



Podiatry Coding & Billing Alert

Your practical adviser for ethically optimizing coding, reimbursement, and efficiency in podiatry practices

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Hallus Valgus

28298 for Austin-Aiken Procedure? Not So Fast

Wait until you've seen the whole op note before assigning osteotomy code.

Getting a lot of denials for your hallux valgus corrections, and you swear you're pinpointing the right procedure in your coding book? You could be dealing with double osteotomies—which means there's another hidden procedure in the op report that you're missing.

If this is the case, your first step is to become familiar with synonyms for common bunionectomy procedures so you can easily spot a second osteotomy. For example, 28296 (*Correction, hallux valgus [bunion], with or without sesamoidectomy; with metatarsal osteotomy [e.g., Mitchell, Chevron, or concentric type procedures]*) is also known as an Austin procedure. Doctors might also refer to it as a metatarsal osteotomy.

Another common hallux valgus correction with multiple names is 28298 (... *by phalanx osteotomy*). Podiatrists may also call it a great toe osteotomy, an Aiken osteotomy, a proximal phalangeal or phalangeal osteotomy, a cheater Aiken, oblique Aiken, or a distal Aiken.

Check out this handy Web site for more detailed explanations of different bunion procedures: [www.footdoc.ca/Website%20Bunion%20\(Surgery\).htm](http://www.footdoc.ca/Website%20Bunion%20(Surgery).htm).

Go Back to the Basics

After you've trained your eye to spot an osteotomy, the next step is to look for two separate procedures. Remember, during an osteotomy, a surgeon divides the bone and/or excises a piece of it. And the easiest way to tell if the podiatrist did a double osteotomy is to look for just that: *two* osteotomies. Double osteotomies could involve two in the metatarsal, or one in the proximal phalanx and one in the metatarsal, says **Walter Pedowitz, MD**, a practicing orthopedic surgeon in Linden, N.J.

Important: Not all bunion corrections involve osteotomies, so don't assume that two different hallux valgus corrections are both osteotomies. For instance, the simple resection of the medial eminence (the bony protrusion) of the first metatarsal, 28290 (... *simple exostectomy [e.g., Silver type procedure]*), does not involve an actual osteotomy.

Some osteotomies involve various cuts such as a "V" cut, a "Z" cut or even parallel cuts, but podiatrists still consider these single osteotomies.

Cover All of Your Bases

The bottom line is, if you see a familiar procedure name such as "Aiken," don't jump to 28298 (... *by phalanx osteotomy*).

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Your CPT book does indeed call this the “Aiken procedure,” but many podiatrists pair the Aiken with another osteotomy.

Tip: Usually, a double osteotomy chart note will include documentation that the podiatrist operated on two separate sites.

For example, if you see in addition to the Aiken a complex, biplanar, double-step cut through the neck of the first metatarsal, these two osteotomies would make the entire procedure a double osteotomy, and the correct code is 28299 (... *by double osteotomy*).

And just as the single osteotomies have several names, remember that you’ll also be dealing with interchangeable names that describe a combined distal osteotomy and phalanx osteotomy. Podiatrists may call this double procedure an Austin-Aiken, a first metatarsal and distal osteotomy, a Chevron-Aiken, or a Chevron with an osteotomy of the great toe.

Final step: Once you’ve established that the procedure is a double osteotomy, remember that osteotomies bundle soft tissue work, lengthening tendons, sesamoid work and the insertion of fixation devices such as K-wires, screws, and plates. □

Part B Pay

CMS Slashes 2012 Conversion Factor by Over 27 Percent Vs. Current Rates

Plus: Pay for podiatry may increase a little, while other specialties will drop even more.

Get ready for another year of nail-biting to find out whether your Medicare payments will be dramatically reduced. The calendar year 2012 Physician Fee Schedule conversion factor is \$24.6712, notes the 2012 Medicare Physician Fee Schedule Final Rule, printed in the *Federal Register* that will be published on Nov. 28.

This amounts to a dismal 27.4 percent cut compared to the current rate of \$33.9764. CMS acknowledges that this massive cut may not be set in stone, stating, “While Congress has provided temporary relief from these reductions every year since 2003, a long-term solution is critical. We will continue to work with Congress to fix this untenable situation so doctors and beneficiaries no longer have to worry about the stability and adequacy of their payments from Medicare under the Physician Fee Schedule.”

