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All Medicare fees are par, office, national unless otherwise noted.

Practice management

Doc getting too old? Address the impairment, not the age, experts say

If you suspect an aging provider is no longer competent to perform, experts suggest you lean on the "no longer competent" rather than the "aging" angle. Also, document the issue and try to reach a reasonable accommodation with the provider.

In 2015, the AMA found that 23% of practicing physicians were 65 or older. This "graying" physician population

*(see **Impairment,** p. 4)*

Coding

Without ICD-10-CM recourse, turn to coding alternatives for vaping sicknesses, injuries

The increase of vaping and the use of e-cigarettes should have you brushing up on coding approaches as related health risks increase throughout the country. ICD-10-CM carries no medical coding guidelines or classifications for e-cigarette use or vaping, but you have several avenues to sufficiently report such diagnoses.

On Aug. 30, the Centers for Disease Control and Prevention (CDC) issued a health advisory warning Americans that the use of e-cigarette products could result

*(see **Vaping,** p. 7)*

Billing

Anthem's new prepay review policy will target Correct Coding Initiative bundles

Review your practice's use of modifiers that break edit pairs and check the policies for using those modifiers if Anthem is in your payer mix. Anthem BlueCross BlueShield, the nation's second largest private health insurer, rolled out a prepayment review of claims reported with common Correct Coding Initiative (CCI) modifiers starting Sept. 1.

At least 19 Anthem plans have announced that they will initiate a prepayment clinical validation review process for claims with a range of modifiers, including **25** (Significant, separately identifiable E/M service), **59** (Distinct procedural service), **57** (Decision for surgery), **LT** (Left side) and **RT** (Right side) "and other anatomical modifiers," states the notice published in the July edition of the Provider Newsletter for a variety of Anthem plans.

Physician organizations are concerned about the latest audit, which comes on the heels of a decision to audit claims with modifier 25.

"The latest policy update announced by Anthem will cause further apprehension on the part of practicing physicians that patient access to treatment will be delayed or denied completely by these changes. Physician concerns will be well founded," says Debra J. Parsons, M.D., president, Colorado Medical Society, Denver.

However, the impact of the prepayment audit may be lighter than the modifier 25 policy. The scope of the audit will be limited, Anthem says.

"This is a pre-pay audit that will apply to all claims. However, only a very small percentage of claims — approximately 3% — will be flagged for review, and those will primarily be claims that have procedure code combinations that may be reported together with the appropriate modifier only when specified criteria are met," says Joyzelle Davis, public relations director for Anthem Inc. in Denver.

To determine whether you're likely to be audited and boost your chances of winning an appeal, perform your own internal audit. Pull a sample of claims that were reported with a CCI modifier and check the documentation for the claims against the policies for unbundling the edit pairs. "The appropriate use of modifiers is based on the definition and guidelines that come from industry coding resources — including [the] AMA CPT Manual, CPT Assistant, CMS policies and edits — and Anthem's policies," Davis says.

Just as importantly, practices should be on the alert for documentation requests from Anthem to avoid stalled revenue.

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Finally, practices should reach out to their state or specialty medical association for continued guidance on this issue.

"We are fortunate to have a solid working relationship with several of Anthem's local executives and we will soon be reaching out to them to gain a better understanding of the rationale for these changes. Physician organizations in Colorado and across the country will be eager to learn more," Parsons says. — *Julia Kyles, CPC (jkyles@decisionhealth.com)*

Correct Coding Initiative

CCI follows AMA coding policy fix for bone allograft codes in October update

The Oct. 1 update of Medicare's National Correct Coding Initiative (CCI) code pairs actually brings a bit of good news for orthopedic practices. It is following up on a significant correction that the AMA made to its coding policy for two new 2019 bone allograft codes **20933** (Hemicortical intercalary, partial) and **20934** (Intercalary, complete).

