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Compliance

Warning: How EHRs can increase your medical malpractice liability

Review how your electronic health record (EHR) documents patient care. Some of the features providers rely on to save time and enhance documentation may create errors in the record and cause or contribute to patient harm.

EHRs also may not support the physician's testimony, and in a medical malpractice case, that can hurt the doctor's credibility and give the appearance that she's liable.

About 70% of physicians have adopted EHRs. However, EHRs also are increasingly the cause of or a contributing

*(see **EHRs**, p. 5)*

Coding

CCI update: Don't overbill for obesity behavioral counseling, E/M visits

Pay attention to the time requirement and shore up your documentation when you perform group behavioral therapy for obesity, which is now bundled with a batch of E/M and psych codes in the latest National Correct Coding Initiative (CCI) edits.

Effective July 1, CCI version 21.2 edits stipulate that you can bill code **G0473** (Face to face behavioral counseling for obesity, group [2-10], 30 minutes) with E/M service codes

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

Accountable care organizations

ACO rule finalizes high-end track 3 but offers little for track 1, 2 models

You're more likely to benefit from new options for accountable care organization (ACO) participants in a June 4 final rule on the Shared Savings programs if you're moving from a low- to a high-risk model than if you're just starting out.

A signal feature of the rule, which finalizes plans in the Dec. 1 proposed rule, is the new track 3 model with a top sharing rate — the maximum amount of savings the ACO can get for exceeding its benchmarks — of 75%. That's a big advance on the top rate of 60% in track 2, the program's other risk-sharing model, and presumably a draw for more practiced ACOs to accept more risk (*PBN 12/8/14*). Track 1 gives participants a chance to earn bonuses for saving Medicare money on quality care but, unlike tracks 2 and 3, offers no downside risk for failing to exceed benchmarks.

Track 3 participants get other perks as well, such as a skilled nursing facility (SNF) waiver, which will make it easier for track 3 ACOs to send patients to those facilities without an intervening three-day hospital stay.

How the rule amends tracks 1, 2

Track 1 and track 2 participants got some encouragement: Track 2 participants, for example, will be able to choose their own maximum savings/loss rate (MSR/MLR), which affects how much they can be rewarded or penalized based on the number of beneficiaries assigned to the ACO. CMS believes that will "reduce risk for smaller ACOs" until they're ready to step up to a more advanced model. "CMS has made the risk programs less treacherous," says Richard Lucibella, CEO of Accountable Care Options in Boynton Beach, Fla. "Those who did well in track 1 or 2 may be encouraged to move to the next level."

CMS also did a favor for track 1 ACOs that want to stay in that model by dropping a proposal that would have lowered to 40% the savings of ACOs that did not move up to track 2. Had CMS kept that proposal, "I think this would have discouraged some ACOs from continuing with the program," says Carrie Nixon, CEO of Healthcare Solutions Connection and managing member of the Nixon Law Group in Vienna, Va.

But track 1 and 2 ACOs will be denied some important track 3 benefits: not only the SNF waiver, but also voluntary beneficiary alignment and prospective assignment, which give ACOs an earlier and more reliable idea of which beneficiaries they'll be judged on than the current system that assigns patients after the fact. "The beneficiary churn those [tracks 1 and 2] ACOs have experienced makes it difficult for these ACOs to manage a population because the beneficiaries keep changing quarter to quarter," says Nixon.

The National Association of Accountable Care Organizations (NAACOS) is also disappointed. "I remain skeptical that enough improvements have been made

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EDITORIAL

Have questions on a story? Call or email:

President: Steve Greenberg
1-301-287-2734
sgreenberg@decisionhealth.com

Vice president: Tonya Nevin
1-301-287-2454
tnevin@decisionhealth.com

Content manager, medical practices:
Karen Long, 1-301-287-2331
klong@decisionhealth.com

Editor: Roy Edroso, 1-301-287-2200
redroso@decisionhealth.com

Editor: Richard Scott, 1-301-287-2582
rscott@decisionhealth.com

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to track 1 to sustain the growth we have been seeing and am concerned that large numbers of current ACOs are not ready to take on the higher risks of track 2, 3 or CMMI's [upcoming] Next Generation ACO program," said NAACOS CEO Clif Gaus in a statement. — *Roy Edroso (redroso@decisionhealth.com)*

Resource:

- Final rule, Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations: *www.federalregister.gov/articles/2015/06/09/2015-14005/medicare-program-medicare-shared-savings-program-accountable-care-organizations*

Accountable care organizations

Pioneer ACO test results inconclusive after two years, GAO report implies

While inconclusive, a recent Government Accountability Office (GAO) report found some evidence that the Pioneer accountable care organization (ACO) model may not be sustainable over the long run.