Physician advocacy organizations were quick to decry the cuts. “Payments for Medicare physician services have fallen so far below increases in medical practice costs that there is a 20 percent gap between Medicare payment updates and the cost

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of caring for seniors,” said AMA president **Peter W. Carmel, MD**, in a Nov. 1 statement.

Even CMS officials agreed that the 27.4 percent cut would be devastating, but remained hopeful that the government might rectify the situation before the pay cuts kick in. “This payment rate cut would have dire consequences that should not be allowed to happen,” said CMS administrator **Donald Berwick, MD**, in a Nov. 1 statement. “We need a permanent SGR fix to solve this problem once and for all. That’s why the President’s Budget and his Plan for Economic Growth and Deficit Reduction call for permanent, fiscally responsible reform and why we are committed to working with the Congress to achieve a permanent and sustainable fix.”

As most practices know, last December, Congress voted to not only stave off a 25 percent cut to your Medicare pay. However, that vote only kept the cuts at bay through Dec. 31 of this year—and that date is right around the corner. Effective January 1, your Medicare pay is set to drop again based on the new 2012 Fee Schedule information, unless Congress intervenes to reverse the cuts.

Some Specialists Will See Gains, While Others Will Find Cuts

In addition to dealing with conversion factor fluctuations, some specialties will face additional cuts. The hardest hit practices will be those that specialize in radiation oncology, as well as radiation therapy centers. These cuts will most definitely have a significant impact on specialty practices that are already financially stretched.

Good news: Medicare predicts that payments to podiatry practices will actually increase 2 percent in 2012. Some of your colleagues in other specialties, however, won’t be so fortunate.

The list below shows which specialties will face the biggest Part B cuts in 2012 based on changes to RVUs and other adjustments in these specialties. Keep in mind that these

numbers do not include the impact of the January 2012 conversion factor changes, the Fee Schedule confirms:

Radiation oncology and radiation therapy centers: Pay for these specialists will drop by 6 percent next year. Other imaging-based specialists should fare slightly better, with radiologists seeing only a 3 percent cut, interventional radiologists facing a 2 percent cut, and nuclear medicine specialists dealing with a 1 percent drop in pay.

Audiology: RVU changes will cause audiology practices to see their pay drop by 4 percent in 2012.

Psychology, Social Work, Diagnostic Testing Facilities: These specialists will all face 3 percent cuts across the board in 2012, the Fee Schedule indicates.

Cardiology, pulmonology: Both of these specialties will face 2 percent cuts in 2012, as will interventional pain management specialists, thoracic surgeons, and cardiac surgeons.

Other Specialties Will See Gains

As was the case last year, the government is seeking to give primary care practices financial boosts, with family practices and internal medicine specialists both benefiting from a 1 percent gain next year over 2011 RVU amounts.

Other practices that will see their pay rise will be portable x-ray suppliers, who will watch RVUs increase on average by 4 percent, and the following specialists that will see 2 percent gains next year: podiatrists, optometrists, chiropractors, and nurse anesthetists.

The complete Fee Schedule will be posted in the Nov. 28 *Federal Register*, but is being published online ahead of print for a limited time at www.federalregister.gov/agencies/centers-for-medicare-medicaid-services. □

Modifier Mythbuster

Learn the Truth Behind 3 More Common Modifier 24 Myths

Hint: Know your payer’s policies on billing complication treatment.

To ensure payment for E/M services your physician performs within the global period of a surgical procedure, you must know the ins and outs of modifier 24 (*Unrelated evaluation and management service by the same physician during a postoperative period*).

Last month, we busted the first two myths: Modifier 24 applies to any service done in the post-op period and scheduled office visits rule out modifier 24. Now tackle three more modifier 24 myths to ensure you’re submitting clean, successful claims.

(Continued on next page)

Myth #3: You Can Never Use Modifier 24 For Complication-Related Services

When you report postoperative services to payers that follow CPT guidelines, you'll need to append modifier 24 to the E/M code to indicate that the service took place during the surgery's global period.

Pointer: "Complications of surgery can be separate and billable in some cases, unless the payer is following Medicare rules," says **Joseph Lamm**, office manager with Stark County Surgeons, Inc. in Massillon, Ohio. "Medicare does not allow post-operative complications (hematoma, seroma, infection, etc) to be reimbursed unless there is a need to return to the operating room. At that point, a different modifier comes into play."