Those add-on codes each have specific lists of primary codes with which they can be billed, listed in parenthetical notes beneath each allograft code. But in the 2019 CPT manual, the AMA got the lists of primary codes a little jumbled. That is, some of the codes that should have appeared beneath code 20933 were linked to code 20934 instead. The association published the corrected primary code lists in the May 2019 CPT Assistant and they will also appear in the 2020 CPT manual.

Now Medicare has adjusted its CCI code pairs to reflect that fix. In version 25.3, CCI follows the AMA errata to delete code pairs that include code 20934 as a column 2 component of the following codes:

- **20955** (Fibula bone graft microvasc).
- **20956** (Iliac bone graft microvasc).
- **20957** (Mt bone graft microvasc).
- **20962** (Other bone graft microvasc).
- **23146** (Removal of bone lesion).
- **23156** (Removal of humerus lesion).
- **24116** (Remove/graft bone lesion).
- **24126** (Remove/graft bone lesion).
- **25126** (Remove/graft forearm lesion).
- **25136** (Remove & graft wrist lesion).
- **27130** (Total hip arthroplasty).
- **27132** (Total hip arthroplasty).
- **27134** (Revise hip joint replacement).
- **27138** (Revise hip joint replacement).
- **27236** (Treat thigh fracture).
- **27244** (Treat thigh fracture).
- **27356** (Remove femur lesion/graft).
- **27638** (Remove/graft leg bone lesion).
- **28103** (Remove/graft foot lesion).
- **28107** (Remove/graft foot lesion).

In addition, CCI adds code pairs that bundle code 20933 as a column 2 component of the above codes, also per the AMA. The new edits have a modifier indicator of "1," which means the provider can override them when the situation warrants. To override in this case, the two codes would have to address separate problems the provider is treating.

The new code pairs are retroactive to Jan. 1 this year, according to CCI; however, it is unclear whether the deleted pairs are similarly retroactive. It is worth asking your Medicare administrative contractor about if you have some denials you would like to resubmit.

MUEs hit foot fusion code again

Meanwhile, in the update to medically unlikely edits (MUEs), Medicare continues to cut the number of units of foot arthrodesis code **28740**. In July, CMS lowered the MUE to two units of service for the code.

As of Oct. 1, that number drops to one unit of service on a single calendar day when the same provider treats the same patient. The code descriptor for 28740 states: "Arthrodesis, midtarsal or tarsometatarsal, single joint." To report fusion of multiple joints, you are to report either code **28730** or **28735**, the CPT manual states.

Medicare also lowered the MUE value for new 2019 knee arthrography code **27369** — the code is payable only once per day starting Oct. 1, down from two units of service per day. Both the MUEs for 28740 and **27369** have MUE adjudicator indicators of 2, corresponding to a date of service edit, meaning they can be overridden with a modifier. — *Laura Evans, CPC (levans@decisionhealth.com)*

Impairment

(continued from p. 1)

has been noted as a potential patient care and safety issue, according to outlets such as Medscape, which recently held a roundtable on the subject of aging physician competence, and The New York Times, which in February asked, "When Is the Surgeon Too Old to Operate?" The Times mentioned mandatory assessment protocols such as the "aging surgeon program" at Baltimore's Sinai Hospital, which evaluates the abilities of elder physicians.

"This has become a hot topic in the last 10 years or so among the medical communities, because you have an increasing number of late career physicians, and with it a huge demand by the public to hold physicians in general accountable — take, for instance, the demand for accountability due to the opioid crisis," says Miriam Mackin, an attorney with Nelson Hardiman in Los Angeles.

But it's an observable fact that many physicians are fully capable of practicing well into what many of us would consider old age. "I know physicians in their 80s who are outstanding in their specialty and there's no reason why they shouldn't practice," says Karen Rotgin, head of her own law firm in Uniondale, N.Y. At the same time, there are "doctors in their 50s who may develop issues, whether cognitive or physical, that impair their ability to treat," she says.

In fact, the key federal law on age discrimination, the Age Discrimination in Employment Act of 1967 (ADEA), prohibits bias "against persons 40 years of age or older." At the time of its drafting, explains Aaron W. Tandy, a partner with the Pathman Lewis law firm in Miami, it was presumed most professionals would retire at 65, which may have lowered expectations as to when age discrimination would kick in.

