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

President signs Medicare payment fix bill, delays reimbursement cut

You are now guaranteed stable Medicare reimbursement rates for one year. President Barack Obama signed the Medicare and Medicaid Extenders Act of 2010 on Dec. 15. The new law will prevent cuts of roughly 30% to physician payments in 2011 ([PBN 12/13/10](#)) and will allow CMS to adjust its conversion factor up from the reduced rate of \$25.5217 found in the Medicare Physician Fee Schedule.

It's not known what the exact 2011 rate will be, but expect it to be near the 2010 conversion factor of \$36.8729.

'Red Flag Rule' altered

Another piece of legislation awaiting the president's signature will no longer allow you to be subject to the "Red Flag Rule." Congress, through the Red Flag Program Clarification Act of 2010,

(see *pay fix*, pg. 6)

Get ready for big immunization changes in 2011

You'll face some big new changes when it comes to immunization billing in 2011, thanks to new codes that will affect both your older patients on the Medicare side and your pediatric patients on the private-payer side.

The Medicare change: The longstanding code **90658** (flu vaccine, 3 years and up, \$11.37) will no longer be payable starting Jan. 1, 2011. On the same date, five new Q codes take effect, replacing 90658. These new codes indicate the brand of the flu vaccine and are being implemented because of "a program need to create separate billing codes for each brand-name vaccine product," CMS says in Transmittal 815, released Nov. 19.

(see *immunizations*, pg. 6)

Part B News takes its scheduled holiday recess next week. Look for our next issue on Jan. 3, 2011. If news breaks before then, we'll publish it immediately on www.partbnews.com. Register for this exclusive access by logging onto the website today. If you need assistance accessing the website, call 1-877-602-3835.

4 new CPT changes will reshape debridement coding in 2011

Your work is cut out for you when it comes to wound care coding in 2011, thanks to CPT changes aimed at making debridement services easier to bill. There are code deletions, new add-on codes and new documentation requirements, experts say.

Here's the list of changes:

1. Two debridement codes, **11040** and **11041**, have been deleted and you will use active wound care management codes **97597** (\$78.17 in 2011) and **97598** (\$26.18 in 2011) instead. **NOTE:** All 2011 prices are estimates.

2. Documentation requirements for 97597 and 97598 have changed in two ways. First, providers no longer have to indicate whether anesthesia was used for these codes, says Jenny Jackson, MPH, practice affairs associate for the American College of Surgeons (ACS) in Washington, which had advocated for the debridement changes. Second, providers must now document the surface area debrided, in units of 20 sq. cm. Most surgeons are already in the mindset of documenting surface area, as they are required to do so for many other debridement services, so this won't be a major new burden, Jackson believes.

3. Three new debridement codes, **11045**, **11046** and **11047** (\$33.55, \$58.63 and \$96.24 respectively), have been added. These add-on codes are being inserted out of order in the CPT book, and must be billed as add-ons

to **11042-11044**, says Margie Scalley Vaught, CPC, content coding specialist for DecisionHealth, the publisher of **Part B News**.

4. Fracture debridement codes **11010-11012** have a new documentation requirement, Vaught says. You must indicate whether you washed out the wound by specifically stating so, and giving details using phrases such as "removed gross contamination by washing" and mention the specific substance, such as mud, asphalt, manure and so forth, she says.

Use these detailed coding scenarios from the ACS's Jackson to compare coding rules and reimbursement under the current process against the 2011 process:

- **Clinical scenario 1:** "A woman presents with multiple wounds from an ice skating accident. She suffered a grossly contaminated open fracture dislocation of the right thumb, and palmar surface injuries to the left hand and thigh. Her right hand required debridement through the subcutaneous tissue, muscle fascia, and muscle of a 3 cm x 3 cm area with reduction and internal fixation. Her left hand required debridement down to and including bone of a 3 cm x 2 cm area. Her left thigh required debridement down to and including bone of a 6 cm x 10 cm area."