Some of the 23 ACOs participating in the Pioneer program have earned significant bonus dollars. But as the report notes, other ACOs actually increased Medicare spending.

The demonstration, now in its final year of a three-year contract, is testing rewarding providers with quality-weighted bonus payments when they save Medicare money and holding them liable for some of the extra cost when they don't.

But as the GAO cited, 13 original Pioneer participants withdrew from the program.

The report — requested by the House Ways and Means Committee — also cites allegations by critics of the Pioneer program that some participating ACOs were limiting beneficiary access to necessary but expensive services "or avoiding beneficiaries with greater health care needs altogether."

Of the 23 ACOs that participated in 2013, 11 averaged about $11 million each in shared savings while six of the 23 produced about $23 million in total shared losses. The remaining six ACOs didn't produce shared savings or shared losses. — *Burt Schorr (burt.schorr@verizon.net)*

Resources:

- GAO report Results from the First Two Years of the Pioneer Accountable Care Organization Model: *www.gao.gov/products/GAO-15-401*

HIPAA

Improve usability but mind HIPAA if using personal mobile devices for work

Let physicians and other staff use their own mobile devices for transmission of protected health information (PHI) — once you've optimized the technology for security and usability.

Practice communications are increasingly mobile communications. About 83% of health care workers reported that their physicians use mobile technology to provide patient care; 71% said their nurses did as well, according to the most recent Mobile Technology Survey from the Healthcare Information and Management Systems Society (HIMSS). But the devices have to be managed to keep from creating an undue HIPAA security risk.

Some practices, like corporations in other fields, give their employees work devices that remain under the control of the company so they can institute their own security modifications, including the ability to remotely wipe the unit. But because mobile devices are ubiquitous, some practice administrators are adopting a "bring your own device" or BYOD policy, whereby health care providers use their own phones and tablets to handle work, including patients' PHI (*PBN 2/9/15*). But that's only after letting the practice's IT people outfit the phone with HIPAA-compliant software, such as virtual private network (VPN) capability, that allows more secure communication with PHI.

Experts caution that users must be on board with the security features or they simply won't use them — and may just go rogue and start handling PHI outside your security parameters. To encourage effective use, overcome "historic barriers of poor usability, arduous security and a lack of mobile integration," says David Parpart, executive consultant at NavisHealth in Santa Clara, Calif.

'Containerize' files

One issue that may make users balk at BYOD is the "nuclear" option — that is, the chance the phone will have to be remotely wiped if it's lost. Even when using work-issued devices, "people use it for personal and business purposes, so if it's lost, all their stuff gets wiped too," says Jennifer Searfoss, CEO of SCG Health, Ashburn, Va.

Solution: Use technology that separates work from personal files. Brad Rostolsky of law firm Reed Smith says his firm uses the third-party app Good, "a fully

encrypted uber-secure email app that sits within its own partition of the phone." The business files are "containerized" from the user's personal files and when the company is forced to wipe it, only the work part gets wiped.

Whatever software you use, remember "it also requires the individual who lost or had their device stolen to report the incident, which can be a gap in the process," Rostolsky says. That will be easier for them to do if they don't have to worry about losing their vacation photos as well.

Hard for thieves but easy for users

Whether it's a loaner or personally owned, a mobile device should be difficult for outsiders to access but simple for the user. One way to make it harder for thieves is double authentication — two ways to identify yourself to the device — rather than simple password access. But it shouldn't be cumbersome.

Solution: Make your two-part authentication easy. "There are three ways to validate a user: by who you are (e.g., a fingerprint), by something you have with you (the phone's UDID [unique device identifier]) or by something you know (a PIN number)," says Parpart. Using two of those three features as authenticators would be simple for the user, he says.

