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What's new in INCISIVE MD?

This document describes the most recent updates to INCISIVE MD. This release updates the application with additional contract options and improvements for managing disputes.

Who should read these release notes?

If you are an INCISIVE MD user ...

Read this entire document for revised features included in this update.

If you are the clinic technical contact ...

No action is required by you. The INCISIVE MD application will auto-detect and install the update when the user attempts to log into the application following the release of the update. For clinic's using terminal services, please contact INCISIVE Support for instructions and the update to manually upgrade your user's profiles.

National Correct Coding Initiative (CCI) Updates

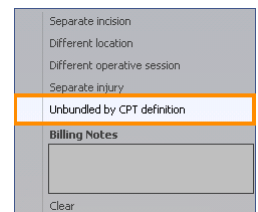
This update includes both the CCI 15.0 and 15.1 updates. For the second quarter 2009 revision (version 15.1), over 77,300 new coding edits related to orthopedic codes were added by CMS. Customers interested in viewing a list of these CCI edits may go to the INCISIVE Support website and view a summary document we have created.

Corrected \$0 Expected for Arthroscopic Chondroplasty

In our effort to properly code for Medicare's G0289, arthroscopic foreign body removal in a different compartment of the knee, we were properly switching the 29877 or 29747 for G0289. Unfortunately, for contract terms where the G0289 option was unchecked, the application always calculated the expected amount for the chondroplasty at \$0 regardless of whether a CCI Edit distinct reason was selected. The application now properly calculates the expected amount once a distinct reason is selected for the chondroplasty.

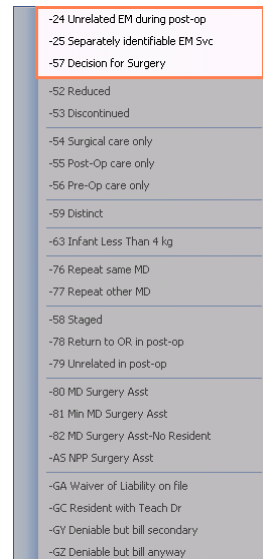
CCI Edit Additional Distinct Reason Added

An additional distinct reason has been added to the **Coding Edits** tab **Select Distinct Reason** drop down list called **Unbundled by CPT Definition**. This was requested by orthopedic spine surgeons for the common situation in which a surgery includes a spinal decompression procedure; AMA CPT codes 63001 - 63066, along with a Posterior Lumbar Interbody Fusion (PLIF), CPT code 22612 - 22164. The definition of CPT 22612 includes the phrase "(other than for decompression)" which provides for a distinct reason for the decompression procedure. So instead of writing out an explanation, users may now check **Unbundled by CPT Definition**.



Additional Manual Modifiers Added

You are now able to manually apply Evaluation & Management (E&M) Modifiers 24, 25, and 57 to your procedures. To manually apply these modifiers while coding a surgery, go to the **Summary** tab and left click in the **Modifiers** column of the procedure row and select the modifier.

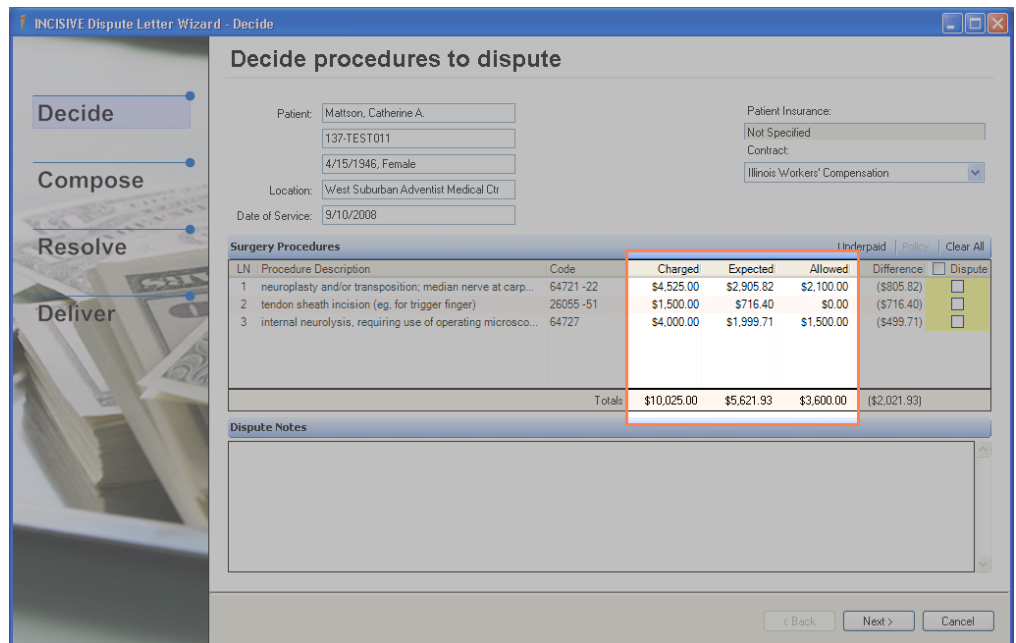


Date and Dollar Columns Sortable

You can now sort the **Surgeries** and **Disputes** grids by date and dollar amounts. Previously, date and dollar columns were sorted based upon their text, so a set of dates like 1/1/09, 2/1/09, 11/1/09 would be sorted as 1/1/09, 11/1/09, 2/1/09. The same would happen for column containing dollar amounts. This has been corrected and these columns will now sort in the expected order. For the **Surgeries** grid **Surgery Date**, surgery plans with undefined dates will list TBD for To Be Determined and will be listed before any dated surgeries.

Charged, Expected, and Allowed Columns Reordered

For the **Disputes** grid and the **Disputes** wizard **Decide** pane **Surgery Procedures** grid, the display order of the **Charged**, **Expected**, and **Allowed** columns have been reordered so that the **Charges** column is first, the contractual **Expected** amount second, and the payer **Allowed** amount last. This is done so that the numbers will usually read highest to lowest.