- **2010 coding (using 2010 rates):** Bill **26665** (treat thumb fracture, \$587.02), combined with **11011** (debride skin/muscle, fx, \$490.41) with modifier **51** (multiple procedures) and **11044** (debride tissue/muscle/bone, \$363.20) with modifier 51.

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- **2011 coding (using 2011 rates):** Bill 26665 (treat thumb fracture, \$664.45), combined with 11011 (\$562.31) with modifier 51, with 11044 (\$363.20) with modifier 51. Additionally, to cover her 60 sq. cm left thigh debridement, the add-on code 11047 (debride bone, add-on, each additional 20 sq. cm, \$96.24) is billed three times.

Remember: The multiple procedure payment reduction (MPPR) kicks in for the codes with modifier 51 appended. Bear this in mind when comparing reimbursement values.

- **Clinical scenario 2:** “A man who was rollerblading fell and suffered injuries to the palmar surface of both hands and the anterior aspect of his right leg. No bones were fractured. His right hand required minimal wound cleaning of a 4 cm x 4 cm area of erythematous epidermis. His left hand required debridement through the subcutaneous tissue of a 3 cm x 10 cm area. His right leg required debridement down to and including bone of a 5 cm x 10 cm area.”

- **2010 coding (using 2010 rates):** Bill 11040 (\$43.51), combined with 11042 (\$68.58) with modifiers 51 and **59** (separate anatomical site) and 11044 (\$363.20) with modifiers 51 and 59.

- **2011 coding (using 2011 rates):** Bill 97597 (active wound care, 20 cm or less, \$78.17), combined with 11042 (\$68.58) with modifiers 51 and 59, with add-on code 11045 (\$33.55) billed once. Finally, 11044 (\$363.20) is billed with the add-on code 11047 (\$96.24) tacked on twice. — *G. Huang*

Most changes in CCI 17.0 aimed at addressing new CPT 2011 codes

You will face the latest set of Correct Coding Initiative (CCI) edits when you return to work on Jan. 3. CCI version 17.0 technically takes effect Jan. 1, but Jan. 3 is the first business day of 2011. This newest round of edits contains a total of 29,600 changes, up from the 19,702 changes in CCI version 16.3 ([PBN 9/27/10](#)), a **Part B News** analysis shows.

The majority of these changes – 67% – are new edit pairs that bundle a variety of supporting services (ECGs, wound repairs, sutures, imaging guidance) into a diverse range of surgical procedures. One reason for the increase in edits from CCI version 16.3 is the addition of new codes introduced in CPT 2011.

Remember: You'll be paid for the comprehensive code (those listed in column 1 of the **Part B News** CCI Scorecard below) of the edit pair when an edit is activated.

The new pairs are distributed across the spectrum. About 21% of the new pairs affect gastroenterology and cardiology surgeries (**90000** code range), 15% affect anesthesia (**00000** range), 14% affect technical codes and 13% affect cardiovascular system surgeries (**30000** range). The remaining pairs impact musculoskeletal procedures (**20000** range) and eye surgeries (**60000** range), which had about 9% and 7% respectively.

The two codes most commonly being bundled into surgeries are both for fluoroscopic guidance: **77001** (\$125) for central venous access device placement, and **77002** (\$82.23) for needle placement. **NOTE:** All prices are estimates for 2011, and use the current conversion factor of \$36.8729.

About 33% of the new pairs have a CCI indicator of “0” and thus will no longer be separately billable, even with a modifier. The remaining 67% of new pairs have an indicator of “1” which allows you to unbundle them.