5 more mobile must-dos

- **Turn mobile communication into a practice initiative and enlist key people as leaders.** Don't just put software on phones and hand them back, says Harry Nelson, a partner with Nelson Hardiman in Los Angeles.

"Since this is an ongoing culture change, it is valuable to enlist doctors in leadership positions and doctors who are more sensitive to legal compliance to be testing and adopting solutions," says Nelson. Managers also should find incentives to encourage adoption, measure progress and set goals for organizational compliance, he adds.

- **Enforce your policies.** Part of the "risk mitigation" required by HIPAA rules involves policies and procedures that show a good-faith effort at regulating employee behavior with PHI (*PBN 7/21/14*). It helps to track access via IT logs for authorized use, says Matthew R. Fisher, an associate with the Mirick O'Connell law firm in Worcester, Mass. Logs can tell what user and what kind of device has accessed your files.

"Have real policies that make sense, train on them and make clear that you'll take immediate action on violations — maybe a warning written in the file, maybe the loss of a vacation day — something that forces the employee to take notice," says Rostolsky. "Termination should also be on the table depending on the facts and circumstances of the issue. The government responds to that because the provider is supposed to be proactive."

- **Use encryption.** Make mobile devices more secure with modifications to ensure the messages are encrypted, such as text-messaging apps with a HIPAA compliance angle (*PBN 6/24/13*). E-mail programs should be able to assure that the message can't be read until it has been transmitted to your device.

- **Get the business associate agreement (BAA).** Companies, even some email giants, will sign the BAA required for your third-party vendors in the HIPAA mega-rule, says Searfoss. Microsoft, for example, will enter into that contract with health care providers who use its Office 365 software, which allows mobile mail access.

- **Educate users on security gaps.** "You could have a secure browser, the most secure software and then connect over a coffee-shop Wi-Fi that's not secure," says Searfoss. Train users on how to use their equipment properly. — *Roy Edroso (redroso@decisionhealth.com)*

Part B News briefs

- **Senate Finance Committee approved a bill to tackle the appeals backlog at the administrative law judge (ALJ) level.** Nearly 900,000 Medicare claims now await ALJ hearings. The legislation offered by Finance Chairman Orin Hatch, R-Utah, would increase fiscal 2016 funding for the Office of Medicare Hearings and Appeals (OMHA) by $127 million and by $2 million for the HHS Departmental Appeals Board, the last stop for administrative appeals.

As voted out on June 3, the bill also would authorize OMHA to augment its ALJs with a new category of hearing officer, the Medicare "magistrate." Beginning Jan. 1, 2017, magistrates would be responsible for the smallest claims, currently those between $150 and $1,460.

In addition, the bill would direct HHS to establish a process to allow ALJs and magistrates to issue decisions.

- **ICD-10 update: New bill seeks two-year "grace period" for providers.** The bill introduced June 4 by Rep. Gary Palmer, R-Ala., H.R. 2652 (Protecting Patients and Physicians Against Coding Act of 2015), has gained

numerous co-sponsors since its introduction but has seen no other action since it was referred to the House Committees on Energy and Commerce and Ways and Means the day it was introduced.

The bill follows H.R. 2247 (ICD-TEN Act) and H.R. 2126 (Cutting Costly Codes Act of 2015), both of which are sitting in committees (*PBN 5/25/15*).

For its part, the AMA House of Delegates is backing the grace-period idea. The group passed a resolution June 8 to push for a two-year ICD-10 grace period. During that time, the AMA resolution directs that CMS should not deny physician claims because of coding errors. The resolution was introduced by Alabama urologist Jeff Terry, M.D.

EHRs

(continued from p. 1)

factor in harm to patients, who are using the errors against physicians in litigation. For instance, the number of malpractice claims The Doctors Company has handled in which the EHR is cited as a contributing factor has jumped from two claims from 2007 to 2010 to 19 in 2011, 28 in 2013 and 26 in just the first two quarters of 2014, according to the latest data, says David Troxel, M.D., medical director of The Doctors Company, Napa, Calif.