The existence of ADEA — not to mention state-level ADEA-based laws — may leave practice managers apprehensive that any attempt to keep an enfeebled, elder provider from giving substandard and even dangerous treatment to patients will subject them to prosecution. Certainly multi-million-dollar judgements like the $15.4 million in damages awarded to sports columnist T.J. Simers in his age discrimination case against the Los Angeles Times would make any employer nervous.

Focus on impairment, not age

One issue for practices is they don't generally have the many levels of oversight in the form of "fail-safes and committees" that hospitals have, Tandy says. He thinks you're on safer ground if you focus not on age but on the care and safety issue, as well as on reasonable accommodations you can make with the provider.

For one thing, providers can be impaired for a number of reasons. They may be suffering from drug, alcohol or mental health issues (*PBN 4/26/18, 8/22/19*). "Some signs that somebody might not be performing well could be due to, for example, undergoing chemotherapy rather than to age — or other issues that are treatable," Tandy says. "Therefore employers need to be sensitive when undertaking evaluations."

Whatever the issue is, it need not mean an end to your professional association with the provider. "Let's take a specialist who sometimes performs surgery," Rotgin says. "Let's say this particular physician has developed an impairment, maybe tremors, which could potentially make for a negative situation in the operating room and could pose a danger to patients. One option might be that the physician no longer performs surgery and only does consults. This can be a solution — at least for the short term, because some illnesses do progress and that accommodation may not be viable down the road."

If the stress of workload is an issue, you might offer the provider shorter hours. Tony Stajduhar, president of Jackson Physician Search in Alpharetta, Ga., says his company recently surveyed more than 500 physicians and found that "48% would like to reduce their hours prior to retiring, a more affordable alternative than temporary staffing options."

4 tips for better handling

- **Create written protocols that spell out how physician impairment is judged and dealt with.** "It might be their employment agreement or a partnership agreement or a shareholders' agreement or a combination," Rotgin says. "In any case it should have a roadmap that says when someone can be terminated or put on disability, or needs to be bought out."

- **Hold a non-confrontational meeting with the physician.** While in a sense you will be confronting the physician, the tone of your meeting on this topic "should not be accusatory," Rotgin says. "It needs to be a concerned discussion that doesn't threaten and opens up to a broader discussion which may present some options" for resolution. Also, "you have to document that conversation, which should be up front and professional," Tandy says. "And it probably doesn't hurt to have more than one person in the room with you."

(continued on p. 6)

Benchmark of the week

A tale of two sides: Practices report more right- than left-side modifiers

When delivering common injection and procedure services, providers tend to veer to the right side of the body more often than the left. That's what an inspection of claims with **RT** (Right side) and **LT** (Left side) modifiers reveals.

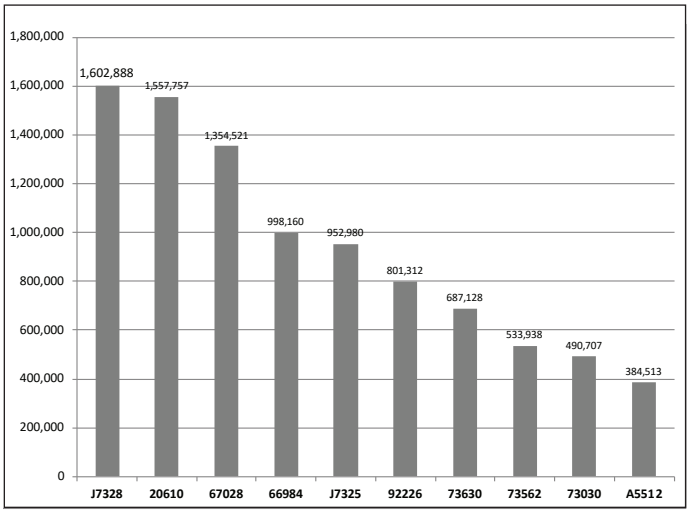
Medical practices reported five codes appended with the RT modifier more than 1 million times apiece in 2017, according to the latest available Medicare claims data. The top-billed codes include injection services to address pain, such as **J7328** (Hyaluronan or derivative, gelsyn-3, for intra-articular injection, 0.1 mg); **20610** (Arthrocentesis, aspiration and/or injection, major joint or bursa [eg, shoulder, hip, knee, subacromial bursa]; without ultrasound guidance); **67028** (Intravitreal injection of a pharmacologic agent); and **J7325** (Hyaluronan or derivative, synvisc or synvisc-one, for intra-articular injection, 1 mg).