This ratio of bundling and unbundling code pairs is practically identical for the 9,559 deletions. Many of these are happening because old codes being replaced with new codes. A significant example is the unbundling of intracavitary chemotherapy code 96445 from

CCI Version 17.0 Scorecard

Changes effective January 1, 2011

Code Range	CCI code-pair add.	CCI code-pair del.	Mut. excl. code-pair add	Mut. excl. code-pair del.
Tech codes	2,745	214	7	93
00000	2,971	1,077	0	0
10000	16	397	11	17
20000	1,729	589	1	1
30000	2,599	2,463	10	3
40000	2,118	530	20	7
50000	942	16	1	0
60000	1,381	171	7	18
70000	803	312	2	3
80000	91	35	9	2
90000	4,085	3,621	156	75
HCPCS	115	134	3	0
Total	19,595	9,559	227	219

Source: **Part B News** analysis of CCI edits. Editor's note: The code range is based on the comprehensive code of the edit pair.

all manner of inpatient visits, including the massively billed hospital care codes **99221-99223** and **99231-99233**. The reason? 96445 is being replaced by **96446** (\$192.85) in 2011.

NOTE: There are 48 deleted edit pairs with retroactive effective dates, which means you can resubmit claims with dates of service as far back as July 2010 to have previously bundled services be separately billed.

TIP: One such pair worth noting is **36000** (place needle or intracatheter in vein, \$27.65), which had included transforaminal epidural injection code **0231T** (carrier priced). This edit pair is being deleted retroactive to July, which means you can resubmit claims to separately bill both services – assuming you determine that the extra pay boost is worth the time and money to resubmit.

On the other hand, 32 new edit pairs also have retroactive dates, which means CMS could technically hit you with an overpayment. However, this sort of action is not common and only occurs during audits, according to Frank Cohen, principal and senior analyst for the Frank Cohen Group LLC in Clearwater, Fla.

CCI 17.0 is still heavy on surgery services, but the emphasis shifts more to cardiovascular surgeries, unlike versions 16.3 and 16.2, which had focused on the 20000, 40000 and 50000 code ranges ([PBN 7/5/10](#)).

Here's a few top highlights from CCI 17.0 that either appear frequently among the edit pairs changed, or affect top-billed services.

- New remote retinal imaging codes **92227** (\$12.54) and **92228** (\$32.45) for monitoring diabetic retinopathy

is being bundled into all inpatient and office visits, new and established (**99211-99215**, **99217-99239**).

- **93461** (R&I hrt art/ventricle angiography, \$1,555.67) is a new code in CPT 2011 that replaces heart catheterization codes **93510** and **93526**, thus absorbing all manner of supporting services including arterial X-rays **75741-75746**. These imaging services may not be overridden with a modifier.

- Other cardiovascular surgery codes new to CPT 2011 follow suit, including revascularization codes **37220-37235**. Supporting procedures that are logically bundled into these include blood vessel repair codes such as **35201** (repair blood vessel, neck, \$1,083.33) and artery exposure codes such as **34812** (expose for endoprosth, femorl, \$391.96). These may be overridden with a modifier.

- Pelvic CT scans (**72192**, \$265.85) are now bundled into abdominal CT scans (**74170**, \$482.67), which were billed more than 1.1 million times in 2009. This represents a considerable pay hit to diagnostic radiologists.

— G. Huang

Revenue cycle management

Online patient registration tools can save time, boost revenue, but come with caveats

Your practice can see patients more quickly while making fewer paperwork errors using online, electronic patient registration tools, a growing technological trend that will boost your bottom line, practice managers say.

Caveat: These services aren't free and come with a learning curve both for your staff and patients, which could slow you down at least temporarily when your existing paper-based system already works well.

The concept: Online patient registration spans a variety of different tools, but the idea is to have patients, especially new patients, fill out paperwork more quickly and accurately using a computerized system. Some registration tools allow patients to do this securely on the Internet before stepping foot in your practice; others are "kiosk-based" and provide your practice with computer pads or stations in your office that patients use once they arrive.

At Joel E. Holloway MD's solo dermatology practice in Norman, Okla., new patients are offered a chance to fill out registration forms online at home, says Trisha

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Go to www.partbnews.com today and download your edition of the Non-Physician Practitioner Report.

The **NPP Report** is free only to **Part B News** readers as part of their newsletter subscription. The December issue includes a guide to improve work flow for wellness visits with NPPs, plus updates to the multiple procedure payment reduction (MPPR) on therapy services and analysis of electronic health records (EHRs) on NPP costs.