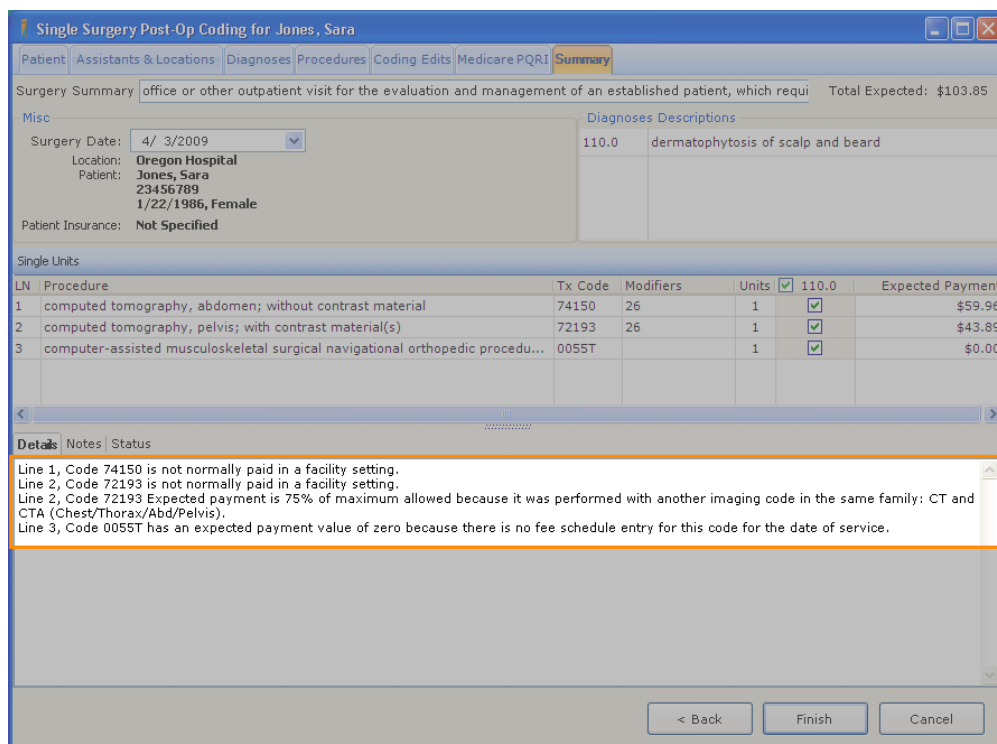
Disputes Charged, Expected, and Allowed Now Updated

In previous versions of the application, the **Disputes** grid **Charged**, **Expected**, and **Allowed** columns only updated once. This could cause the numbers not to match the **Disputes** wizard **Decide** pane **Surgery Procedures** grid totals when additional

payments are received by the clinic. The **Disputes** grid will now updates each time additional payment information received from a clinic’s practice management system via INCISIVE IS integration.

Billing Notes Improved

We have added billing notes for when an expected amount is \$0 and the reason is because there was no price available for the procedure code under the contract terms. This can happen because no price is listed for fee-based contract term or the procedure has a zero RVU value and no carve out has been added to the RVU-based contract term. In addition, when contract terms indicate that either endoscopic or multiple imaging reduction methodologies apply to an expected amount, a billing note will be listed that these methodologies were applied.



How do I check for missing procedure price in a fee-based contract term?

For fee-based contracts, go to the contract term for the surgery’s date of service, **Edit** the contract term and go to the **Fee Schedule** tab; scroll down the list of procedures and prices to see if the procedure is listed. If not, click **Add** in the toolbar and enter the procedure code and price, and then **Save**.

How do I check for a missing procedure carveout in RVU-based contract term?

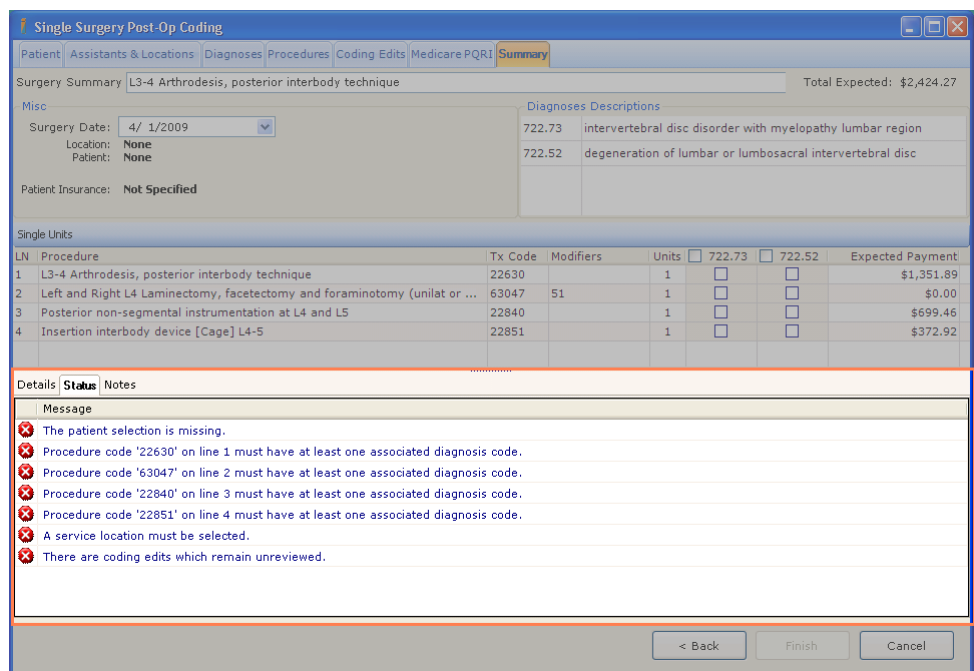
For RVU contracts, go to the contract term for the surgery’s date of service, **Edit** the contract term and go to the **Carveouts** tab; scroll down the list of procedures and prices to see if the procedure is listed. If not, click **Add** in the toolbar, enter the procedure code and price for both the facility and non-facility locations, and then **Save**.

