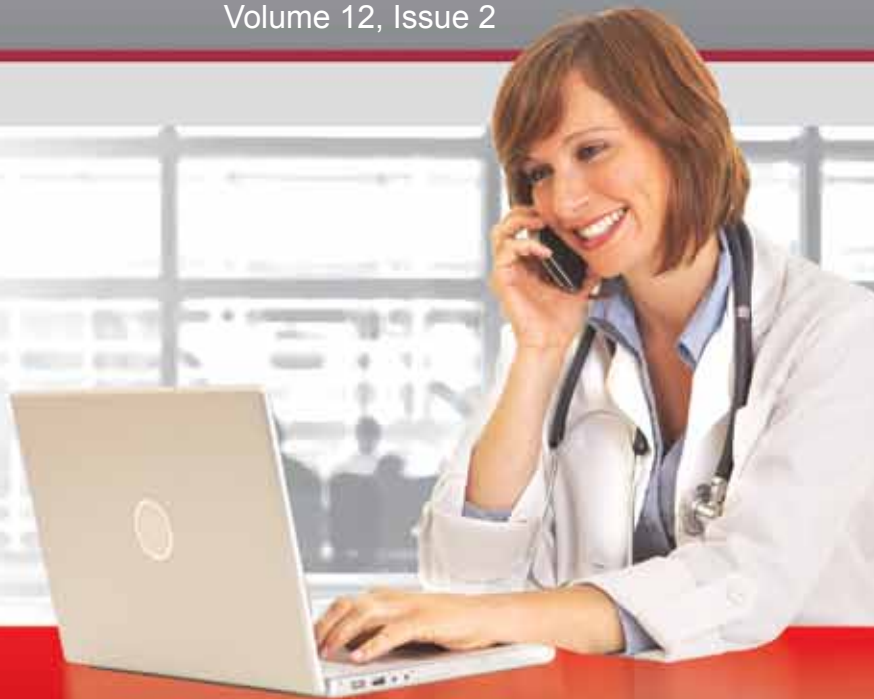




# ADVISOR

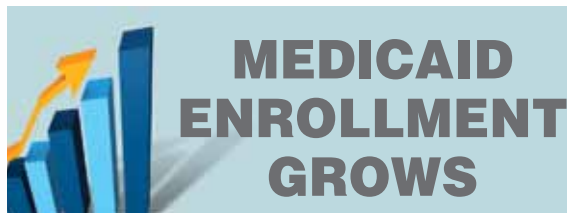
Medical Billing & Compliance  
Bimonthly Newsletter



The AcSel Advisor is now available via email. Just email, [info@acselmedical.com](mailto:info@acselmedical.com) and place the word **“Advisor”** in the subject field to receive your copy!

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**CMS** has reported a significant increase in Medicaid enrollment due to the Affordable Care Act. Since the Health Insurance Marketplace opened, more than 3 million individuals have enrolled in Medicaid or CHIP through the end of February 2014. Enrollment is expected to increase even more as the eligibility determinations continue to grow. In states that expanded coverage for Medicaid enrollment, most of the age group is under 65, which covers 133 percent of the Federal Poverty Level. To date, 26 states and DC have expanded their Medicaid programs. There is no deadline for states to expand. Under the Affordable Care Act for the first three years, coverage for newly eligible adult beneficiaries is fully federally paid. For the following years, payment is never less than 90%.

**To read today’s report visit:**

<http://medicaid.gov/AffordableCareAct/Medicaid-Moving-Forward-2014/Downloads/February-2014-Enrollment-Report.pdf>



Who hasn’t heard that **ICD-10** has been delayed? With the House passing the SGR bill which included a year delay to **ICD-10**, followed by the Senate and the President signing off on the bill, what is next? Are you one of those that is giving “thumbs up” to this delay or are you ready to “burst the bubbles” and move on?

Recommendation is to continue with your preparation to this change. For those of you that have been preparing all along with training your staff and your providers, this may be a blessing in disguise. We now have one more year to ensure our providers are providing more specific documentation to enable assigning the most accurate diagnosis code(s), and preparing the proper education to our staff to code the physician’s services.

## ICD-10-CM NEWS CORNER

Delayed another year!?! Yes, but will you be prepared October 1, 2015? It is amazing how fast time gets away from us. Here it is the second quarter of 2014.

**AcSel Medical Solutions** is here to provide education to you, your staff and your providers. We are available to do five (5) charts per provider at \$20.00 per chart which includes a report of our findings - is the documentation compliant, non-compliant or not coded to the highest level of specificity.