To download your **NPP Report**, go to the **Part B News** website and click on the **PBN Library** tab. You'll then see the **NPP Report** archive, where you can download the report and access past **NPP Report** issues.

Scott, practice administrator. About half of new patients opt for the online submission, which is powered by a website called SubmitPatientForms.com. The top benefit is legible documentation, which all but eliminates data entry errors for patients who fill out forms online, Scott says.

SubmitPatientForms.com also allows a practice to send reminders and track the progress of patients who begin to fill out a form, but stop mid-way, says Keith Rossein, DDS, a longtime dentist and co-founder of the website. Beyond legible documentation, his service also outputs completed forms in a variety of image, PDF and spreadsheet formats that can be imported into some practice management systems (PMSs) and electronic health record (EHR) systems.

Kiosks don't give the advantage of having paperwork done before an appointment, but are useful for patients who aren't computer-savvy, because your staff are immediately on hand to help them use the systems. Many kiosk systems, such as Phreesia, can more readily transfer electronically entered patient data into compatible EHRs and PMSs.

Example: Phreesia, a "patient check-in" tool that comes in the form of electronic pads given to participating practices, is used at Arthritis Associates of Mississippi, in Jackson. The pads are handed to patients who complete paperwork on them, have their insurance eligibility checked by the system (using third-party software that works with 300 payers, according to Phreesia's website) and are prompted to pay their copays and deductibles. These features have made Phreesia a time saver, says Joan Senteney, practice manager.

Disadvantages are costs, learning curves

Phreesia charges a flat \$50 per month, per provider for these basic services, but the cost spikes sharply if you opt to use the pads' credit card swipers, which add a cost of \$1 paid for every \$25 charged on a card. The costs are worth the benefits, says Chaim Indig, CEO of Phreesia in New York City. "We save a ton of time and drive revenue for our practices." Phreesia's user surveys suggest that the systems saves "an average of between eight and 10 man hours for an individual provider, per week," Indig says.

Phreesia – and any in-office kiosk – also can pose a challenge to older patients who aren't computer-literate, an Arizona practice manager says. Having staff help

these patients defeats the purpose of saving time, the practice manager points out.

For his part, Indig says his company has surveys showing that more than 80% of patients who have used Phreesia prefer the system to a packet of papers on a clipboard.

Non-kiosk systems such as SubmitPatientForms.com are cheaper – \$49 per practice per month – but don't have the in-office electronic eligibility verification and optional credit card swiper that Phreesia has. The service also charges a one-time fee of \$995 to convert up to 12 pages of your office forms to its own format, if you don't like its free generic forms, Dr. Rossein says.

The bottom line: Both kiosk-based and online registration tools are proven to improve the legibility of patient-entered data, and can speed work flow by allowing electronic data entry into your record systems when they are compatible.

Kiosk systems like Phreesia offer more features in your office at a higher cost, while online registration sites like

MA physicians must be part of medical necessity audits

Expect to see physician involvement during medical necessity reviews conducted by Medicare Advantage (MA) plans, thanks to a new requirement proposed by CMS. This would prevent MA plan officials without direct knowledge of providing medical care from making unfavorable decisions when auditing your claims.

The Nov. 10 proposed rule would implement this health care reform provision found in the Affordable Care Act. Once the rule is finalized, after a 60-day comment period, you could fight medical necessity determinations that don't involve a physician or MA medical director.

"We believe Congress expected that appropriate health care professionals would review initial determinations involving medical necessity," CMS says. These professionals would have "sufficient medical and other expertise," including knowledge of the Medicare program and patients.

CMS estimates that 95% of MA plans already have a medical director overseeing decisions involving medical necessity. However, the proposed rule would standardize the process and require these physicians to be licensed to practice medicine in your state.