Add-on Codes Expected \$0 if Primary Code is \$0

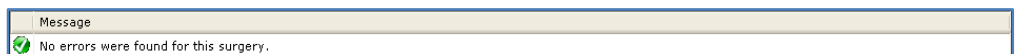
Previously, if a CCI edit had not been reviewed the application would price add-on codes even if the primary procedure had an expected amount set to \$0. The application will now set the add-on codes price to \$0 when the primary is also \$0.

Error Checking Usability Improved

As INCISIVE MD includes a greater number and more sophisticated error checking, the number of possible error pop-up boxes to be displayed was becoming unmanageable. The surgery planning and coding wizard **Summary** tab has been redesigned to include a **Status** tab. The **Billing Details** and **Notes** have also been incorporated into this new user interface element. Instead of pop-up dialogs occurring, the user will now be informed when information is missing or actions not completed by the display of error messages under the **Status** tab.



If a user clicks on the error message row, the application will switch to the tab where the error may be corrected. When all errors have been corrected, the user will be informed that no more errors are present.



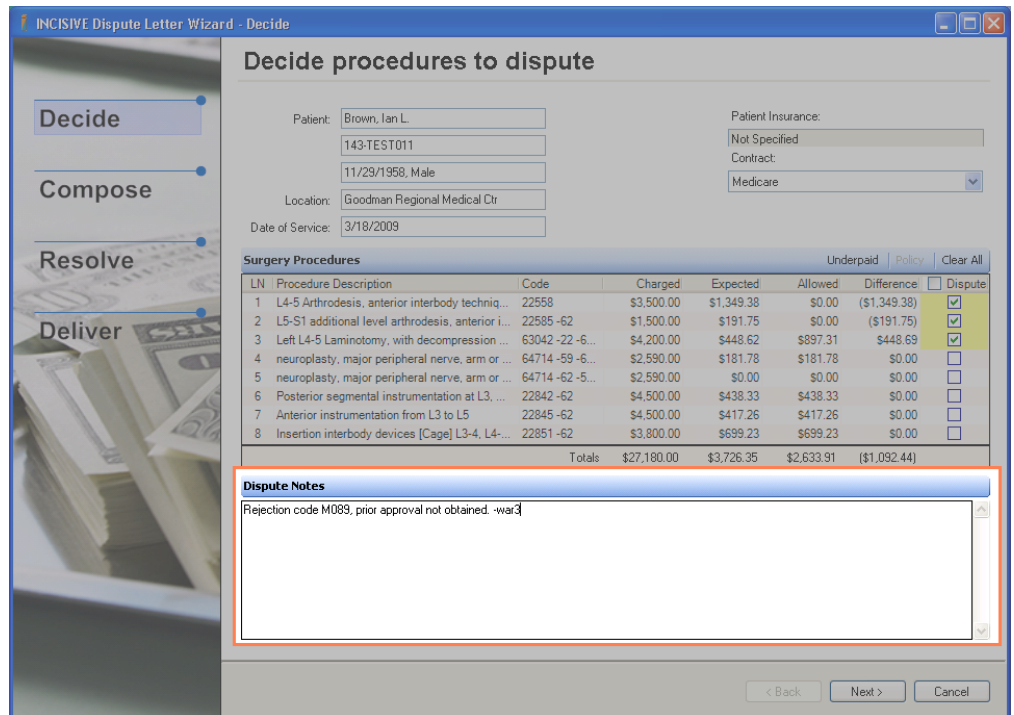
If no errors are present when the user clicks on the **Summary** tab, the **Notes** tab will be displayed.

Surgery Planner Equipment Checkboxes Removed

Based upon user feedback, the checkboxes on the surgery planner next to each of the equipment items have been removed. The feedback from customers was that the hospital surgery schedulers were calling the clinics to determine which of the items should have been checked. So to remove the confusion the checkboxes have been eliminated.

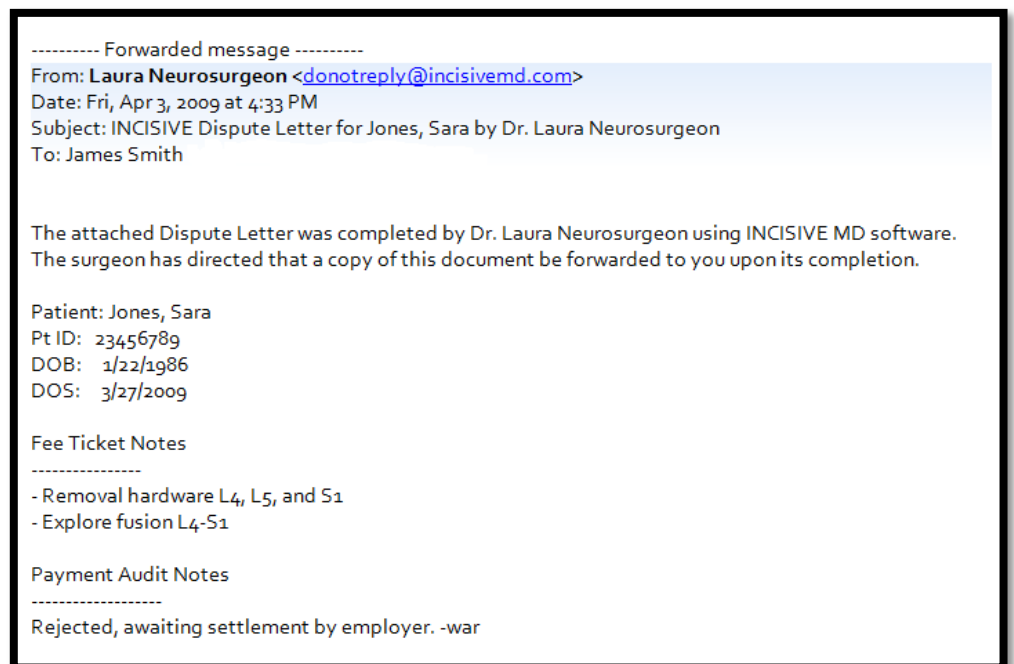
Disputing Notes Added

You will now be able to add notes to your disputes. A new **Notes** text box has been added to the **Disputes** wizard's **Decide** pane. These notes will remain with the viewers of the dispute.



