over at each location and in the end did so successfully to the satisfaction of not only the organization but to the reluctant providers as well. I have to choose this over many equally interesting accomplishments based on my passion for providing education to new and veteran coders as well as health care providers.

Douglas B. Palmer, BS Health Administration, CCS-P has over 17 years of Practice Management, Revenue Cycle Management, HIM and Consulting experience. He has worked with medical practices of all sizes, been on the management team of some of the countries leading healthcare facilities, and has consulted with prominent insurance carriers. He is expert in all reimbursement methodologies, revenue cycle issues, EMR implementation and HIM management. He has overseen and managed the recovery of millions of dollars in revenue for clients and past employers. As the principal at Phys Assist Consulting, he prides himself on being personally involved and connected with each end every client and exceeding clients expectations as

the minimum acceptable outcome.

He can be contacted at d.palmer@phys-assist.com or at **(888) 873-0735**.

AMA Updates Vaccine CPT Codes for 2012 – 2013 Use

As they have since 2006, the American Medical Association released updated CPT codes for vaccines last week ahead of the 2013 official code book release.

Some of the highlights of the semi-annual report:

- **Code 90653** – has been ACCEPTED for inclusion in the 2013 codebook production cycle
  "Influenza virus vaccine, inactivated, subunit, adjuvanted, for intramuscular use"
- **Code 90739** – has been ACCEPTED for inclusion in the 2013 codebook production cycle
  "Hepatitis B vaccine, adult dosage (2 dose schedule), for intramuscular use"
- **Code 90672** – has been ACCEPTED for inclusion in the 2013 codebook production cycle
  "Influenza virus vaccine, quadrivalent, live, for intranasal use"
- **Codes 90685, 90686, 90687, 90688** were ACCEPTED for inclusion in the 2014 codebook production cycle
- **Codes 90655, 90656, 90657, 90658, and 90660** will include the term "trivalent", meaning "conferring immunity to

three different pathogenic strains or species”

You can learn more about the changes for July 2012 at the AMA’s Category I Vaccine Code Page

---

ICD-10 Implementation Strategies for Physicians – My Notes from the CMS Provider Call

The new winner of my ongoing competition for the CMS Employee Speaker contest is Dr. Daniel Duvall, Medical Officer, Hospital and Ambulatory Policy Group Center for Medicare! During a recent ICD-10 call, Dr. Duvall spoke clearly, was easy to understand and kept my attention.

Why are we moving to ICD-10?

ICD-9 has deficiencies, such as:

- Not enough detail for analyzing diseases
- Not enough detail for payment
- Insufficient attention to:
    - Medical encounters for reasons other than death
    - Non-lethal manifestations
- Out of room for new codes
- Obsolete family groups

- Unable to address 30 years of medical knowledge of etiology
- Inadequate attention to continuum of disease and clinically relevant subsets

ICD-10 brings to the table:

- Appropriate payment via stratification of morbidity (“My patients are sicker”)
- Specificity needed for episodes of care, Affordable Care Organizations, Hierarchical
  Condition Categories, and quality monitoring
- Better quality in research/clinical trials
- Identification of consistent cohorts
- Improved outcomes from population analysis
- Targeting resources to diseases: specialty, county, environment
- 2010 computational power cannot use 1980’s information

The detail is demanded not by government nor by payers but by specialty societies.

What exactly is ICD-10?

- Stands for International Classification of Diseases
- Developed by World Health Organization (WHO)
- The order of chapters is just like ICD-9
- Was originally released in 1993 and adopted by other countries
- Approximately 2000 diseases (families)
- Approximately 70,000 specific codes
- ICD-10-CM (diagnoses) will be used by all providers in every health care setting
- ICD-10-PCS (procedures) will be used only for hospital claims for inpatient hospital procedures
- ICD-10-PCS will not be used on physician claims, even those for inpatient visits (procedure coding system)

Will ICD-10 change the use of CPT and HCPCS?

There will be no impact on Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes – CPT and HCPCS will continue to be used for physician and ambulatory services including physician visits to inpatient.

How much of a headache will ICD-10 really be?

Dr. Duvall characterized how difficult the transition to ICD-10 will be for each stakeholder group, by assigning them stars and headache types. The more stars, the more head-pounding the transition will be!