You have until Jan. 11, 2011 to submit comments on this rule. You can do so by going to www.regulations.gov and search for the rule number "CMS-4144-P." — C. Fiegel

SubmitPatientForms.com focus exclusively on getting paperwork completed electronically before patients step inside. You can use either, or both; in fact Phreesia is testing a new feature that will function like SubmitPatientForms, but no details on pricing or a release date are available, beyond “early 2011,” Indig says. — *G. Huang*

On the Internet:

- ▶ SubmitPatientForms website: www.submitpatientforms.com
- ▶ Phreesia website: www.phreesia.com

pay fix

(continued from pg. 1)

narrowed the scope for who the Federal Trade Commission (FTC) can define as a creditor and subject to the Red Flag Rule.

The act clarifies enabling legislation that requires financial institutions and creditors to follow guidelines and take certain safeguards to prevent identity theft. The FTC initially applied the rule to all businesses that collect sensitive information, such as Social Security and credit card numbers, and were supposed to apply to physician practices and other small businesses in 2008.

Advocacy groups and politicians have since argued the rules placed a burden on not just financial institutions but all businesses, and implementation of the rule had been delayed until Jan. 1, 2011 (PBN 6/7/10).

The AMA says it expects that Obama will sign the bill. — *C. Fiegl*

immunizations

(continued from pg. 1)

Translation: Each brand costs Medicare a different amount, so the change takes this into account, says Cynthia Hughes, CPC, coding and compliance specialist for the American Academy of Family Practitioners (AAFP) in Leawood, Kan.

The five new Q-codes are:

- **Q2035** (Afluria). Payment limits will be determined by your carrier or Medicare Administrative Contractor (MAC), because no national limits are available, CMS says.
- **Q2036** (Flulaval). The national limit is \$7,439.
- **Q2037** (Fluvirin). The national limit is \$13,253.
- **Q2038** (Fluzone). The national limit is \$12,593.
- **Q2039** (Not otherwise specified flu vaccine). Like Q2035, there is no national payment limit and your local carrier or MAC gets to set the limit. **NOTE:** The national limit is the most you could get paid for these codes, but state-level prices will vary, says Collette Shrader, CCP-P, compliance and education specialist for