Patient and Notes added to Document Routing Email

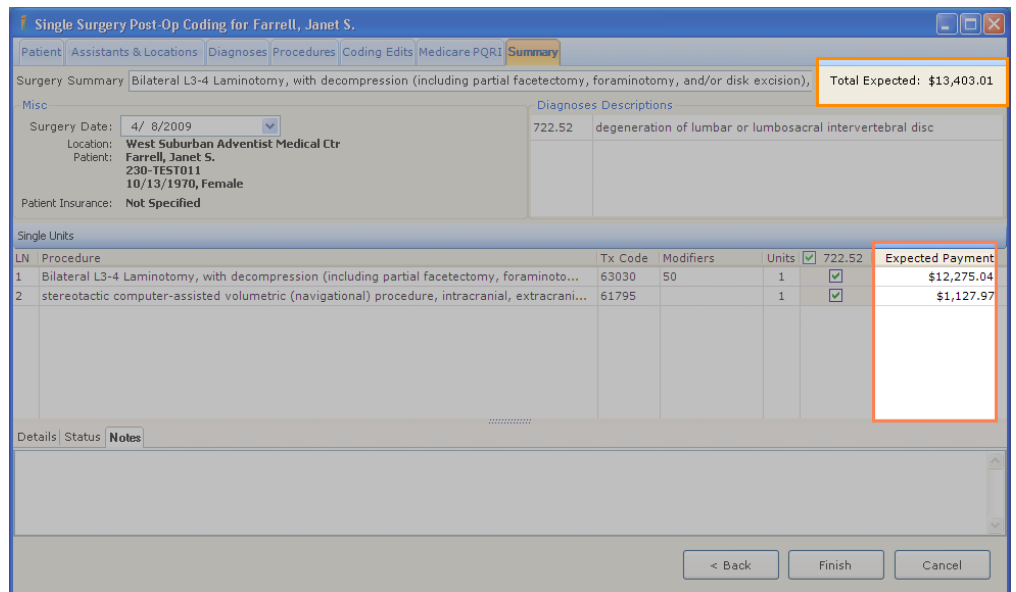
To aid in communicating changes to fee tickets and dispute letters, a patient's basic demographic information along with any planning or coding **Notes** will now be displayed in the document routing email. An example email is below.



NOTE Customers need to ensure the distribution of INCISIVE MD surgery plans, fee tickets, and dispute letters via document routing comply with their clinic's HIPAA policies.

Contract Expected Amounts Displayed

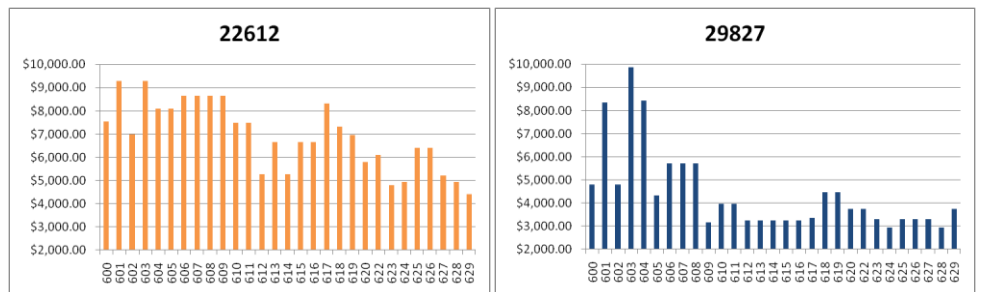
There is an available user option to display the calculated expected amount on the coded surgery **Summary** tab. An additional column is displayed in the **Surgery Procedures** grid which shows the expected amount based upon the contract selected and modifier adjustments. We have added the total amount for the claim to the **Summary** tab. With this option turned on, expected amount will now also be displayed when planning a surgery.



Maximizing IL Workers Compensation Reimbursement based on Facility Location

For customers in Illinois who plan their workers compensation cases with INCISIVE MD, you can now determine the best facility for maximizing your reimbursement. As background, the Illinois Workers Compensation medical fee schedule is geographically priced based upon facility's ZIP code. There is a wide range of pricing between ZIP codes. The charts below illustrate the different 2009 pricing for procedure codes 22612 and 29827. Notice the wide range of pricing between neighboring ZIP codes.

