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THE CODE

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Billing for G0463

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There seems to be an ongoing misconception of when and how to use Code G0463. In the 2014 Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center Payment System (ASC PS) Final Rule (November 27), the Centers for Medicare and Medicaid Services (CMS) collapsed all of Evaluation and Management (E&M) codes for clinic visit Ambulatory Payment Classifications (APCs). Healthcare Common Procedure Coding System (HCPCS) level II Code G0463 (hospital outpatient clinic visit for assessment and management of a patient) was created to replace Current Procedural Terminology (CPT) Level I Codes 99201-99205 (new patient visit) and 99211-99215 (established patient visit), and was assigned to APC 0634. Therefore, instead of being reimbursed based on the patient's condition (acuity) or the types of hospital/nursing services rendered, all clinic visits are now paid a single flat rate.

On April 7, 2000, the Federal Register (65 FR 18504) published a final rule specifying the criteria that must be met for a determination regarding provider-based status. "The regulations at existing 42 CFR §413.65(b)(2) apply the same criteria to facilities on the main provider campus as to off-campus facilities, and state that before a main provider may bill for services of a facility as if the facility is provider-based, or before it includes costs of those services on its cost report, the facility must meet the criteria listed in the regulations." Provider-based status is a Medicare status for hospitals and clinics. It is a national model of practice for integrated healthcare delivery systems. So what does this mean? It means that physician offices are considered to be departments of the hospital. In the provider-based billing model, also commonly referred to as hospital outpatient billing, patients may receive two charges on their combined patient bill for services provided within a clinic.

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If you have an article or idea to share for *The Code*, please submit to:
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To make life vibrant and meaningful, rise in the morning with determination, go to bed with satisfaction and in between strive for perfection!

Dr. Anil Kumar Sinha

Billing for G0463 *(Continued from page 1)*

One charge represents the facility or hospital charge and one charge represents the professional or physician fee. The provided-based charge code (G0463) was created for hospital use only, representing any clinic visit under the OPPS, therefore eliminating the need to identify whether the patient is new or established. Secondly, this code does not require an organization to use any specific criteria to determine a level of service. HCPCS Code G0463 is used for all FACILITY evaluation and management visits, regardless of the intensity of service provided. While this code simplifies some aspects of submitting a hospital outpatient claim for a facility evaluation and management service, it does not eliminate the need for detailed clinical documentation. Clinical support staff is still required to document the services and education provided to the patient during their visit. Therefore, there must be clinical documentation by the clinical support staff found in the chart to substantiate billing G0463 by the facility representing overhead expenses. Submission of a physician history and physical or a physician progress note as part of an appeal does not provide evidence to support facility cost and will be denied.

So in conclusion, please note that Code G0463 affects facility billing only, not coding for physician services.

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/a03030.pdf
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/mm8572.pdf

Stars of MiraMed

This month's Star is …

Arun Alexander
Director of Operations
MiraMed Philippines Group, LLC – Philippine Branch

MiraMed's brightest shining star this month is Arun Alexander.

John Felix Labay

Arun Alexander is a Six Sigma trained professional with over 10 years of experience in managing multi-million dollar operations that spread across different geographies. He is currently leading MiraMed Philippines Group, LLC as Director of Operations with a headcount of over 600 and he is responsible for business growth, profit & loss and service delivery. Arun has extensive experience in partnering with clients to develop their offshoring strategy and to help set up and manage shared service centers globally.

Arun's competence has greatly contributed to the successful set-up delivery center in Manila, Philippines for MiraMed Philippines Group, LLC with a very aggressive timeline, through strong collaboration and communication with the cross-functional teams that include Technology, Human Resources, Finance, Client Operations, Training and Process Excellence. He has an exceptional growth record from 50 to over 600 full time employees within three years since the launch of Manila Operations, and has increased from one to two centers with over 600 Medical Coders (inpatient and outpatient) and Medical Billing Professionals.