The actual number of claims triggered by EHR errors may be higher but not recorded because the patient doesn't mention the EHR in the claim. Additionally, problems such as discrepancies in the EHR, missing documents or other errors don't surface until later in the litigation.

But experts predict that the number of EHR-related malpractice cases will grow quickly. Not only has EHR use skyrocketed, but typically several years elapse between the incident that harmed the patient and the onset of the legal action, points out Reed Gelzer, M.D., MPH, co-facilitator, HL7 EHR records management and evidentiary support profile standard workgroup and head of Trustworthy EHR in Newbury, N.H.

At best, the records are unreliable or just plain wrong and don't support the care that the physician provided. "The EHR won't back physicians up in court even when everything they're doing is correct," warns Gelzer. At worst, the EHRs caused or helped cause an error in patient care, causing harm to the patient. And most EHR vendor contracts absolve the vendor from liability for design or technological errors that cause patient harm, so the physician ends up alone on defense.

"In any medical practice claim, the medical record is very important. This is a big issue that has risen to the surface," says Troxel.

8 ways your EHR could cause problems

- **Design errors.** The way an EHR is set up can create medical record errors or inconsistencies. For instance, during a record request for a malpractice claim that came three years after the death of a newborn, the EHR automatically updated the record and stated the baby was a "3-year-old child." The record also noted that the baby had died. That was prejudicial for the jury, says Gelzer.
- **Technology/system failure.** For example, a patient died after the hospital's emergency department captured the patient's medication list but the information didn't get communicated to the inpatient record, causing a vital medication to be dropped from the list, says Gelzer.
- **Lack of an EHR alert.** Practices may need to create additional clinical decision support alerts beyond the EHR's defaults, says Troxel. For instance, one malpractice claim arose because the EHR did not have a drug alert for gender. The physician typed "flo" into the EHR to prescribe Flonase for a female patient, but the EHR auto-filled a prescription for Flomax, which is used for enlarged prostate and is not FDA-approved for women. The patient took Flomax and developed hypotension, a side effect of the drug.
- **Excessive alerts.** Too many alerts can cause "alert fatigue," which can lead a clinician to ignore the alarms and miss an important one (*PBN 4/1/13*).
- **Too much data.** EHRs record a variety of details such as time stamps. Some of the information is not necessary and can be detrimental to the physician in a medical malpractice case. For instance, the EHR may provide a checklist based on general guidelines. When a doctor doesn't check each box on the list, a jury could think he didn't follow the standard of care for the service. "Guidelines are just guidelines," Troxel points out.

The data can also call into question a physician's handling of the patient. "If you only took seven seconds to look at a drug dropdown [list], it looks bad to a jury," Troxel notes.

- **Vendor withholds data from the practice.** Some EHR vendors won't release a physician's electronic records when the physician moves to a different vendor until the physician pays a fee. Unless and until the physi-

cian coughs up the money, he's working from incomplete or no data, warns Allan Ridings, senior risk manager and patient safety specialist for the Cooperative of American Physicians, Los Angeles.

- **Inconsistent processes to release of information.** Often two printouts of the same record request will differ. For instance, the data may be presented in different formats or only one printout will include graphs. This will raise questions about the accuracy of the records, says Gelzer. If the practice relies on a record that looks different from the one provided to the patient, it could look to a jury as if the practice withheld information or even tampered with the record.

- **Lack of information about EHR-related patient safety issues.** Some vendor contracts contain gag clauses, which bar providers from sharing design or other issues about their EHRs that adversely affect patient care. Some voluntary and internal reporting venues exist but not a mandatory program. The Office of the National Coordinator for Health Information Technology (ONC) intends to create a health IT safety center but its implementation date is uncertain, says Troxel.

4 EHR errors practices make

- **Inappropriate use of copy/paste.** Physicians who use the copy-and-paste functions without editing their work can bury new and significant findings under rehashed information (*PBN 1/17/14*). They can enter outdated or incorrect information. One claim Troxel is familiar with involved a physician who saw a patient who may have been exposed to tuberculosis during a trip abroad. The physician used the history-and-physical default template from before the trip, which stated that the patient was not exposed to tuberculosis. As a result, the physician didn't inquire about the possibility of exposure. The patient ended up in a hospital emergency department with tuberculosis meningitis.