**Illinois Workers Compensation Medical Fee Schedule for 2009
Maximum Allowable for Procedure Codes 22612 and 29827**

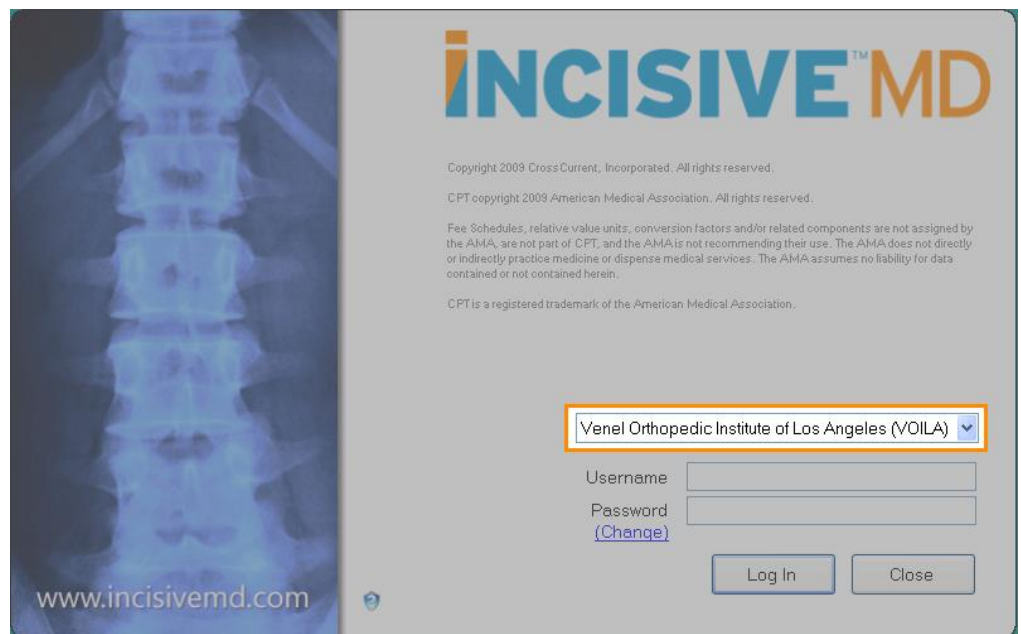


With the expected amount display option turned on, a user can select a facility, switch to the **Summary** tab to see the total reimbursement for the case based on the facility's location. Then go back and switch through their other facilities to see what the case's reimbursement would be for those other locations.

To activate this option, you need to contact INCISIVE Support and request to have this option to display for your user login.

Multiple Clinic Login Now Supported

For customers that log into more than one INCISIVE MD clinic, users will now be able to switch between these clinics before logging in. To switch between INCISIVE MD clinics, you will need to log out and select the desired clinic from the clinic drop down list. Users desiring this feature need to contact INCISIVE Support in order for this feature to be configured on their workstations. Users who log into only one clinic will not see any change and can ignore this feature update.



AMA CPT Guidelines Implemented as Contract Option

Many times payers develop their own set of payment policy indicators for how Modifiers 50, 51, 62, 66, and 80 are to be coded. Medicare, Washington Labor & Industry, and Illinois Workers Compensation are three such payers. For commercial payers who have not developed their own policy indicators, they usually direct providers to code according to AMA CPT. Previously, INCISIVE MD used Medicare's indicators for all contracts except Washington Labor & Industry and Illinois Workers Compensation. This caused much consternation on the part of coders who wanted to code based upon solely AMA CPT. Users can now select which set of policy indicators to use.

Selecting between which set of payment policy indicators will directly change the way INCISIVE MD codes a surgery. The following vignettes will illustrate the differences between AMA CPT and payer payment policy indicators for several common scenarios.

The screenshot shows the 'Edit Contract Term' dialog box with the following details:

- Contract Term:**
 - Display Name: Cascadian BCBS 2008
 - Start Date: 1/1/2008
 - End Date: 12/31/2008
- Options:** (highlighted with an orange box)
 - Use Payment Policy Indicators from: Medicare
- Multiple Procedure Adjustment Schedule (%):**
 - 1st: 100%
 - 2nd: 50%
 - 3rd: []%
 - 4th: []%
 - 5th+: []%
- Treat multiple service units as:**
 - one unit per line
 - roll-up multiple units
- Optional Medicare Rules:**
 - Require Medicare PQR1
 - Substitute G0289 for 29874 and 29877 when Billed with Other Arthroscopic Knee Procedures
 - Use Medicare G-Codes for Pelvic Ring Fracture Codes

Co-Surgeon on Spine Instrumentation Codes

There is an AMA CPT Guideline that states to “not append modifier 62 to spinal instrumentation codes 22840-22848 and 22850-22852.” While Medicare’s payment policy indicators have Modifier 62 set to a value of 1, “Co-surgeons could be paid, though supporting documentation is required to establish the medical necessity of two surgeons for the procedure.” When you switch between contracts that use Medicare and AMA CPT Guidelines, and you have a physician assistant-at-surgery selected with the default role of co-surgeon, the application will change the options available for selection. For contracts using AMA CPT Guidelines, you will not be able to select co-surgeon for spine instrumentation; you only can select assistant (Modifier 80) or minimal assistant (Modifier 81).

Co-Surgeon on Bone Graft Codes

As with the spinal instrumentation codes, there is an AMA CPT Guideline that states, “do not append Modifier 62 to bone graft codes 20900-20938.” However, Medicare allows CPT code 20900, 20902, 20920, 20922, 20931, 20937, and 20938 to be appended with Modifier 62 because the payment policy indicators have Modifier 62 set to a value of 1, “Co-surgeons could be paid, though supporting documentation is required to establish the medical necessity of two surgeons for the procedure.”

Multiple Bone Graft Codes

Illinois Worker’s Compensation allows more than one spinal bone graft code to be paid per surgical case. Medicare allows only one to be paid per surgical case. When a surgical case has a combination of bone graft codes 20931, 20937, or 20938, the highest paid bone graft code will be paid at 100% and the other bone graft codes will have a Modifier 51 appended and normal multiple procedure reduction applied to the expected amount.

AMA CPT Coding for Physician Assistants

To determine when physician assistant-at-surgery could be coded with using Modifiers 62, 66, and 80, we used the American College of Surgeons (ACS) "[Physicians as Assistants at Surgery: 2007 Study](#)". The table below provides the equivalent values to Medicare's payment policy indicators.

ACS Consensus	Medicare Payment Policy Indicators	
	62 - Co-Surgeon	80 - Assistant
Almost Always	2 = Co-surgeon permitted	2 = Assistant may be paid
Sometime of the Time	1 = Co-surgeon permitted when medically necessary	0 = Payment restriction unless medical necessary
Almost Never	0 = Co-surgeon not permitted	1 = Assistant may not be paid

For Modifier 66, the procedures listed in the ACS study indicated with an "O" will allow the checking of **Team Surgeon** on the **Surgical Role** drop down menu.

NOTE The indication that a physician would almost never be needed to assist at surgery for some procedures does NOT imply that a physician is never needed. The decision to request that a physician assist at surgery remains the responsibility of the primary surgeon and, when necessary, should be a payable service. The application will not allow you to select **Assistant** from **Surgical Role** drop down; in these rare cases where this is medically justified, we suggest a note be added to the surgical case indicating the circumstances and roles of the physicians involved with the procedure.

