



**Medicare Now Covers Smoking
and Tobacco Cessation
Counseling**



Effective March 22, 2005 Medicare Part B will cover two new levels of counseling, intermediate and intensive, for smoking and tobacco use cessation. According to Medicare this coverage will be limited to patients who use tobacco and have a disease or adverse health effect found by the U.S. Surgeon General to be linked to tobacco use or who are taking certain therapeutic agents whose metabolism or dosage is affected by tobacco use as based on FDA approved information. All patients must be competent and alert when these services are provided. Two attempts are covered each year by Medicare Part B and each attempt may include a maximum of four intermediate or intensive sessions. A maximum of eight sessions in a twelve month period are covered. For billing purposes, Medicare has established two new G Codes that can be used starting July 5, 2005.

G0375 – Smoke/Tobacco Counseling 3-10 minutes payment \$12.88

G0376 – Smoke/Tobacco Counseling greater than 10 minutes \$25.30

Before July 5, 2005 use the unlisted procedure code 99199 when billing for these services. Include one unit per session in the unit's field column. The hospital will also receive payment when the service is billed by the physician/PA/NP. If you also provide a visit on the same day as the smoking cessation service you will need to add the 25 modifier to the office visit to show it was a separately identifiable service. Please remember that documentation in the patients' medical record should adequately describe the counseling session and you will need to document time spent counseling the patient on smoking cessation. The diagnosis code billed should be the code that describes the condition that is affected by the smoking. For example if the patient is experiencing shortness of breath then bill ICD-9 code 786.05.

For questions or additional information regarding the above, contact the Compliance Office at 615-343-7766.



Proper Use for Check Boxes in Templates



In the May issue of the *Compliance Compass*, we addressed the appropriate use of templates and how they can be a very helpful tool for physicians if they are used appropriately. Not only can they help to improve documentation quality, but they can also save physicians time spent in their documentation. Templates can also help provide more complete documentation.

Check boxes are a popular tool used within a template. The important thing to consider when using check boxes is to make sure you have space for pertinent positives as well as pertinent negatives. It is not sufficient to just have one box per element. This leaves the documentation open for interpretation as to whether the checked findings are the only systems that were reviewed or if all systems were reviewed, and the boxes checked were the only positive findings. **If a finding is abnormal, the abnormality should be described.**

The best practice would be to list the systems to be reviewed or examined, have a check box for yes and no, and then elaborate on the findings. This will eliminate any grey area. If the box is checked yes, there was a positive finding. If the box is checked no, the finding was

negative. If the box is not checked, the system was not reviewed or examined.

Screening vs. Diagnostic Test Visits

Coding

Screening is the testing for disease or disease precursors so that early detection and treatment can be provided for those who test positive for the disease.

Screening tests are performed **when no specific sign, symptom, or diagnosis is present** and the patient has not been exposed to a disease. **The testing of a person to rule out or to confirm a suspected diagnosis because the patient has a sign and/or symptom is a diagnostic test, not a screening.** In these cases, the sign or symptom should be used to explain the reason for the test. However the final diagnosis should be submitted if known at the time of billing.

Scenario I:

Q: A patient presents to the GI clinic with complaints of chronic epigastric pain. Patient has never had a screening colonoscopy and requests one. The physician schedules the patient for a colonoscopy. Colonoscopy found no anomalies.

A: What is the correct ICD-9 code(s)?

- a. V76.51 Screening colonoscopy
- b. V76.51 Screening colonoscopy/
789.06 Epigastric pain



- c. 789.06 Epigastric pain

Scenario II:

Q. Patient presents with complaints of dysphagia (787.2). An EGD was scheduled and an esophageal stricture (530.3) was identified, along with a mild hiatal hernia (553.3). An EGD with balloon dilation was performed.

A. Which ICD-9 code(s) should be submitted for billing?

- a. 530.3
- b. 553.3
- c. all the above with code 787.2 as the primary
- d. all the above with code 530.3 as the primary
- e. b and c only with b as the primary

ANSWERS:

Scenario 1- answer is c: The patient is symptomatic (epigastric pain) and 789.06 is covered under the LMRP for a colonoscopy.

CAUTION: Abdominal pain, other than epigastric, is not a covered LMRP diagnosis for a colonoscopy. So if a patient presented with RUQ pain and a colonoscopy was performed with no anomaly found, RUQ pain (789.01) would not support the decision to perform a colonoscopy.

Scenario 2 - answer is e: The statement should read with B as the primary. The patient presents with symptom of dysphagia (787.2) and an EGD is warranted. An esophageal stricture (550.3) is identified along with

a hiatal hernia (553.3). The definitive finding is the stricture; the stricture supports the EGD with dilation. The hiatal hernia can be assigned as an additional finding.

NPI's Are Coming



The National Provider Identifier (NPI) is a new provider number that will replace current provider numbers that you currently use with multiple health plans. This new number must be used by HIPAA covered entities. With national standards and identifiers in place, health care providers will be able to submit claims to any health plan in the US. Most health plans must begin to accept and use the NPIs starting May 23, 2007. Vanderbilt's credentialing office will be applying for your NPI on your behalf. Additional information is available at www.cms.hhs.gov/hipaa/hipaa2. The site also contains Frequently Asked Questions.



Medicare Coverage of Services Involving Investigational Devices



Medicare has very specific rules regarding coverage of services that involve investigational devices. If you are enrolling Medicare patients in a clinical trial that involves investigational devices you must be informed of the rules related to billing.

There are two types of devices Category A and Category B.

Category A

Effective January 1, 2005 Medicare covers routine costs associated with clinical trials involving Category A devices. **The device itself is never covered by Medicare, and coverage of the routine care in the trial must be approved by the Fiscal**

Intermediary Medical Director Dr. Dan Duvall and the Carrier Medical Director Dr. Robert Hoover. Approval to bill for routine care must be obtained before the study begins and any billing occurs.

Category B

Services provided using Category B devices may be covered by Medicare based on the National Coverage Decision (NCD) for clinical trials or by following the approval requirements for a Category B Device. **If coverage is based on the NCD, the device is non-covered and only routine care costs are reimbursable.** If coverage is based on approval obtained by the Fiscal Intermediary and Carrier Medical Director, the device may also be covered as the Medical Director has the option of approving coverage of the device in addition to routine care. **The Medical Directors for both Cigna and Riverbend must be contacted and must grant approval for billing of services related to Category B devices before patients are enrolled.**

For questions or additional information regarding the above, contact the Compliance Office at 615-343-7766.