- **Overreliance on the EHR.** EHRs are not a substitute for medical training and experience. "Remember these are written by programmers, not doctors," notes Ridings. For example, the EHR used by the hospital that treated the first patient to be diagnosed with Ebola in the United States didn't highlight recent travel history to Ebola-stricken countries. That was allegedly overlooked in the patient's history despite the patient's obvious symptoms, causing a delay in diagnosis.

- **Incomplete EHR training.** Providers who don't receive adequate training may fail to understand that when they go back in the record to enter additional information, the time stamp could give the appearance that the doctor rendered treatment days, weeks or months after it actually occurred. A skeptical jury might not believe it was a simple documentation error, Gelzer says. Providers who aren't trained may overuse the free text function, so the information can't be searched later, Ridings adds.

- **Human error.** Physicians are making data-entry errors or not double-checking auto fill-ins on lists or templates. They're using copy-and-paste functions but not editing their work, causing outdated or wrong data to

be included or the one sentence of what's new and significant to be buried in all of that information. — *Marla Durben Hirsch (pbnfeedback@decisionhealth.com)*

Editor's note: *Stay tuned for tips to reduce EHR errors in an upcoming issue of* Part B News.

CCI

(continued from p. 1)

99201-99215 on the same date of service only if your documentation supports the two services and clearly shows medical necessity.

That's because Medicare bundled G0473 and more than 100 codes with a modifier indicator of "1," which allows you to report the two services on the same day provided medical necessity supports it.

Example: You see a patient to check on hypertension levels, and the patient subsequently takes part in a group counseling session for obesity. Make sure you document the elements of the E/M visit that occurred prior to the counseling session in addition to noting your time for the 30 minutes you spent on G0473.

The latest edits involving G0473 are a good reminder "not to double dip," explains Betsy Nicoletti, president, Medical Practice Consulting in Northampton, Mass. Billing an E/M service with G0473 when the entire office visit involves the behavioral health screening and nothing

Benchmark of the week

Avoid CCI edits for group counseling with common psych codes

You risk overpayments of nearly $150 if you bill for newly bundled psychotherapy and group counseling codes that are now the target of National Correct Coding Initiative (CCI) edits.

CCI version 21.2 edits bundled **G0473** (Face to face behavioral counseling for obesity, group [2-10], 30 minutes) with more than 100 codes, including common psychotherapy codes that are billed often and are tied to millions in reimbursement *(see story, p. 1)*.

The three psychotherapy codes below — **90791**, **90792** and **90832** — and health and behavior assessment code **96150** totaled more than $218 million in reimbursement for approximately 4.4 million services, according to 2013 Medicare claims data, the latest available.

On Jan. 1, code G0473 replaced **G0447** "to improve payment accuracy," states an April 8 MLN Matters article. You'll see that G0447 bore a high denial rate — 31% — in 2013 that corresponds to about $2.5 million in lost charges.

With the CCI version 21.2 edits, effective July 1, Medicare is targeting these code pairs to make sure providers aren't submitting two claims for the provision of one service. "These are technically supposed to be standalone codes, but they leave the door open just in case," advises Margie Scalley Vaught, a consultant based in Chehalis, Wash., about Medicare's decision to bundle the services. Unless you detail medical necessity for each of the bundled codes, you'll be out $147.31 when you bill psychiatric diagnostic code 90792, for example, according to 2015 Medicare physician fee schedule data (national, non-facility).

If you do provide distinct services to the same patient on the same date, make sure your documentation clearly shows what work you performed to gain reimbursement for two codes. — *Richard Scott (rscott@decisionhealth.com)*

Group counseling, psych codes show high denial rates

Code	Now bundled with	Total services	Denied services	Denied amount	Paid amount	Denial rate
G0447/G0473*	99201-99215, 99217-99288, 99291-99354, 99497	159,493	48,981	$2,500,948.79	$2,766,858.21	30.7%
90791	G0473	1,038,151	118,065	$22,067,113.32	$88,255,519.76	11.4%
90792	G0473	606,915	65,859	$15,184,449.70	$47,638,362.12	10.9%
90832	G0473	2,617,394	216,269	$21,460,869.02	$80,986,901.84	8.3%
96150	G0473	98,445	18,479	$1,108,809.07	$1,222,806.01	18.8%

*Effective Jan. 1, 2015, code G0437 replaces G0447. The "bundled with" information listed in the chart pertains to G0437, and the claims data reflects G0447 billing.