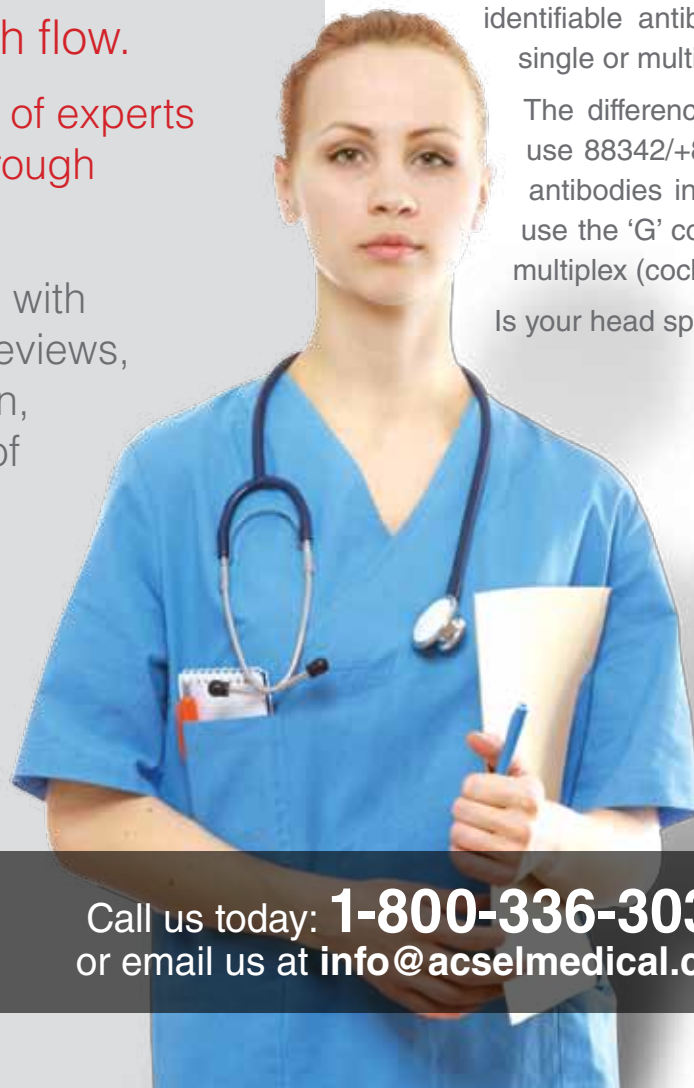
Education to your staff and providers is considered a consultation charge. Please call AcSel Medical Solutions for details and rates.

**Existing AcSel clients will receive a 10% discount.**

Don't let ICD-10 take a bite out of your cash flow.

Let AcSel's team of experts help lead you through the change.

We can help you with documentation reviews, ICD-10 education, implementation of the new coding guidelines, and any other revenue cycle management services your practice may need.



## CHANGES TO THE BILLING OF IMMUNOHISTOCHEMISTRY (IHC) STAINS



2014 revised the wording on the **CPT** code 88342 and added a new code 88343. **CPT** says 88342 represents "each separately identifiable antibody per block, cytologic preparation, or hematologic smear; first separately identifiable antibody per slide." 88343 is "each additional antibody per slide."

Medicare didn't like this so they implemented their own codes...G0461 and G0462. G0461 says "per specimen, first single or multiplex antibody stain." G0462 says "each additional single or multiplex antibody stain."

**DIFFERENCE?** **CPT** 88342 and 88343 are "per block" and Medicare G0461 and G0462 are "per specimen."

Also, 88342/88343 is reported "per separately identifiable antibody" while G0461/G0462 is "per single or multiplex antibody stain."

The difference will also mean that you should use 88342/+88343 to separately bill for distinct antibodies in a "cocktail" stain, but you cannot use the 'G' codes to do so. The 'G' codes count multiplex (cocktail) stains as a single unit.

Is your head spinning yet?

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# RADIATION ONCOLOGY UPDATES FOR 2014



As we are accustomed to finding with each New Year, there are changes to the **CPT** codes. Whether it be a new code that has been released, modifications to an existing code's description, or the deletion of a code.

Listed are billing changes that will now affect your reimbursement... some good, some bad.

77014 – The initial CT guidance for placement of the radiation therapy fields – **NOW INCLUDED** under the complex simulation 77290.