Additional Features added to RVU Contract Terms

Underlying the entire INCISIVE Coding Engine is a sophisticated set of business rules related to our contract options. As we have added additional customers, we have encountered a wider variety of provider-payer contracts and additional ways that payers model their contracts. Our goal is always to provide you with the means to calculate an expected amount based upon your contract terms. To that end, we have added more sophistication to setting up your contract terms in this release.

The next sections provide the details related to the new options for RVU contracts. Many of these tabs are also applicable to fee-based contract terms as well.

RVU Contract Term – General tab

1 Contract Term

- **Display Name**

This is the name of the contract term as it will be displayed on a surgery's **Fee Ticket** document and on the surgery planned or coded **Summary** tab.

- **Start Date**

The first day the contract terms can be used. This date cannot overlap with another contract term start or end date.

- **End Date**

The last day the contract terms will be used. This date cannot overlap with another contract term start or end date. It is recommended to set the date to 12/31/2050 for contract terms that are evergreen or do not have a specific end date.

2 Options

- **Use Payment Policy Indicators From**

You can select which set of payment policy indicators to use for Modifiers 50, 51, 62, 66, and 80 coding. You can select from Medicare, AMA CPT, Illinois Workers Compensation, and Washington Labor & Industry.

- **Multiple Procedure Adjustment Schedule (%)**

Enter the specific multiple procedure reduction percentages for the payer. The cardinal numbers refer to the relative line of service on a claim. If you leave an item empty, INCISIVE MD will use the percentage for the lowered numbered item. If no percentages are entered, then 100% will be used for all lines of service.

- **Treat Multiple Service Units**

This is to switch between having procedure codes with multiple units to be displayed on several lines with only a single unit or on one line with the total number of units.

- ③ **Optional Medicare Rules**

- **Require Medicare PQRI**

Enabling this item will activate whether a user will be required to enter PQRI information when patient demographics and coding meet the data requirements for PQRI Measures 20 through 24.

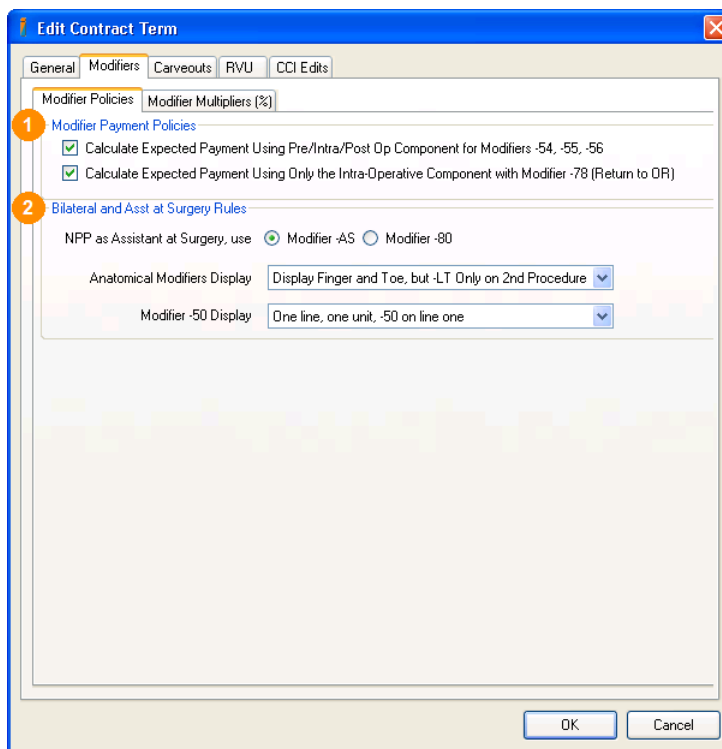
- **Substitute G0289 for 29874 and 29877**

Enabling this ensures the application will substitute secondary chondroplasties with the Medicare G0289 instead of their respective AMA CPT code.

- **User Medicare G codes for Pelvic Ring Fractures**

Enabling this will direct the application to substitute the Medicare G codes for the AMA CPT pelvic ring fractures codes.

RVU Contract Term – Modifiers tab



Modifier Policies tab

1 Modifier Payment Policies

This sets how the Expected amount will be adjusted when Modifiers 54, 55, 56, and 78 are added to a procedure. If this option is enabled, the appropriate Work RVU portion of pre-operative, inter-operative, and post-operative components will be used to figure the modifier multiplier. See the table on the next page for which components are included with which modifier. If this option is not enabled, then the percentage defined for the modifier under the Modifier Multipliers (%) tab will not be used.

Modifier	Pre-Op	Intra-Op	Post-Op
54	✓	✓	
55			✓
56	✓		
78		✓	

2 Bilateral and Assistant-at-Surgery Rules

These settings will determine how the location, bilateral, and non-physician provider (NPP) modifiers will be displayed.

- **NPP as Assistant-at-Surgery**

This determines whether Modifier 80 or AS will be displayed when a NPP assistant is selected for a procedure. The default value is Modifier AS for RVU contract terms and Modifier 80 for fee-based contract terms.

- Anatomical Modifiers Display**
 This option controls how the anatomical modifiers for fingers (FA - F9), toes (TA - T9), and morphology (LT and RT) will be displayed on your procedures. Your three choices are: **Display Finger and Toe, but -LT Only on 2nd procedure; Do Not Display Anatomical Modifiers;** or **Display All Anatomical Modifiers.** Your choice of displaying anatomical modifiers will not affect whether Modifier 59 is displayed on a procedure. The default choice is **Display Finger and Toe, but -LT Only on 2nd procedure** which will display all finger and toe modifiers but will only show a morphology modifier on the second procedure of a bilateral set.
- Modifier 50 Display**
 Most payers want to have Modifier 50 on one line and pay for one unit at 150% of the base allowed amount. Some payers want to have the Modifier 50 handled in other ways. This option allows you to set the way Modifier 50 is displayed. Your three choices are: **One line, one unit, -50 on line one, Two lines, one unit, 50 on line two,** and **One line, two units, -50 on line one.** The default value is **One line, one unit, -50 on line one.**

Modifier Multipliers (%) tab

You can enter the adjustment factor for each modifier that may affect the pricing of a procedure. If no adjustment factor is entered, then 100% will be used. By default, the industry standard percentages will be used when a new contract term is created. The table on the next page lists the default values for modifier multipliers.