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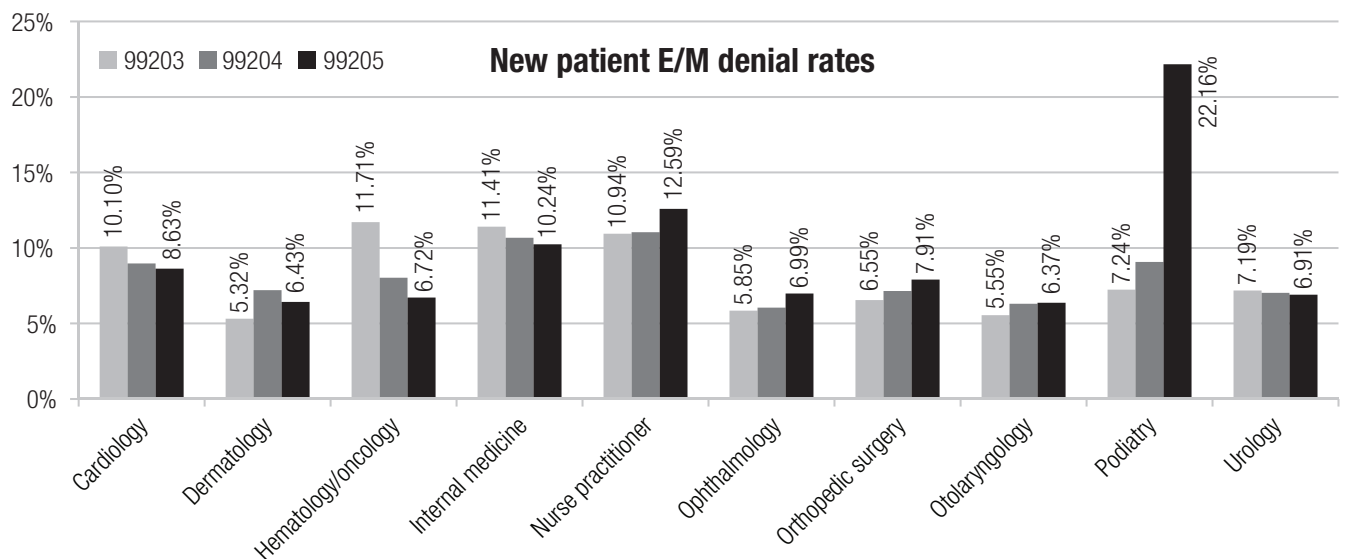
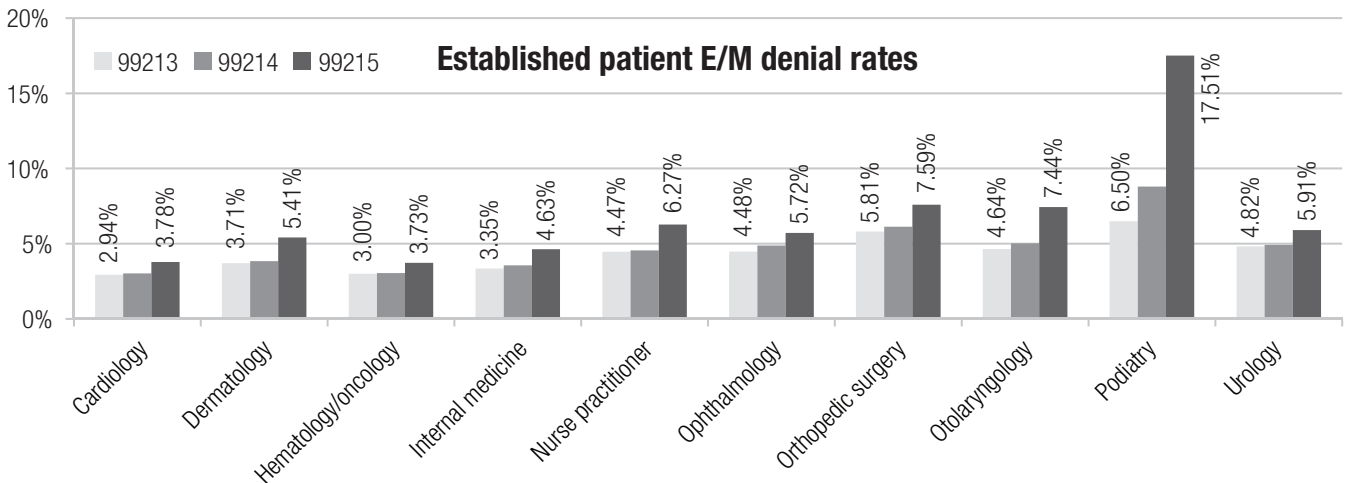
PAS 2010

Benchmark of the Week: New vs. established denial rates by specialty

Summary: This chart compares the denial rates for new and established office visits, levels 3 to 5, by specialty based on the latest CMS claims data from 2009. These specialties were chosen to cover a diverse array of practices. **NOTE:** Data labels indicate the actual denial rate for the level 3 and level 5, omitting level 4.

Breakdown: Podiatry stands out as having the worst denial rates across the board for E/Ms, with particularly high denials for the level 5 visits. However, podiatrists billed few level 5s, totaling 8,765 between both new and established in 2009. Established E/Ms represent the bulk of utilization, with these specialties billing 104.6 million such visits in 2009, versus 6.3 million new E/Ms billed. The familiarity with established E/Ms may contribute to their lower denials. Dermatologists perform the best overall when considering both new and established codes.