Also surpassing the million-claim mark is **66984** (Extracapsular cataract removal with insertion of intraocular lens prosthesis, manual or mechanical technique) when appended with the right-side modifier, which is on track to suffer a pay drain in 2020 (*PBN 8/26/19)*.

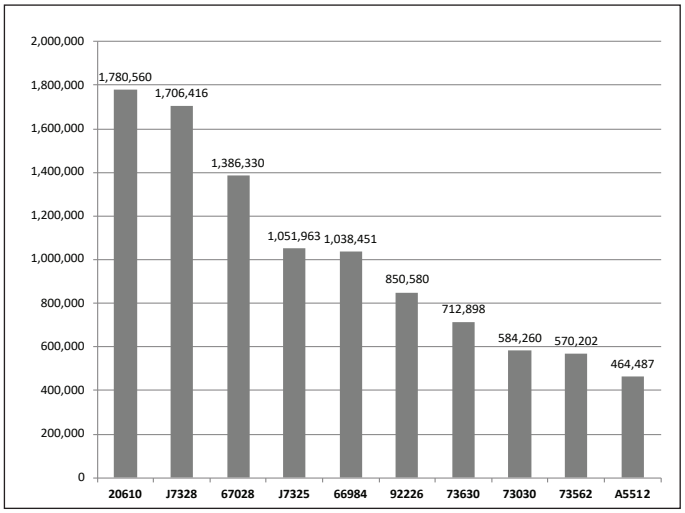
The left side is a bit lonelier, according to the claims analysis. Three codes with the LT modifier, instead of five, exceed the 1 million claims threshold. They are, in a different order, the same three codes that practices reported most often with RT. The other two LT-appended codes in the top five mirror the RT-appended claims, as do the rest of the 10 most-reported codes.

Practices see modest denial rates on their RT- or LT-appended claims. The highest denial rate on any of the 10 most-billed codes sits with shoe-insert service **A5512**-RT, with a 9.1% attrition rate. The A5512-LT combination, in contrast, has a denial rate of just 7.3%. — *Richard Scott (rscott@decisionhealth.com*)

Top 10 services billed with modifer LT in 2017



Top 10 services billed with modifer RT in 2017



Source: Part B News *analysis of Medicare claims data*

(continued from p. 4)

If the conversation goes sideways and you have reason to believe the physician represents a danger to patients, "you may have a legal obligation to report the physician and your concerns to the appropriate agencies," Rotgin says. These may differ from state to state, but would certainly include medical boards. If it isn't obvious, you should also be in contact with your lawyer about the matter.

- **Include testimony from witnesses.** In case the discussion between you and the physician becomes adversarial, any observation of impairment from colleagues or patients that comes to management should be affirmed by the witness where possible, "and human resources should likely take point in organizing everything," says Stacy Caprio, an independent business consultant based in Chicago.

- **Consider mandatory screenings.** While age-based discrimination is off limits, age-based screenings can be OK if everyone has to take them. The California Public Protection and Physician Help Program recommends an age-based physical and cognitive screening that "applies equally to all members of the medical staff who have reached the specified age." It's like mandatory drug testing for employees or the regular recertification that some jurisdictions require of their police officers and firefighters, Tandy says. — *Roy Edroso (redroso@decisionhealth.com)*

Vaping

(continued from p. 1)

in "severe" pulmonary disease. The CDC warned that children, young adults, pregnant women and adults who do not currently use tobacco products should avoid the use of e-cigarettes. The agency further reported that lipoid pneumonia associated with inhalation of lipids in aerosols generated by e-cigarettes has also affected users.