Smoking: An Education

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According to the American Lung Association, every year in the United States of America, more than 480,000 people die from tobacco use and secondhand smoke; making it the leading cause of preventable death in this country. We are well aware of the hazardous effects of smoking to a human body. Cigarette smoke contains more than 7,000 chemicals, at least 69 of which are known to cause cancer[1]. Smoking has an effect on almost every organ in our body and is the main cause of chronic respiratory and heart conditions, yet many are still ignoring the facts. Most lung cancer and Chronic Obstructive Pulmonary Disease cases are attributed to smoking tobacco products. The risk of dying from cigarette smoking has increased over the last 50 years in men and women in the United States[2]. Is quitting really worth it? Yes, as it can reduce the risk of harboring life-threatening conditions due to smoking tobacco products and it can improve the quality of your life.

In the ICD-10-CM, there are code assignments for smoking and they vary based on what type of tobacco product the person is consuming. This falls under category F17, Nicotine Dependence, and its subcategories depend on the type of tobacco products (e.g., cigarettes, chewing tobacco, etc.). The 6th character specifies the status of the person's nicotine dependence (e.g., uncomplicated, in remission, with withdrawal). No codes are to be assigned for tobacco abuse and history of tobacco use or abuse. In coding pregnant patients who are smoking, two codes are assigned to fully describe the condition, O99.33- (Smoking (tobacco) complicating pregnancy, childbirth, and the puerperium) and a code from category F17 to specify the type of tobacco product and the status of the person's nicotine dependence. For past history of tobacco dependence, assign Code Z87.891 (Personal history of nicotine dependence).

[1] U.S. Department of Health and Human Services. How Tobacco Smoke Causes Disease: The Biology and Behavioral Basis for Smoking-Attributable Disease A Report of the Surgeon General.
[2] U.S. Department of Health and Human Services. The Health Consequences of Smoking—50 Years of Progress: A Report of the Surgeon General. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014 [accessed 2015 Oct 5].

Are You A Good Auditor?

John Christian Sayo, RN, COC-A,
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Direction: All Medical Coding staffs are encouraged to send their correct codes based from the case provided. They must present their codes along with coding clinics, coding guidelines or any coding references applicable for any codes that are to be **Added**, **Deleted** or **Revised**. Answers to this scenario will be published in our next issue.

A 60-year-old female who underwent a Hartmann's procedure one year ago for complicated diverticulitis comes in today complaining of abdominal pain. She presented to the hospital, requesting a colostomy takedown. On admission, CAT scan was performed and showed a parastomal hernia involving the transverse colon which was causing the abdominal discomfort. In order to avoid further complications, it was decided that she undergo surgery for her hernia. Patient also has hyperlipidemia and hypertension which were managed during the hospital stay. She was taken to the operating room and was prepped and draped in the usual surgical fashion. The procedure was started with an 8 cm infraumbilical midline incision using her prior surgical wound. Dissection was carried down to the fascia and retractors were placed. Some omental adhesions to the abdominal wall and small bowel adhesions were gently dissected with Metzenbaum scissors. Attention was then turned to the colostomy site. The transverse colon was reduced from the hernia and the hernia sac was also divided. The colostomy then dropped into the abdomen and the stoma was carefully removed. The parastomal hernia site was closed using uninterrupted sutures from both the outside and the inside. Intestinal anastomosis was performed, colostomy site was closed and surgical site was irrigated with saline solution. Hemostasis was obtained and the skin was closed with staples. There were no complications during or after surgery.

- Procedures performed: Colostomy takedown, Lysis of adhesions, Parastomal hernia repair
- Postoperative diagnosis: Incarcerated parastomal hernia

	ICD-10-CM
Principal Diagnosis	K43.5
Secondary Diagnosis	E78.5
Secondary Diagnosis	I10
Secondary Diagnosis	K66.0
	ICD-10-PCS
Principal Procedure	0WQF4ZZ
Secondary Procedures	0DN80ZZ

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Are You a Good Auditor? *(Continued from page 4)*

Correct Answer from Previous Case Scenario:

	ICD-10-CM	Audit Remark
Principal Diagnosis	Q05.9	Assign T85.86XA as the principal diagnosis. The patient was admitted because of the plugged shunt and the treatment was focused on this. The post-operative diagnosis states that the plugged shunt was caused by a thrombus, thus, assigning this code is correct. As per ICD-10-CM index pathway: Complication -> ventricular shunt -> thrombosis = T85.86
Secondary Diagnosis	T85.86XA	Revise Q05.9 (Spina bifida, unspecified) to Q05.2 (Lumbar spina bifida with hydrocephalus). The documentation states that the patient has undergone multiple procedures at the lumbar spine. The patient also has a VP shunt to drain CSF from her hydrocephalus. Therefore, Q05.2 is more specific. As per ICD-10-CM guideline, we need to code to the highest specificity. As per ICD-10-CM index pathway: Myelomeningocele -> see Spina bifida -> Spina bifida -> lumbar -> with hydrocephalus = Q05.2
Secondary Diagnosis	Z98.5	Revise Z98.5 (Sterilization status) to Z98.2 (Presence of cerebrospinal fluid drainage device). As per ICD-10-CM index pathway: Status -> shunt -> ventricular
	ICD-10-PCS	**Audit Remark**
Principal Procedure	00163K4	Revise 00163K4 to 00163J6. The body system is CNS; root operation is bypass; body part is cerebral ventricle; approach is percutaneous; device is synthetic substitute since there was no documentation that a tissue was used, and the catheter is typically a synthetic substitute in this type of procedure (but still, querying the provider is the best option for this); qualifier is peritoneal cavity since the shunt replaced was a shunt from cerebral ventricle to the peritoneal cavity. Add PCS code 00P63JZ for the removal of the VP shunt. This is coded since there was a previous shunt that was removed and replaced by a new shunt.

Coding Case Scenario

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Direction: Code for ICD-10-CM Diagnosis and Procedure. Answers to this scenario will be published in our next issue.

The patient is a 49-year-old white female. She has been seen by Dr. X in his office for physical examination and it was found that she has a pelvic mass. She was sent for an ultrasound which confirms the diagnosis of probable left ovarian mass and was sent for further evaluation. The surgical team suggested that she undergo total abdominal hysterectomy and bilateral salpingo-oophorectomy. The doctor sent her for cancer antigen 125 and it came back negative. She was also sent to Dr. Y to evaluate her sigmoidoscopy to make sure there were no lesions in the rectum. She had a discussion with the physicians about the procedure and she agreed to undergo surgery. Informed consent about the operation was given and complications of anesthesia and surgery were also discussed. As per past medical history, the patient has medications for long-standing diabetic chronic kidney disease stage five as well as levothyroxine sodium for her postsurgical hypothyroidism. Her left thyroid lobe had been removed in the past due to a benign tumor. These medications were continued during her hospital stay.

Operative Report

- Preoperative diagnosis: Ovarian cysts
- Postoperative diagnosis: Bilateral dermoid ovarian cysts
- Operation: Total abdominal hysterectomy with bilateral salpingo-oophorectomy
- Anesthesia: General

Description of Operation:

Under the above anesthesia, the patient was placed in the supine position and prepared and draped in the usual manner. A Pfannenstiel incision was made, carried through all layers, all bleeding controlled with cautery. Fascia was recognized and turned into and dissected transversely. The muscles were separated manually and peritoneum recognized and turned into and dissected vertically. A pelvic evaluation revealed a slightly enlarged uterus. Otherwise, bilateral ovaries revealed multiple cysts, some of them with papillary projection. There was no ascites and omentum revealed to be normal. An O'Connor-O'Sullivan retractor was used, fundus of the uterus grasped with the tenaculum, the round ligament grasped bilaterally and 30-chromic suture placed on each side. Heaney clamp placed on the infundibulopelvic ligament bilaterally, in this way both ovaries and tubes were removed. Kocher clamps were placed, cardinal ligaments cut and sutures placed on. This procedure was performed to the cervicovaginal junction and both the uterus and cervix was removed.

Correct Answer from Previous Case Scenario:

	ICD-10-CM	Coding Remark
Principal Diagnosis	M12.512	This is a sequela of the left shoulder fracture. Therefore, the site for the traumatic arthropathy is left shoulder as well.
Secondary Diagnosis	S42.92XS	The fracture for the left shoulder fracture has given the patient traumatic arthritis. Thus, this should be coded as a sequela.
Secondary Diagnosis	F10.229	The patient was intoxicated when he arrived and he is dependent on alcohol.
Secondary Diagnosis	Y90.4	This is a convention from F10.229, to use as additional code for blood alcohol level.
Secondary Diagnosis	W34.00XS	This is coded as sequela because the gun shot happened previously which gave the patient the left shoulder fracture.