Source: Part B News *analysis of 2013 Medicare claims data, the latest available*

else means that you're "using the same 30 minutes and pretending that [you're] doing two services instead of one," says Nicoletti.

Don't bill an E/M erroneously. Instead, bill the G0473 by itself if the counseling was all you provided. Otherwise, clearly indicate which other service the provider delivered if you're going to bill an E/M along with the counseling code — and attach modifier **25** (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) to the E/M code. "They'll have to support that they did two separate services," advises Margie Scalley Vaught, a Chehalis, Wash.-based consultant.

No claims data is available for G0473 because the code launched Jan. 1. However, G0473 is an update to code **G0447** (Face-to-face behavioral counseling for obesity, 15 minutes), which plagued providers with a 31% denial rate in 2013, according to 2013 Medicare claims data, the latest available. In 2013, providers billed G0447 nearly 160,000 times and received $2.8 million in reimbursement for the screening code against more than $2.5 million in denied claims.

Tip: Use the correct diagnosis code when billing G0473 or your claim will get denied, according to an April 8 MLN Matters notice: "The MACs will recognize HCPCS code G0473 but only when billed with one of the ICD-9 codes for body mass index (BMI) 30.0 and over (**V85.30-V85.39**, **V85.41-V85.45**)."

Bonus tip: Prepare for the switch to ICD-10. Once ICD-10 is effective, the related ICD-10 codes are **Z68.30-Z68.39** and **Z68.41-Z68.45**.

Counseling bundles include other settings, codes

The CCI edits also bundle G0473 with hospital and emergency codes **99217-99288**, critical care and nursing facility codes **99291-99354** and advance care planning code **99497**.

Be careful about billing other psychiatric services on the same date of service as group behavioral obesity counseling. The latest CCI edits also bundle G0473 with the following psych codes:

- **90791** (Psychiatric diagnostic evaluation)
- **90792** (Psychiatric diagnostic evaluation with medical services)
- **90832** (Psychotherapy, 30 minutes with patient and/or family member) to **90869** (Therapeutic repetitive transcranial magnetic stimulation [TMS] treatment; subsequent motor threshold re-determination with delivery and management)
- **96150** (Health and behavior assessment [e.g., health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires], each 15 minutes face-to-face with the patient; initial assessment) to **96154** (Health and behavior intervention, each 15 minutes, face-to-face; family [with the patient present]).

Watch colorectal cancer screening bundles

The CCI version 21.2 edits make clear that you can't bill stool analysis and other testing codes with colorectal cancer screening code **G0464**. The CCI edits attach a "0" modifier to the following code-pair bundles, which means Medicare won't pay for the two services when they're provided to a patient on the same date of service:

- G0464 and **°G0328** (Colorectal cancer screening; fecal occult blood test, immunoassay, 1-3 simultaneous)
- G0464 and **81275** (Gene analysis [v-Ki-ras2 Kirsten rat sarcoma viral oncogene] variants in codons 12 and 13)
- G0464 and **82270** (Stool analysis for blood to screen for colon tumors)
- G0464 and **82272** (Blood, occult, by peroxidase activity [e.g., guaiac], qualitative, feces, 1-3 simultaneous determinations, performed for other than colorectal neoplasm screening)
- G0464 and **82274** (Blood, occult, by fecal hemoglobin determination by immunoassay, qualitative, feces, 1-3 simultaneous determinations).

Keep an eye on optometry code bundles

For optometrists, don't bill **67966** (Removal of over one-fourth of the eyelid involving lid margin) when you repair the ectropion or entropion without documented medical necessity because the latest CCI edits bundle 67966 with **67916-67917** and **67923-67924**. Also, injection code **67028** is bundled with paracentesis codes **65800**, **65810** and **65815**. — *Richard Scott (rscott@decisionhealth.com)*

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