Simulation codes 77280, 77885, 77290 – definitions have now changed. Intermediate is now “two separate treatment areas.” Please refer to your **CPT** book and the definitions before these codes.

77295 - has a new name **3-D Radiotherapy Plan** – still can only bill one during a course of treatment.

Evaluation and Management codes (99201-99205) (99211-99215) (99221-99223) - most carriers are now bundling all the **Radiation Oncology** codes billed on the same day into the E/M service. Modifier -25 is no longer getting just the E/M paid on the same day as any of the other 77000 range codes...it is the only code being paid.

As a provider that tries to make the treatment process easier on their patient and do their consult on the same day as the initial simulation and treatment plan, you are now being penalized. You are saving your patient of an inconvenience but the insurance companies are cheating you out of the high dollar services rendered on the same day. The 99000 codes make up about 10% of reimbursement so this is a great loss. 90 day rule for follow-up visits after end-of-treatment – no longer in Medicare's RVUs so bill out your service.

77300 – any units billed over 10 are now consider outlier for an audit

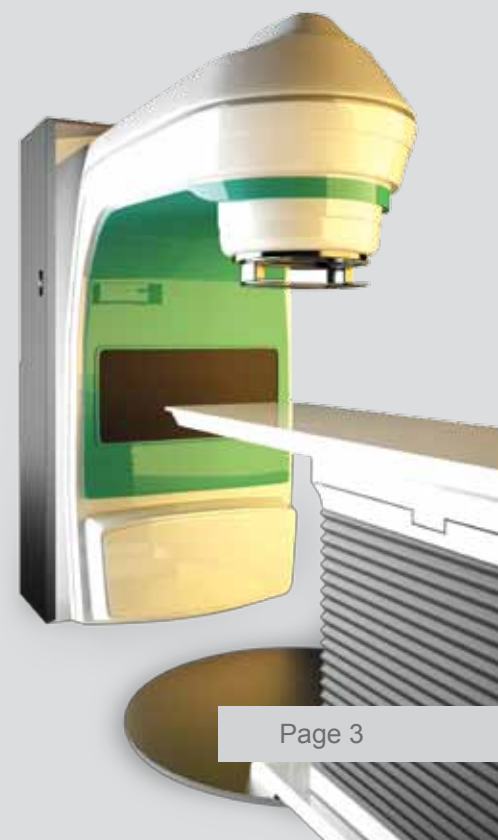
What to look for in 2015? At this time, our resource is telling us there are 23 codes on the chopping block...many may be deleted or modified. One of the major changes is to IMRT delivery. The plan is to develop three new **CPT** codes which will be based on time. There will be a code for the first 45 minutes of delivery for simple (774x1), another for the first 45 minutes of delivery for complex (774x2) and another code (774x3) for each additional 15 minutes of time used with the two previous codes mentioned. However, before these codes go into effect, they will require finalization by **CPT** and **CMS**.

CMS continues to push for developing alternatives to fee-for-service to providers which will mean the elimination of **CPT** based fee schedules. Are we looking at eventual elimination of all **CPT** codes?



Worried about how ICD-10 will affect your revenue cycle?

The transition will affect more than the coding aspect of medical billing. AMS provides the tools, processes and services necessary to prepare your practice for a smooth transition.







# Can you *Code* it...???

It is important to know the main body systems and understanding the components, the major combining form (medical terms) and their major function whether you are selecting a CPT or a diagnosis code. Starting in this newsletter: Integumentary System...what components make up this body system?

A. Skin

B. Sweat glands

C. Nails

D. All of the above

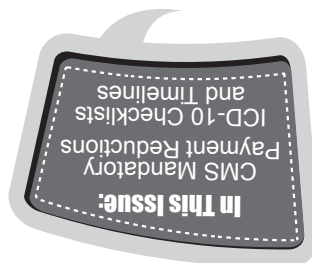
**LAST ISSUE'S ANSWERS:** Answer 'C'... always code the know diagnosis as your primary.

Find us on the web: [www.acsel.org](http://www.acsel.org)



Since 1977, **AcSel Medical Solutions** has provided world class billing services throughout the U.S. to practices such as yours. Our seasoned staff of expert billing professionals is able to assist your practice in all aspects of the business of medicine, in all sub-specialties. AcSel is committed to competent, compliant processes that maximize our clients' cash flow.

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2876 Guardian Lane Virginia Beach VA 23452, Phone: 800-336-3038 Fax: 757-463-6572 Email: info@acselmedical.com