CMS and CPT agree: If the physician must return to the OR to treat a postop complication, both Medicare and private payers will pay at a reduced rate when you append the appropriate modifier to the surgical CPT code describing the surgeon's treatment of the postsurgical complication. If the surgeon returns to the operating room to surgically correct a post-operative complication during the global period of

a previous surgery, the correct modifier is 78 (*Unplanned return to the operating/procedure room by the same physician following initial procedure for a related procedure during the postoperative period*).

Bottom line: Determining whether complications of the surgery/procedure count as unrelated, and therefore mean you'll use 24, means "you must know what the guidelines are for the insurance company being billed," says **Charlotte T. Tweed, RHIA, CPC**, coding auditor and inpatient/surgery coder in the department of medical education/coding at Florida Hospital in Orlando. "Medicare considers all complications part of global unless the patient is taken back to the OR. Most commercial insurances however will allow complications to be billed during global with the modifier 24."

Myth #4: There Must Be a New Diagnosis If You Use Modifier 24

While a different ICD-9 diagnostic code might indicate that the E/M service performed in a global period was unrelated to the surgery, you do not have to have different diagnoses to append modifier 24 and to receive payment for those services.

"It is not necessary that the two services have a different diagnosis but it should be clear that the service is performed to discuss results, prognosis and treatment options and that any work done related to the surgery (change bandages, check wound, etc.) is not used to support the level of service billed," says **Marcella Bucknam, CPC, CCS-P, CPC-H, CCS, CPC-P, COBGC, CCC**, manager of compliance education for the University of Washington Physicians Compliance Program in Seattle.

Caveat: "It is not mandatory to have a different diagnosis," Tweed agrees. "However, that said, for some insurance companies it is easier to get them to pay for the E/M completed during post op if the diagnosis is different."

Are You Prepared for Upcoming Coding Changes?

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You Be the Coder

Diabetes Patient, Post-Amputation

Question:

A patient visited our clinic for a checkup for some ulcers on her right ankle. She had the toes on her right foot amputated six months ago due to gangrene. She has type II diabetes, peripheral vascular disease (PVD), and malignant hypertension. How should I code her condition?

Delaware Subscriber

Answer: See page 87. □

Pitfall: “Do not code the E/M if the documentation is short!” Tweed warns. “This would be considered fraud and certainly not an area where any coder [or biller] should go. The proper use of modifier 24 can legally increase revenue and should be applied if applicable.”

Myth #5: You Should Never Use Modifiers 24 and 25 Together

You may find yourself in situations where you need to combine the forces of modifiers 24 and 25 (*Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service*) to avoid a denial of a claim.

“You can use 24 and 25 on the same claim, if you are seeing a patient for a completely new issue within the post op period, a procedure was done that same day, and the E/M code is

significant and separately identifiable from the procedure,” Lamm confirms.

Example: A patient undergoes major surgery. During the postoperative period, the patient comes for an office visit that is absolutely unrelated to the first surgery. At the unrelated E/M visit, the physician also performs a minor surgical procedure (such as a biopsy or cystoscopic examination) unrelated to the initial surgical procedure. In this case, you will append both modifiers 24 and 25 to the E/M code — modifier 24 to allow payment of the E/M service in the global period of the initial surgery and modifier 25 to allow payment of the E/M service along with another procedure performed on the same day.

Tip: Always use the postoperative modifier (24) first, before you use other modifiers. Most computers sequence their edits, putting the postoperative period edits as the primary edit. □

Collections Q&A

Create a Solid Financial Policy That Tells Your Patients Exactly What You Expect

Get answers to your top financial policy questions from a billing expert.

Having a financial policy is essential for any practice’s financial success. A detailed and documented policy helps both your employees and your patients know how your practice handles the financial side of healthcare.

Follow this advice from billing and reimbursement expert, **Cyndee Weston, CPC, CMC, CMRS**, executive director of the American Medical Billing Association in Davis, Okla., to ensure your practice employs financial policies that work and then that you adequately communicate those policies to your patients.

Question 1: Why Do We Need a Clear Financial Policy?

