CODING Q&A

'Destruction' Codes, Global Periods, Working with Provider Representatives, and Denial of G0431-QW

DAVID STERN, MD, CPC

Q. Our physician did a shave excision and sent it to pathology. It came back as malignant. She now wants to bill using the destruction codes of 17260-17286. We coders are trying to tell her that she needs to bill for the shave excision, because she documented clearly that she performed shave excision. What is the correct way to bill for this procedure?

– *Name withheld*

A. Per CPT Assistant 2009: These codes, i.e., destruction of benign or premalignant lesions (codes 17000-17250) and the destruction of malignant lesions (codes 17260-17286), do not apply to "removal by excision or shaving of skin lesions using surgical instruments such as a knife, scalpel or other similar tools."

Q. I was at the (UCAOA) conference in Orlando this year and enjoyed your sessions on coding. I have a question for you about billing during a surgical global period.

We are on a flat rate for a lot of our insurances, and these contracts will pay us for one visit per day. For other insurances, we are paid as fee for service. We are billing all claims, even for suture removals and checks for I&Ds at either the assigned flat rate code (S9083) or a low-level E/M.

Is it appropriate to bill these flat-rate payors for the follow-up visits to surgical procedures because they do not seem to deny as global? Some coders have written that it is inappropriate to code and bill for these services. I would, also, like your feedback as to whether it is appropriate to bill a low-level E/M to the Medicare-based fee schedule payers.

– *Anonymous*

A. If you are coding the procedure code for a specific payor, then 10 days of routine care is included in the procedure. You should not bill an E/M for routine follow-up care during the global period.

If you code visits with a flat-rate code (same code no matter what the visit), then the global period rules do not apply. You would code the same flat-rate code for follow-ups. Some payors, however, may require you to refer the patient back to the primary care physician for all follow-up visits.

Your best procedure is always to check with each payor to determine their rules for coding procedures and coding during global periods related to procedures.

Q. In light of the new [payor name withheld] policy (effective 12/1/10) that will no longer allow S9088: Is there any way to fight this, other than to opt out of our contract?

– *Question submitted by Shirley Robinson, Batesville, IN*

A. It is always a good idea to stay in contact with your provider representative. Let your representative know how this will hurt your bottom line. Explain your additional costs of hiring staff to work weekends and holidays and days when very few patients arrive at the clinic. Maybe they will reverse their decision and compromise by giving you a little more on your fee schedule. It is worth a try.

If you can't come to a reasonable compromise, however, you may consider cancelling your contract. At that point, they may take your demands more seriously, or you may find that they are willing to live without you. Your question should be (and you want to answer it before cancelling anything): "Are we willing to live without that payor?"

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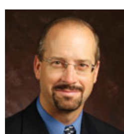

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OCCUPATIONAL MEDICINE

A written and deployed time management plan is as important as your sales and marketing plan. Consider the following for a proactive time management plan:

1. Complete a two-week time management audit once a quarter and adjust to the findings of each study. Look for the least productive five hours of your weekly routine and eliminate those activities.
2. Cluster activities. For example, considerable time can be saved by placing all of your outgoing phone calls during a set time period (e.g., first thing in the morning) and making your in-person sales calls between 11 a.m. (assume you have a lunch meeting scheduled with a prospect) and 4 p.m.

   Likewise, and as noted previously, sales calls should be arranged to minimize travel time. Add these clusters to your weekly schedule and stick with it.

   Be selective with the information you routinely collect and maintain. Use software applications that will help you maximize the return on the time you invest.
3. Manage your telephone time. Suggested techniques include:
   - Think before you dial. Review the facts (e.g., history, current proposal) and know your objectives.
   - Script your voicemail message, should you not reach the person directly.
   - If you do not need to speak directly to the person but just want to leave a message, make the call before or after regular business hours.
   - During a call, be considerate of the prospect's time. Ask if it's a convenient time, get right to the point, state your objectives, and minimize small talk
   - Supplement or replace voicemail with email as circumstances dictate.
   - Develop a phone station in which you have key numbers, product descriptions, and competitive advantage statements immediately at hand.
5. At the end of each day, develop an action plan for the following day. Set priorities for the discrete tasks on your to-do list.

Numbers are compelling. Consider: If one hour a day can be shifted from minimally productive tasks to direct sales, you would have an additional 240 hours a year to cultivate sales. This is the equivalent of an additional *six weeks* of full-time sales effort.

Simply focusing on time management can easily make the difference between a break-even situation and an extraordinarily profitable one. ■

CODING Q & A

Q. For the code 17110 (Destruction (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular proliferative lesions up to 14 lesions), the description reads "up to 14 lesions." In the units field, do we put the number that were removed, or bill as one unit because the code description states "up to 14?"

– *Question submitted by Tina McCart, Louisiana State University Health Sciences Center, Shreveport, LA*

A. Use CPT code 17110 just once, when the doctor performs (or attempts) destruction of up to 14 lesion. Do not place the number of units in the units field, as this is a single code that is billed identically (i.e., a single code), whether the patient has one lesion destroyed or 14 lesions destroyed. ■

Q. Medicare is denying reimbursement for the G0431-QW (Drug screen, qualitative; single drug class method (e.g., immunoassay, enzyme assay), each drug class). At first we were billing G0431-QW with nine units, but then Medicare started denying the claims for the frequency or units.

Medicare states they don't have the frequency for the code in their system, so what would be the best way to bill these (or have you heard about anyone else having this problem)?

– *Question submitted by Tammy Scott, Physician Practice Resources, Chattanooga, TN*

A. For some codes, Medicare does not publish frequency limits if they suspect that the knowledge of these limits for a specific code might be abused. One would suspect that this code is exactly that type of code, especially since Medicare specifically noted that this new code was implemented in January 2010 because, "it had come to CMS' attention that some companies were using questionable billing practices concerning CPT Code 80100 and CPT Code 80101. Therefore, CMS created two new G codes to operate in place of and alongside existing CPT Code 80100 and existing CPT Code 80101."

Medicare has noted that codes for this procedure have been "abused" in the past, so it would seem likely that Medicare does have a frequency limit for this code. You may be coming up against their unpublished limits. ■

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