Standard Modifier Multipliers

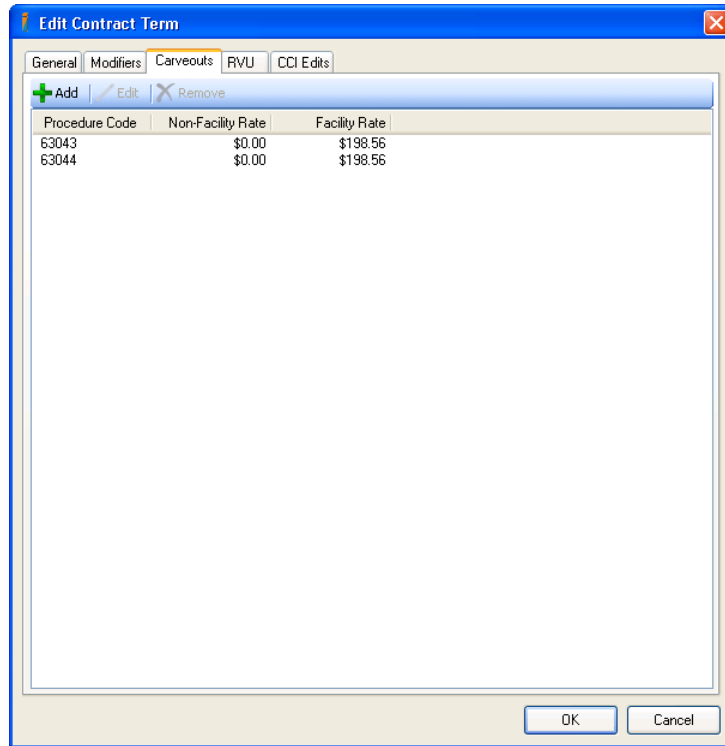
	Modifier	%
AS	PA, NP, or CNS services for Assistant-at-Surgery	17
22	Unusual procedural services	120
50	Bilateral procedure	150
52	Reduced services	50
53	Discontinued procedure	50
54	Surgical care only	75
55	Post-operative management only	15
56	Pre-operative management only	10
58	Staged or related procedure or service by the same physician during the post-operative period	100
62	Two surgeons	62.5
66	Surgical team	62.5
76	Repeat procedure by same physician	100
78	Return to the operating room for a related procedure during post-operative period	85
79	Unrelated procedure or service by the same physician during the post-operative period	100
80	Assistant surgeon	20
81	Minimum assistant surgeon	20
82	Assistant surgeon (when qualified resident surgeon not available)	20
99	Multiple modifiers	100

If you are setting up a contract that uses the Medicare standard multipliers percentage, the table on the next page indicates the differences between the standard percentages and Medicare.

Medicare Modifier Multipliers

	Modifier	%
AS	PA, NP, or CNS services for Assistant-at-Surgery	13.6
80	Assistant surgeon	16
81	Minimum assistant surgeon	16
82	Assistant surgeon (when qualified resident surgeon not available)	16

RVU Contract Term - Carveouts tab



Medicare has not assigned RVU values to some procedures and so their respective expected amounts are \$0. Procedures that have a Medicare Status Code of "C", carrier-priced, unlisted procedures (99 codes), and all new technology procedures (T codes) will be in this category. To allow for the manual setting of prices for these procedures, you can enter individual prices for both facility and non-facility locations of service under the **Carve Outs** tab. The table below lists the AMA CPT 2009 procedure codes that Medicare has designated as carrier-priced status codes that are available in INCISIVE MD. If you do not need to contact your Medicare carrier to determine their allowed amounts for these procedures, you will have to accept the amount provided on paid Medicare remittance advice.

Procedure Codes with Zero RVU Value

15431	15847	21742	21743	24940	63043	63044
70170	70555	70557	70558	70559	72291	72292
73530	76001	76496	77013	77371	78608	95951
95965	95966	95967	96379	99082	99143	99144
99145	99148	99149	99150			

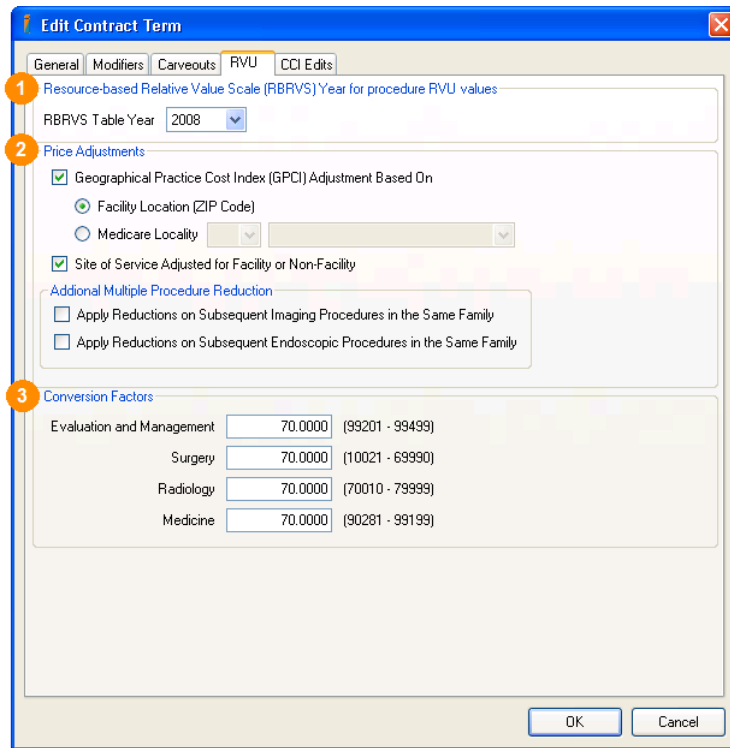
Unlisted Procedures

15999	20999	21299	21499	21899	22899	22999
23929	24999	25999	26989	27299	27599	27899
28899	29799	29999	64999	76497	76498	76499
78399	78699	95999	96379	99199		

New Technology Procedures

0019T	0054T	0055T	0062T	0063T	0092T	0095T
0098T	0101T	0102T	0106T	0107T	0108T	0109T
0110T	0160T	0161T	0163T	0164T	0165T	0169T
0171T	0172T	0195T	0196T			

RVU Contract Term - RVU tab



1 Resource-based Relative Value Scale (RBRVS) Year for Procedure RVU Values

Specify the RVU year to be used for setting the RVU values for the procedure codes.