Takeaways: The denial trend for established E/Ms goes from low level 3 denials to high level 5 denials, but it's a lot more complicated for new E/Ms. For these services, four specialties see higher denials on the level 3s than level 5s. Hematology/oncology is a particularly clear example. The highest denials on new E/Ms are seen by internists and nurse practitioners, who are often found in primary care practices. Overall, the established E/Ms are well below 10% for most specialties but new E/Ms are commonly above 10%. While they may have less financial impact due to much lower utilization, new E/M visits are a target for internal audits. **TIP:** Don't see your specialty here? Download a PDF table with the same data for 43 specialties by visiting the **Part B News** website at <http://bit.ly/cfgbXi>.



Ask a Part B News Expert

This week's question is answered by Regan Bode, CPC, CPC-H, CPMA, CEMC, ACS-EM, content manager for DecisionHealth and consultant for DecisionHealth Professional Services.

Q It is my understanding you can bill a separate procedure during a non-covered annual wellness visit (99381-99397). Can the additional procedure be a visit such as a **99213**? Which codes would get the **25** modifier?

A You can bill a separately identifiable E/M code at the same encounter as a preventive exam but let's talk about the components of both visits, and what that truly means.

An office visit code (**99211-99215**) must have a chief complaint and the separate E/M documentation should as well. An incidental finding during the preventive exam does not warrant a separate E/M code. There are many items covered within an annual wellness/preventive exam, including (typically) a complete updated history (ROS, PFSH) and complete exam. I will take a careful review of these items to see if any of this information is pertinent to the chief complaint. I find that, at the most, some limited extended exam was done if the patient complains of an injury. Outside that, these items are all contributed to the wellness exam. That leaves only history of the present illness elements and a pertinent review of systems towards your separate E/M. Then there must be medical decision-making towards the problem. I then use the level of HPI and MDM to find my visit. Since I could not use

any ROS (except that pertinent to the problem), I do not find I can ever code this separate E/M higher than a 99213. You will want to review your own compliance plan and internal process for auditing these visits to formulate your own standard.

Remember: Medicare requires the E/M allowable to be carved out of the charge billed to the patient for a wellness exam when performed on the same day. WPS covered this topic again on Sept. 24, 2010 and helps explain the pricing breakdown for "carving out" covered services from non-covered preventive services.

Modifier 25 technically can be used on either code. Since I will want at least the office visit (99211-99215) to be submitted and paid by Medicare/insurance, I will place the modifier on that code, showing it was distinct from the wellness exam on the same day.

On the Internet:

▶ WPS carve-out policy: www.wpsmedicare.com/part_b/business/carveout_services.shtml

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Wenatchee (Wash.) Valley Regional Medical Center. "We won't really know until [CMS publishes its Average Sales Price or ASP list for Q1 2011]," she says.

NOTE: While the effective date is Jan. 1, this change is effective for claims dating back to Oct. 1, 2010. This means you can use either 90658 or the new Q codes on claims with dates of service between Oct. 1 and Dec. 31, 2010.

The private payer change: CPT deleted vaccine administration codes **90465-90468** and replaced them with **90460** and **90461**, to allow you to separately report multiple vaccine/toxoid components for pediatric patients (ages 18 and under). For these younger patients, your providers also are required to document the fact that they counseled patients and/or parents, Hughes says.

Here's how the component billing works:

- Report 90460 once for each separate vaccine administered.

- Report 90461 for each additional component to the vaccine. **NOTE:** 90460 and 90461 cover all routes of administration, Hughes says.

- **Example:** A two-month-old infant gets three vaccines in one encounter, consisting of diphtheria, tetanus and pertussis (often called "DTaP"). Under the new scheme, this is billed as 90460 once (to indicate diphtheria), 90461 twice (to indicate the tetanus and pertussis) and **90700** (the physical vaccine itself).

- Make sure providers document the counseling. Most providers already perform the counseling, often because they are prompted by patients demanding to know about "side effects, does it cause autism, and so forth," Shrader says. **TIP:** The new documentation doesn't have to be long or involved. Adding a simple phrase such as "explained risks and benefits of this vaccine, reassured parent on side effects" is good enough, Shrader says. This phrase or some close variant will be used by providers at her group, she says. — *G. Huang*

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