A financial policy is a “formal set of procedures that your practice follows with regard to collecting money,” Weston explains.

There are several reasons your practices should develop, implement, and continually evaluate a set financial policy, Weston advises. “It’s really a very real part of effective customer service with your patients,” she adds.

You’ll also find that a set financial policy will give your staff the tools they need to do their job collecting from patients. By reviewing your written policies, patients should get a clear understanding of their responsibilities and your practice’s

expectations with regard to financial topics. This can help prevent patients from asking for discounts and payment exceptions.

“The whole idea is that we want financial policies in place so that we can be more effective at collecting,” Weston says.

Question 2: How Do We Communicate the Policy to Patients?

You want to put your policy in writing, and then educate all of your practice staff and also your patients about the policy. You can even post an abbreviated version at your check in or checkout counter to ensure patients are aware of the policies.

“Good policies start with explaining to your patients what you expect so that they understand exactly what you require of them,” Weston says. “Firm, consistent financial policies are a customer service that patients deserve and expect.”

Good practice: Start communicating your financial policies and expectations to patients at the onset of the patient appointment, Weston says. Having patients sign the financial policy indicating that they received a copy of it is a good idea. Then keep a signed copy in the patient’s chart, and give another copy to the patient.

(Continued on next page)

Here's how: For new patients, explain your policies and make written versions available through your practice Web site, by fax, or by mail. For existing patients, you should occasionally remind patients of the policy and notify existing patients any time you make a policy change. "Craft and mail a 'change of policy' letter and put a notice on your Web site and in the office," Weston advises.

Question 3: What Should the Policy Include?

Spell it out: Your written financial policy should include information about anything related to the financial aspects associated with a patient's care, such as no-show fees or penalties assigned if the patient doesn't pay his copay at the time of service.

Your policy should help patients understand several things about insurance, your practice, and other financial aspects of healthcare, Weston advises, including your commitment to providing the best possible care, the fact that insurance is a contract between the patient and insurance company, but you will use your best efforts to obtain the maximum reimbursement, and that sometimes routine services are not covered by insurance and patients must pay those charges at the time services are rendered.

According to Weston, there are many things your written financial policy should explain to patients, including other smaller policies. Consider including information about the following:

- » The importance of maintaining current account information (address, policy, responsible party)
- » Forms of payment your practice accepts (cash, credit cards, checks)
- » Forms of ID required, including if an insurance card is required at every visit
- » Payment guarantee form/signature
- » Patient demographics and patient history forms
- » Returned check fees based on your state's laws
- » Billing cycle or when statements are sent and payments are due
- » Hardship application and documentation
- » Your policies on handling delinquent accounts, including timelines your practice follows and any fees the patient may incur
- » Cancellation policies and charges
- » Where to direct billing inquiries
- » How self pay accounts will be handled
- » Medical record copy/transfer charges and policies. □

Reader Questions

27698 Is Best for 'Brostrom' Procedures

Question:

My podiatrist gave me an op note for a "Brostrom procedure," and I have no idea what this is except that the podiatrist operated on the ankle of a soccer player who had repeated sprains. The note mentions a posterior tibial tendon reconstruction and a lateral tendon reconstruction. Is this part of the Brostrom? If so, what is this procedure and what codes should I report?

Iowa Subscriber

Answer:

The tendon reconstruction you speak of is part of the Brostrom because a Brostrom procedure repairs torn ligaments on the outside of the ankle (lateral ligaments). The podiatrist reconstructs the torn ligaments by shortening them and reattaching them to the lateral malleolus (ankle bone). The best code to report for this is 27698 (*Repair, secondary, disrupted ligament, ankle, collateral [e.g., Watson-Jones procedure]*). □

Base E/M on Time for Counseling/Coordination Only

Question:

If the physician documents: "Time spent in the evaluation of the patient with mostly medical decision making time

(two thirds) is 75 min" can I choose the E/M code based on time alone?

Nevada Subscriber

Answer:

No, you cannot code based on time with just the documentation you have mentioned.

Here's why: You should only code an E/M service based on time alone if at least 50 percent of the visit was spent on counseling or coordination of care.

How it works: According to this year's CPT manual, you can use the code closest to the documented time. "If coding by time, pick the closest typical time," said **Peter Hollmann, MD**, during the "E/M, Vaccines, and Time-Based Codes" session at the CPT and RBRVS 2011 Annual Symposium in Chicago this past fall.

