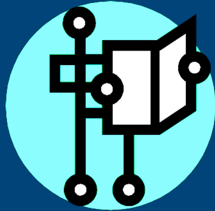

Reimbursement / Coding News You Can Use

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Santa Clara County Medical Association/408-998-8850

Coding Corner:

Can regular blood glucose monitoring (finger stick) be provided for Medicare patients who have a diagnosis of diabetes?

Not unless the service is medically necessary. Medicare wants the patient to self-monitor whenever possible. You would need to show the patient isn't able to self-monitor.

Here's what CMS says in the National Coverage Determination (NCD):

Frequent home blood glucose testing by diabetic patients should be encouraged. In stable, non-hospitalized patients who are unable or unwilling to do home monitoring, it may be reasonable and necessary to measure quantitative blood glucose up to four times annually.

Depending upon the age of the patient, type of diabetes, degree of control, complications of diabetes, and other co-morbid conditions, more frequent testing than four times annually may be reasonable and necessary.

It isn't medically necessary to perform regular finger sticks for a diabetic patient who is being followed by his physician and sticks to the schedule for self-monitoring. **Remember:** Your documentation must clearly support the need for additional testing by the physician.

How to use E/M visit codes now that CMS has eliminated consult codes

Now that CMS has eliminated consult codes beginning January 1, 2010, you will need to bill the appropriate inpatient or outpatient visit codes. The codes affected are outpatient codes 99241-99245 and inpatient codes 99251-99255. CMS cites years of billing confusion and hassles as the driving force behind the decision. The change will be budget neutral because the money spent on consults will be used to boost payment for new and established patient E/M services by about 6%. To make the change budget neutral, CMS increased the work relative value units (RVUs) for new and established office, initial hospital and initial nursing facility visits, services that CMS expects you to bill instead of consults in 2010. CMS will also issue a new modifier and revise global period bundles' payments to aid the transition.

A new modifier will be issued for use by an attending physician when billing an initial hospital care service. The specific modifier code is yet to be determined and no release date has been set. The modifier will clearly spell out who is coordinating care for the patient – the admitting physician of record. The other physicians, who are not the admitting physician – and did not use the modifier – will bill inpatient subsequent care codes for furnishing specialty care to patients. CMS will provide further education materials about the change for billers and physicians and SCCMA will keep its members informed as information becomes available.

Did you know?...

Assignment of Benefits vs. Accept Assignment. These two terms are often confused with one another. Especially with new billers and coders. Assignment of Benefits means the patient or insured is assigning benefits to be paid directly to the provider of services. Accept Assignment means the provider agrees to accept what the insurance company pays.