- Government, CMS & CDC will have 5-star headaches (encephalitis)
- Health Insurance Plans will have four-star headaches (migraine)
- Hospitals will have three-star headaches (cluster)
- Billing Agencies will have two-star headaches (sinus)
- Physicians will have one-star headaches (tension)

What should practices be doing now to prepare?

- Create a new job aid (cheat sheet) or superbill
- Update proprietary software or contact billing software vendor to discuss changes
- Train your coders and billers
- **Train your physicians and providers**

- Purchase new coding books and forms
- Develop a conversion plan –
    - Paper Charts
    - EMR
    - For some small conversion projects it may well be quicker and more accurate to use ICD-10 code books instead of GEMs (crosswalks)

When will the change to ICD-10 happen?

- **Single implementation date of October 1, 2013 for all users**
- Ambulatory and physician services provided on or after 10-1-2013 will use ICD-10-CM diagnosis codes
- Inpatient discharges occurring on or after 10-1-2013 will use ICD-10-CM and ICD-10-PCS code
- ICD-9-CM codes will not be accepted for services provided on or after October 1, 2013
- ICD-10 codes will not be accepted for services prior to October 1, 2013
- Last regular, annual updates to both ICD-9-CM and ICD-10 will be made on October 1, 2011
- On October 1, 2012 there will be only limited code updates to both ICD-9-CM & ICD-10 code sets to capture new technology and new diseases
- On October 1, 2013 there will be only limited code updates to ICD-10 code sets to capture new technology and new diseases
- There will be no updates to ICD-9-CM on October 1, 2013 as the system will no longer be a HIPAA standard
- On October 1, 2014 regular updates to ICD-10 will begin

Q & A (my favorite!)

Q: What will the financial impact be for a small practice to implement ICD-10?

A: This is dependent on how claims are being submitted and if the practice is responsible for paying for the system upgrade to handle ICD-10. If you are using free electronic billing, there should be minimal financial impact.

Q: Is the cost to the American public worth the value ICD-10 is supposed to create? Also, will offices be required to "prove" the new codes by sending medical records to payers?

A: Dr. Duvall answers "Yes" to the first question. As to the next question, that process is related to new codes moving from experimental to actual, not the process of moving from ICD-9 to ICD-10. Payers will not be requesting mass medical records since the change is global.

Q: With 2 years to go, when should we start training the staff?

A: You should start training 6-9 months before October 2013.

Q: There will be a tremendous impact on practices where physicians have not been documenting appropriately as there will not be enough information to choose a code. You are minimizing the physician's time and effort needed to make this change.

A: Anyone who has been documenting correctly will have a relatively easy time choosing an ICD-10 code. Anyone who has been documenting minimally will have a hard time.

Q: What format will the new codes be released in?

A: They are in pdfs now, and they are also available in text and html formats.

Q: What will commercial payers be using for ICD-10?

A: Payers might be using GEMS (General Equivalence Mappings) to map from ICD-10 to ICD-9 if they are not ready.

Resources

General Equivalence Mappings (GEMs) assist in converting data from ICD-9-CM to ICD-10
Forward and backward mappings – **Information on GEMs and their use** – (click on ICD-10-CM or ICD-10- PCS to find most recent GEMs)

The CMS Sponsored ICD-10 Teleconferences **web page** provides information on upcoming and previous CMS ICD-10 National Provider Calls, including registration, presentation materials, podcasts, video slideshow presentations, written transcripts, and audio recordings http://www.cms.gov/ICD10/Tel10/list.asp

Provider Resources (for all providers) http://www.cms.gov/ICD10/05a_ProviderResources.asp

---

Coding for the Rest of Us: Why Everyone in Your Practice

Needs a Basic Knowledge of Coding

There is no one, and I do mean no one, in your medical practice who does not need to know the basics of coding. Here is why:

- Providing services to patients is the business of healthcare. Every person who relies on healthcare for their living should understand something about the business they are in. This should not outweigh the fact that we are privileged to care for patients, but as the saying goes “No money, no mission.”
- It takes a team to produce care. The silos of front desk, billing, nursing and scheduling must come together to share their knowledge and produce a high-quality, reimbursable patient visit. Here are the roles each member of the team plays:
    - The patient calls for an appointment and the scheduler matches the patient’s problem to an appropriate appointment type. The scheduler finds out if the patient is **new or established** and **what the patient’s appointment is for.**
    - The patient arrives for the appointment and the front desk assures that all **current demographic and insurance information is collected**.
    - The nurse rooms the patient, taking vitals, reviewing medications and **reviewing the reason for the visit** – the chief complaint.
    - The physician or mid-level provider cares for the patient, documenting the visit and choosing the **appropriate service and diagnosis codes.**
    - The patient completes the visit by paying any deductibles or co-insurance due and making any future appointments needed. The checkout staff

enters the payments and/or charges if the service codes have not already been posted via the EMR.
- The biller "scrubs" the claim, checking for any errors and **electronically submits the claim to the payer**. The hope is that the claim is clean and will be accepted and paid immediately (within 30 days.)

When staff understands how important their contribution is to the financial viability of the practice and how all the pieces fit together, they are more incentivized to perform.

"Coding" means two things: s**ervice codes** and **diagnosis codes**. Service codes describe office visits, surgery, laboratory, radiology, pathology, anesthesia and medical procedures that are provided by physicians, nurse practitioners, and physician assistants. Diagnosis codes describe signs, symptoms, injuries, diseases, and conditions. **The critical relationship between a service code and a diagnosis code is that the diagnosis supports the medical necessity of the procedure.**

Service codes are called either CPT codes or HCPCS (pronounced "hick-picks) based on the payer/insurer who uses them. Most commercial insurers use CPT (Current Procedural Terminology) codes, but Medicare and Medicaid use HCPCS (Healthcare Common Procedure Coding System.) Codes are globally grouped into Level I and Level II:

- Level I codes include the 5-digit numeric CPT (Current Procedural Terminology) codes. These were developed by the American Medical Association (AMA) in 1966 and remain proprietary to the AMA. The codes are updated in October and become effective as of the next calendar year. They are available as a printed manual or as an electronic file.
- Level II codes are national codes developed by the Centers for Medicare and Medicaid Services (CMS) to describe medical services and supplies not covered in

the CPT. They consist of alphabetic characters (A through V) and four digits.

There are two ways that patient services are coded so they can be billed to insurance companies. The first is through the use of a preprinted coding sheet, which goes by many different names: superbill, encounter form, routing sheet, patient ticket, or billing form. The physician or mid-level provider indicates which services were provided and maps specific diagnosis codes to the services.

The second is abstraction from the medical record. A coder reads the documentation provided by the physician or mid-level provider, and matches codes to the services described in the record. Computerized coding abstraction via an electronic medical record (EMR) is also an option

Here are some basic coding rules that apply to every type of practice:

- Always have the latest edition of CPT and HCPCS. Service codes change annually and it is important to use the correct code for the calendar year. Check new, revised and deleted codes annually and change your encounter form and codes in your billing system to match.
- Attend webinars or seminars annually to stay up-to-date on large-scale coding changes for your specialty or for all specialties. For instance, tobacco cessation counseling is reportable to and payable by Medicare for the first time in 2011 – see a **handy guide here** and every specialty can bill it. You may also want to subscribe to coding newsletters for your specialty or check your physician's specialty society to see what they offer.
- Utilize the National Correct Coding Initiative (NCCI) to make sure which codes are to be submitted individually versus being bundled. Many practices do not know about or use the NCCI information for the simple reason that

it is complex and confusing and changes regularly. Someone in the field who offers great (free) information on the NCCI edits is Frank Cohen **here.**

- Have an in-house crosswalk for provider abbreviations to make sure that they have signed off on what their abbreviations mean. The best of all worlds is requiring the physician or mid-level provider to supply a code as opposed to a description.
- Use scrubbing software tools to check service and diagnosis code mismatches, Local Coverage Determinations (LCDs) for Medicare, any services without appropriate diagnosis codes and any diagnoses without standard accompanying services.
- Audit your documentation regularly to ensure it matches your level of service ("if you didn't document it, you didn't do it") especially if you are not documenting electronically with decision support tools. Audit yourself or hire a firm to audit for you and document lessons learned and any corrective action taken. This should be part of your practice compliance plan. Note that physician regulatory insurance is now available (Google it) for around $1500 per physician per year.
- It is always the physician or mid-level provider's ultimate responsibility to choose the codes that best correlate with what s/he did. When in doubt, always defer to the provider of the service.

Other articles of interest:

How Many Staff Do You Need?

A Perfect Day in Your Medical Practice