That advice echoes previous AMA information. For instance, the August 2004 *CPT Assistant* stated, "In selecting time, the physician must have spent a time closest to the code selected."

Your documented time must equal or exceed the average time given to bill that level. For a 35 minute visit spent on a medically necessary counseling-dominated visit, per CPT you could report 99215 (*Office or other outpatient visit for*

the evaluation and management of an established patient ... Physicians typically spend 40 minutes face-to-face with the patient and/or family).

Keep in mind: CPT notes that “this includes time spent with parties who have assumed responsibility for the care of the patient or decision-making, whether or not they are family members (for example, foster parents, person acting in loco parentis, legal guardian.”

Caveat: Be careful when reporting 99215 based on time only, as Medicare tends to frown on podiatrists reporting that code, say experts.

Remember that although the AMA, via *CPT Assistant*, directs you to code based on the “closest” time, most Medicare payers have always considered the times indicated in CPT’s code descriptors to represent minimums. Under those regulations, the physician would select the lower code (for instance 99214, ... *physician typically spends 25 minutes face-to-face with*

the patient and/or family ...) unless the time was greater than or equal to the higher-level code’s required time (such as 40 minutes for 99215). □

Collect Surgical Deductibles Up Front

Question:

We often have patients who don’t pay their deductible after surgery. Is there a recommended way to collect these payments up front?

South Dakota Subscriber

Answer:

Yes, you may collect a deductible upfront. The first step is to confirm the deductible amount with the payer. Insurance verification services now make it possible for practices to determine if a patient has met his deductible, or how much deductible remains unpaid. Others provide just information on what the total annual deductible is. This information may also be found online. You usually can access updated information before the patient’s scheduled procedure.

Pointer: Before settling on the deductible due, check to see if the patient has Medigap coverage or other secondary insurance that will cover a portion of the payment. Then contact the patient to communicate what his responsibility may be. Try to speak with the patient about collecting the deductible several days, or even weeks, before the procedure, rather than on the day of the procedure.

Make sure you tell the patient where you obtained the information about his deductible, and let him know that the amount is an estimate based on the services your physician expects to perform. Otherwise, you may receive calls from patients after procedures saying they don’t owe any additional fees because they have already paid up front.

Always emphasize that the amount you are collecting is just an estimate, and after their insurance pays, you will adjust the payment amount, which may result in a partial refund or additional monies owed. Some practices use a written surgical fee estimate, which they provide to the patient.

If you cannot collect up front from a patient, you’re left with two options: reschedule the procedure or perform the procedure and hope the patient pays you afterwards when you send a bill. Many practices are opting for rescheduling, especially if the case is elective. The last option to consider would be setting up a payment plan to allow the patient to pay off the amount due over time — an option, granted, which may leave you with a balance to write off. □

— *Answers to You Be the Coder and Reader Questions were reviewed by Arnold Beresh, DPM, CPC, of Peninsula Foot and Ankle Specialists PLC in Hampton, Va.* □

You Be the Coder

Diabetes Patient, Post-Amputation

(Question on page 84)

Answer:

For your patient, code:

- » 443.81 (*Peripheral angiopathy in diseases classified elsewhere*)
- » 250.70 (*Diabetes with peripheral circulatory disorders; type II or unspecified type, not stated as uncontrolled*)
- » V49.73 (*Lower limb amputation status; foot*)
- » 401.0 (*Essential hypertension; malignant*).

Use V49.73 to identify the specific amputation site. You should use the V49.6x and V49.7x codes only to report acquired amputation status due to trauma or surgical amputation due to disease.

For the hypertension, list 401.0 for this patient. Don’t list a code for gangrene because it’s no longer present. The PVD, however, is likely to continue to be a problem, so listing 443.81 is appropriate.

Note: ICD-9 assumes the gangrene is a consequence of a diabetic peripheral vascular circulatory disorder. This is usually true when the gangrene is of the lower extremity. If there is no other stated cause, gangrene is considered a manifestation of diabetes. □

Podiatry

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We would love to hear from you. Please send your comments, questions, tips, cases, and suggestions for articles related to *Podiatry Coding & Billing* reimbursement to the Editor indicated below.

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