An emerging health threat

Developed as a way to assist individuals to quit smoking, e-cigarettes and the process of vaping became popular in the mid-2000s. According to the National Institute on Drug Abuse, basic e-cigarettes supply a vaporized dose of nicotine infused with flavorings or other substances or chemicals into the body. Users inhale these substances in the form of a vapor instead of smoke.

However, medical and government officials today are warning of the dangers of this practice, which includes the substituting of illegal and synthetic substances into the vaping process. Officials have reported a total of 530 cases of confirmed and probable illnesses or injuries from vaping in 36 states as of September, according to the CDC. In recent weeks, multiple news outlets have reported additional lung injuries and deaths due to vaping, and government agencies, including the Food and Drug Administration, have promised an investigative probe. The CDC has confirmed six vaping-related deaths.

Additionally, the American Lung Association revealed that many e-cigarette products may contribute to a rise in the number of cases of "popcorn lung" — a scarring of the tiny air sacs in the lungs resulting in the thickening and narrowing of the airways. Popcorn lung symptoms and general vaping symptoms include coughing, wheezing and shortness of breath.

How to handle vaping illnesses

Recognizing vaping symptoms when an individual seeks medical attention is critical, and clinicians are being urged to assist the CDC and local health departments with the following measures:

1. Report cases of severe pulmonary disease related to e-cigarette use to your state or local health departments. Reporting cases may help CDC and state health departments determine the cause or causes of these illnesses.

From the archive: Master drug-screen billing, navigate new vs. established and more

As a *Part B News* subscriber, you have access to years' worth of guidance on matters that are critical to running a successful medical practice. Dive into a cache of stories from the archive:

Sept. 24, 2018

Avoid specimen validity, drug screen codes on same day except in rare cases

https://pbn.decisionhealth.com/Articles/Detail.aspx?id=528530

Sept. 25, 2017

Heed the 'initial' description of G0438 to get annual wellness visits cleared

https://pbn.decisionhealth.com/Articles/Detail.aspx?id=526206

Sept. 26, 2016

New vs. established: How to bill a new patient for IPPE, E/M in same encounter

https://pbn.decisionhealth.com/Articles/Detail.aspx?id=522556

2. Consult with patients who report e-cigarette use about signs and symptoms of pulmonary illnesses.

3. Gather detailed history if e-cigarette use is suspected regarding the type of vaping substances used. That could include nicotine, cannabinoids, including marijuana, tetrahydrocannabinol (THC), THC concentrates, cannabidiol (CBD), CBD oil, synthetic cannabinoids, hash oil, and any flavorings.

4. Collect for testing if any product or a device remains. Testing can be coordinated with local or state health departments.

5. Remind patients who have received treatment for severe pulmonary disease related to e-cigarette use to have a follow-up evaluation to monitor pulmonary functions.

How to approach coding

There are no specific codes for treating vaping or its abuse, but coding experts suggest several avenues to document ailments and injuries. Maxine Lewis, CPC, president of Medical Coding and Reimbursement in Cincinnati, says clinicians and coders need to identify the consequences of the problem, but codes **94010-94770** (Pulmonary diagnostic testing and therapies) can be used.

Initially, code **Z77.29** (Contact with and [suspected] exposure to other hazardous substances) was a way to document vaping incidents, but with the variety of disorders e-cigarettes and vaping are causing — from burns to lung ailments to dependency — coding can become challenging.

"A code they do suggest we use now is **F17.290,**" says Gina Sanvik, health information management (HIM) practice excellence director at AHIMA in Minneapolis, Minn. "That is the nicotine dependence-other tobacco products [code]. Right now, we are dealing a lot with dependence."

Sanvik also recommends using **F17.291-F17.293** for coding tobacco use dependence.

