Removal of loose bodies with meniscectomies

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During the first of July, I contacted NCCI – Correct Coding Solutions to seek clarification regarding how to correctly bill for removal of loose bodies when meniscectomies of the knee are performed. I received clarification in the middle of July stating that the CCI version 18.3 (due out October 1st, 2012) will reverse the edit of G0289 for loose bodies ONLY (not chondroplasties) with 29880/29881 when performed in a separate compartment.

Example #1: Patient has a lateral meniscectomy and a medial compartment removal of loose bodies. You will be able to report 29881 and G0289;

Example #2: Patient has a medial meniscectomy and lateral chondroplasty and loose body removal – you can only code 29881.

This pertains when doing a chondroplasty and loose body removal in the same compartment; with a meniscectomy it will still be denied. In a letter received for NCCI it also stated that when this edit change comes out it will be retroactive to January 1, 2012. That means that if you were denied for previous loose bodies in a different compartment you should rebill. In the letter there was also reference to possibly holding loose body claims for submission after October 1.

"Physicians who perform an arthroscopic removal of a loose body or foreign body from a different compartment at the same encounter as an arthroscopic knee meniscectomy (CPT code 29880 or 29881) may report the loose body or foreign body removal with HCPCS code G0289. NCCI currently contains edits bundling HCPCS code G0289 into CPT codes 29880 and 29881 not allowing use of NCCI-associated modifiers. These edits will be modified in NCCI version 18.3 scheduled for October 1, 2012 to allow use of NCCI-associated modifiers for this situation. This change will be retroactive to Jan 1, 2012, the effective date of the edits. Physician may choose to delay submission of the claim for payment for G0289 until October 1, 2012."

HCPCS code G0289 should not be reported separately for a chondroplasty performed in the same or different compartment as the meniscectomy since CPT codes 29880 and 29881 include the chondroplasty. Additional, HCPCS code G0289 should not be reported if the loose body or foreign body is removed from the same compartment as the meniscectomy(ies)."
**Physician Proposed Fee Schedule 2013**

**Conversion factor (CF).** CMS projects a reduction of 27% SGR cut to the conversion factor, resulting in a **CF of $24.7124 for 2013**. Expect Congress to weigh in on the cut and the SGR before the New Year deadline. And in fact a new bill has already been started (http://www.govtrack.us/congress/bills/112/hr6142/text)

Primary Care Physicians will be getting around a 7% increase per the proposed fee schedule as well as those physicians that provide primary care type services will get between 3 and 5%. **For CY 2013, CMS projects a reduction of 27 percent and is required by law to include this reduction in these calculations.**

The proposed rule also talks about more work for those treating Medicare patients for **physical therapy**. Several years ago there were multiple proposals about coming up with a system so that Medicare can do away with the ‘exception’ policy. Well it looks like 2013 might be the year for this to take place. In the proposed fee schedule it states “...In 2010, more than 7.6 million Medicare beneficiaries received outpatient therapy services, including physical therapy (PT), occupational therapy (OT), and speech-language pathology (SLP). Medicare payments for these services exceeded $5.6 billion...” The proposal goes on to state for 2013 they are wanting to start a new accountability system a claims based data collection system:

> “As required by section 3005(g) of MCTRJCA, we are proposing to implement a claims based data collection strategy on January 1, 2013. This claims-based data collection system is designed to gather information on beneficiary function and condition, therapy services furnished, and outcomes achieved. This information will assist in reforming the Medicare payment system for outpatient therapy services. By collecting data on beneficiary function over an episode of therapy services, we hope to better understand the Medicare beneficiary population that uses therapy services, how their functional limitations change as a result of therapy services, and the relationship between beneficiary functional limitations and furnished therapy services over an episode of care. The term “functional limitation” generally encompasses both the terms “activity limitations” and “participation restrictions” as described by the International Classification of Functioning, Disability and Health (ICF). (For information on ICF, see [http://www.who.int/classifications/icf/en/](http://www.who.int/classifications/icf/en/) and for specific ICF nomenclature (including activity limitations and participation restrictions), see [http://apps.who.int/classifications/icfbrowser/](http://apps.who.int/classifications/icfbrowser/).)”

We are proposing to require that claims for therapy services **include nonpayable G-codes and modifiers.** Through the use of these codes and modifiers, we would capture data on the beneficiary’s functional limitations
(a) at the outset of the therapy episode, (b) at specified points during treatment and (c) at discharge from the outpatient therapy episode of care. In addition, the therapist’s projected goal for functional status at the end of treatment would be reported on the first claim for services and periodically throughout an episode of care. Specifically, G-codes would be used to identify what is being reported – current status, goal status or discharge status. Modifiers would indicate the extent of the severity/complexity of the functional limitation being tracked. The difference between the reported functional status at the start of therapy and projected functional status at the end of the course of therapy represents the progress the therapist anticipates the beneficiary would make during the course of treatment/episode of care. As the beneficiary progresses through the course of treatment, one would expect progress toward the goal established by the therapist…”

Another proposed extension that will affect Ortho offices will be the expanding of the MPPR for diagnostic imaging. In the proposed rule it states “MedPAC recommended that we apply a MPPR to the PC of diagnostic imaging services furnished by the same practitioner in the same session as one means to curb excess self-referral for these services. The GAO already had made a similar recommendation in its July 2009 report.” They now want to expand the PC and TC payment reduction to ALL diagnostic imaging. “...This approach would apply a payment reduction to the TC of the second and subsequent imaging services furnished in the same session.... This approach would apply a payment reduction to the PC of the second or subsequent imaging services furnished in the same encounter....

The proposed rule also includes:

- A proposal to implement a durable medical equipment (DME) face-to-face requirement as a condition of payment for certain high-cost Medicare DME items;
- A proposal to clarify when Medicare will pay for interventional pain management services provided by Certified Registered Nurse Anesthetists (CRNAs) when permitted by State law. This proposal will foster access to pain management services in areas where states have determined that CRNAs may provide these services.

The proposed rule will appear in the July 30, 2012 Federal Register. CMS will accept comments on the proposed rule until Sep. 04, 2012, and will respond to them in a final rule with comment period to be issued by Nov. 1, 2012.