

# Socioeconomic tips of the month

## Filing for Medicare services

The end of the year is when surgical practices must decide whether to participate in or withdraw from the Medicare program. Surgeons who sign participation agreements agree to accept assignment for all covered services provided to Medicare patients in 2002. Participation agreements and the Medicare fee schedule for the coming year are distributed to surgeons annually by Part B carriers by December 1 of the current year.

Surgeons who choose to be participating providers are reimbursed under the Medicare fee schedule for amounts that are 5 percent higher than those of nonparticipating providers. Medicare sends participating physicians direct payment for 80 percent of the allowable, and their offices are only responsible for collecting the 20 percent copayment and applicable deductibles. In addition, Medicare automatically forwards claims to any Medigap insurer. Finally, participating physicians are listed in the *Medicare Participating Physician/Supplier Directory*.

On the other hand, surgeons who opt to be nonparticipating providers may bill 115 percent of the Medicare nonparticipating allowable. Please visit the ACS Division of Advocacy and Health Policy Web page for more detailed information (<http://www.facs.org/dept/hpa/medenroll.html>).

### Important changes

Regardless of whether a surgeon chooses to participate, there are some changes in the way services provided to Medicare beneficiaries should be reported. Some changes surgeons should be aware of are as follows:

Updates for ICD-9-CM and the 2002 versions of *Current Procedural Terminology* (CPT) and HCPCS have been released.

ICD-9-CM was effective on October 1, 2001, and the 90-day grace period for incorporating the changes into claims ends December 31, 2001. The changes in the 2002 ICD-9-CM index and tabular lists can be downloaded at <http://www.cdc.gov/nchs/>

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### Around the corner

#### December

- Medicare participation agreements due to Part B carriers by December 31, 2001.
- The 90-day implementation period for the 2002 ICD-9-CM codes ends December 31, 2001.

#### January

- Effective January 1, 2002
- 2002 Medicare fee schedule.
- First-quarter update to *Correct Coding Edits*.
- The 90-day implementation period for the 2002 CPT and HCPCS codes begins.
- ACS-sponsored basic coding workshop for surgeons at the Louisiana Chapter meeting on January 11. Contact Irene Dworakowski at 202/672-1507 or e-mail [Idworakowski@facs.org](mailto:Idworakowski@facs.org) for registration information.

[data/index02.pdf](#) and <http://www.cdc.gov/nchs/data/tabulr02.pdf>, respectively.

2002 CPT and HCPCS become effective January 1, 2002. The grace period for incorporating the changes is March 31, 2002. CPT may be purchased directly from the AMA publications Web site (<http://www.amasolutions.com>) or from a vendor. The Centers for Medicare & Medicaid Services (CMS) posts a zip file (ANHCP02.EXE) on its Web site, which contains the Level II alpha-numeric HCPCS procedure and modifier codes, their long and short descriptors, and applicable Medicare administrative, coverage, and pricing data in both Microsoft Excel and delimited text formats. The document *Hrrec02.doc* contains the legends to interpret the administrative and coverage policies. The product can be downloaded at <http://www.hcfa.gov/stats/pufiles.htm#alphanu>.

CMS has made changes in the HCPCS codes and modifiers to allow physicians to bill Medicare in order to get denials for secondary payors for noncovered items and services.

Codes A9190 (Personal comfort item, not covered by Medicare statute) and modifier -GX (Service not covered by Medicare) have been deleted.

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The reimbursement status for code A9270 (Non-covered item or service) has been changed to "Not Valid for Medicare."

Beginning January 1, modifier -GY (Item or service statutorily non-covered) and modifier -GZ (Item or service not reasonable and necessary) should be appended to the code that describes the item or service provided to the beneficiary if a physician wants to indicate that the item or service is not covered or is considered a not reasonable and necessary service under Medicare. These modifiers cannot be used with any HCPCS codes that indicate the item or service is "Not Otherwise Classified."

Code Q3015 (Item or service statutorily noncovered, including benefit category exclusion) or code Q3016 (Item or service not reasonable and necessary) should be reported if no specific code describes the item or service provided to a Medicare beneficiary.

When a service is performed or an item is supplied that is not reasonable and necessary under the specific circumstances, the physician is responsible for notifying the beneficiary in writing by using the advance beneficiary notice (ABN). The provider or supplier should file the pertinent services or items on the claim with the -GA modifier (waiver of liability statement on file). The GA modifier must be used in conjunction with the Q3016 or GZ modifier, not instead or in place of them, with all Part B claims in which an ABN is given.

Also effective on January 1 is CMS's clarification of its coding guidelines for determining the appropriate primary ICD-9-CM diagnosis codes when reporting diagnostic test results (CMS Program Transmittal AB-01-114, September 26, 2001). This program memorandum applies to all diagnostic testing, including clinical laboratory tests, radiology services, pathology services, and medical services, such as electrocardiograms. Of course, diagnostic tests performed on surgical specimens (usually surgical pathology tests) are subject to the policy, but the procedure itself is not. The material that follows substantially simplifies the program memorandum by limiting it to situations in which the physician "ordered" the diagnostic test, performed it, and reports it to Medicare.

If a test confirms a tentative diagnosis, the phy-

sician reporting the test to Medicare should report the confirmed diagnosis. The signs or symptoms that prompted the test may be reported as additional diagnoses if they are not fully explained by or related to the confirmed diagnosis. The physician also may report unrelated and co-existing conditions. Incidental findings may be reported as secondary diagnoses (not the first diagnosis). When a test was done in the absence of signs or symptoms, screening (code V82.9) should be reported as the primary diagnosis code; any results of the test may be recorded as additional diagnoses. If the results of the diagnostic test are normal or nondiagnostic, then the reporting physician should report the sign(s) or symptom(s) that prompted the study. As always, diagnoses should be reported using the ICD-9-CM code that provides the highest degree of accuracy and completeness for the diagnosis resulting from a test or for the sign(s)/symptom(s) that prompted the ordering of the test.

The program memorandum also provides some information to physicians who send their patients or specimens to another facility for testing. Referring physicians are required to provide diagnostic information to the testing entity at the time a test is ordered. An order may be a written document signed by the treating physician/practitioner, which is hand-delivered, mailed, or faxed to the testing facility; a telephone call by the treating physician/practitioner or his/her office to the testing facility; or an e-mail by the treating physician/practitioner or his/her office to the testing facility. If the order is given by telephone, both the treating physician and the testing facility must document the telephone call in their respective copies of the beneficiary's medical records.

On the rare occasion when the interpreting physician does not have diagnostic information as to the reason for the test and the referring physician is unavailable to provide such information, it is appropriate to obtain the information directly from the patient or the patient's medical record. However, an attempt should be made to confirm any information obtained from the patient by contacting the referring physician.

The complete text of the program memorandum may be viewed at <http://www.hcfa.gov/pubforms/transmit/AB01144.pdf>. The latest ICD-9-CM coding guidelines can be downloaded at <http://www.cdc.gov/nchs/data/icdguide.pdf>. 