Your coders also may have to report a burn, lung injury or substance dependency. You need to be diligent when documenting the vaping incident.

"You could be coding a burn from a vaping device malfunctioning," Sanvik says. "Right now, just code the burn and whatever degree of burn. You also have to look out for lung injury and poisoning."

A list of codes you could use related to vaping sicknesses, injuries and dependency may include:

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- **T65.9x** (Toxic effect of unspecified substance).
- **T50.915** (Adverse effects of multiple unspecified drugs, medicaments and biological substances). **Note:** This code goes into effect Oct. 1, 2019.
- **F12.188** (Cannabis abuse with other cannabis-induced disorder).
- **T40.7x5** (Adverse effect of cannabis [derivatives]).
- **T20.00XA** (Burn of unspecified degree of head, face, and neck, unspecified site, initial encounter).
- **J69.1** (Pneumonitis due to inhalation of oils or essences).

While codes for vaping treatments have been introduced to the ICD-10 coordination and maintenance committee, the advocacy for the introduction of specific vaping codes is a "hot area," according to Sanvik.

"I think we're going to see some changes in vaping [codes] just because it is becoming so common," Sanvik says. "With the coordination and maintenance committee, I see a lot of people bringing things forward a couple times a year for new codes."

Sanvik mentioned vaping code changes have been brought forward in 2017 and 2018. — *Jim Dresbach (jdresbach@decisionhealth.com)*

Stakeholders seek expedited process for vaping codes to gain ICD-10-CM approval

Coding the variety of vaping-related illnesses and injuries that you may encounter can prove challenging without dedicated ICD-10-CM code sets (*see story, p. 1*).

To gain further clarity on recent efforts to create dedicated code sets for these types of encounters, *Part B News* reached out to Scott Manaker, M.D., MPH, vice chair of regulatory affairs in the department of medicine at Penn Medicine in Philadelphia and an advocate for adopting ICD-10 codes related to electronic nicotine delivery devices (ENDS). He often lectures nationwide on billing, coding, chart documentation and reimbursement issues. In the Q&A below, Manaker shares what medical societies and industry stakeholders are doing to move forward with new code sets amid the emerging public health threat.

Part B News: **Could you share where you stand on enacting the codes and why it is important for the codes to be added in a timely manner?**

Scott Manaker: In the absence of specific codes, the American Thoracic Society (ATS) and CHEST (American College of Chest Physicians) sought guidance from Centers for Disease Control (CDC) on appropriate coding of vaping- and electronic cigarette-related use, illness and injury.

We have been collaborating with the ICD-10 Coordination and Maintenance Committee (ICD-10 CMC) at the National Center for Health Statistics (NCHS) for several years to develop a series of diagnosis codes to track the use of ENDS (electronic nicotine delivery devices) by patients, including children and teenagers as well as adults. After several presentations in the past two to three years, we have made substantial progress and developed a series of codes that address the concerns of physicians, coders and other constituents. Our proposal has been supported by several sister organizations in the cardiology, pediatric and pulmonary specialties as well. ATS/CHEST plans to present what we hope is the final version of the codes at the forthcoming March 2020 meeting; and we understand the NCHS is also coordinating with programs within the CDC to ensure alignment of involved entities in this current public health crisis.

In your medical opinion, how great of a health crisis do e-cigarettes pose for the general public and specifically for teenagers?

The recent headlines across the country and accelerated publication of medical journal articles about the apparent vaping injuries both highlight the paucity of knowledge and need for far more research as well as diagnosis codes to track use of ENDS. The headlines and medical journal articles also demonstrate this does represent a current public health crisis.

If the codes are approved, when will they go into effect?

Normally, presentations approved at the March 2020 meeting are implemented Oct. 1, 2021, to allow for dissemination and education about new diagnosis codes. However, because of the current public health crisis, we will be requesting accelerated approval and implementation for Oct. 1, 2020. — *Jim Dresbach (jdresbach@decisionhealth.com)*

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