2 Price Adjustments

- **Geographical Practice Cost Index (GPCI) Adjustment Based On**

Select the basis on which cost adjustment will be made. Medicare uses the facilities location (its ZIP code) as the basis for cost adjustment. This is the default value for an RVU contract term. In Illinois, it is common for contracts that are a percentage of Medicare to use a specific geographical location other than the actual facilities location as the basis for cost adjustment. In these cases, you will need to select the state and the specific Medicare locality within that state as the basis for cost adjustment.

- **Site of Service Adjusted for Facility or Non-facility**

This determines if only facility pricing will be used for calculation of expected amounts. If this item is checked, the place of service code associated with a facility will be used for the calculation of the procedures expected amount. If the facility has a Place of Service code equal to 11, office, then the non-facility rates will be used.

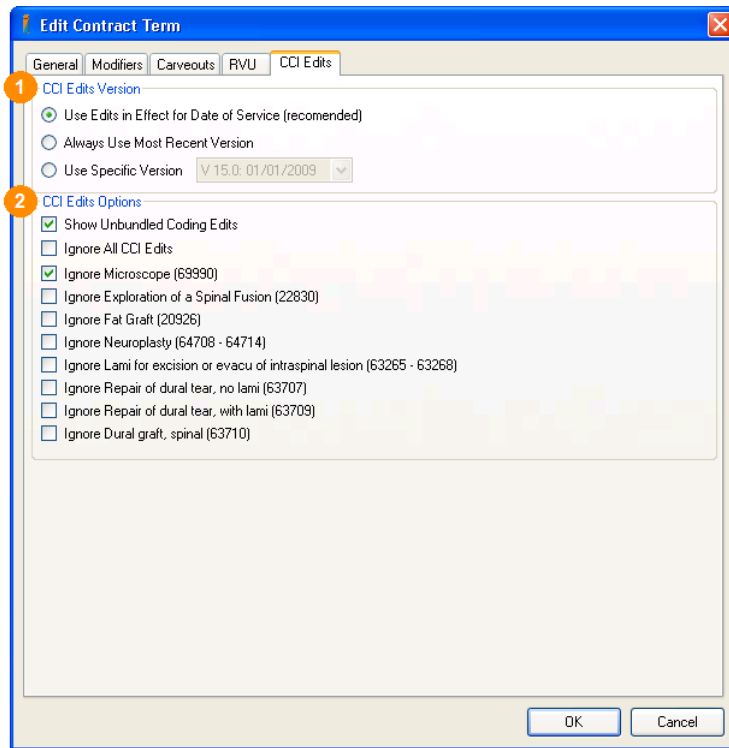
- **Additional Multiple Procedure Reduction**

If the payer uses Medicare's alternative multiple procedure reduction methodologies for imaging and endoscopic procedures as Medicare does, you can select which of these two additional methodologies to apply to these types of codes.

③ Conversion Factors

You can enter the conversion factors for each AMA CPT code range. You can enter up to four decimal places for the conversion factor. For Medicare and most RVU contracts, the conversion factor is the same for all CPT codes. Many workers compensation medical fee schedules that use an RVU based system have different conversion factors for each of the CPT code ranges, so surgeries can be paid more when procedures are performed in the office.

RVU Contract Term - CCI Edits tab



1 CCI Edits Version

Specify which version of Medicare’s national Correct Coding Initiative (CCI) edits to use. The default value is to use the set of edits that were effective on the date of service. Some contracts will specify that the most recent version be used regardless of the date of service. This only has an effect when you are rebilling or billing procedures dated prior to the current quarters CCI edits.

NOTE For the Illinois Workers Compensation contract, only version 12.0 is used. Given the current version is 14.1, any new edits from the last 2 years will not be used when coding. Our users are cautioned about watching their payers denying procedures for bundling using the current version of CCI.

2 CCI Edits Options

Some of our customers have either negotiated CCI edit carve outs with their payers, or their payers have tailored their CCI edits for their providers. In addition, some payers do not use the CCI edits to adjudicate their claims. The options available allow a customer to completely turn off the CCI edits or to selectively turn off specific edits related to the following CPT codes. The table on the next page lists the procedure codes that can have their respective CCI edits turned off.

Optional Ignore CCI Edits CPT Codes

CPT Code	Description
20926	Fat graft
22830	Spine fusion exploration
63265-63268	Laminectomy for excision or evacuation of intraspinal lesion
63707	Repair of dural tear, no laminectomy
63709	Repair of dural tear with a laminectomy
63710	Spinal dural graft
64708-64714	Neuroplasty
69990	Microscope

Unbundled Coding Edits

The other available option is to turn on the unbundled coding edits. This is a sophisticated feature allows users to determine when a always bundled item was not included with another major procedure code. It was developed to answer the surgeon reoccurring question about being able to bill for a microscope when it was used with a procedure that does not have a microscope bundled with it.

INCISIVE MD checks when a CCI Edit bundling pair have a status of 0, meaning the secondary procedure is always considered a component of the primary procedure and would never be a paid. The application will check the other primary procedures to see if this secondary code is also listed for that procedure. When it finds another primary procedure where this is not the case, then it will list this pair on the Surgery Coding CCI Edits tab an unbundling opportunity. The user will have to provide a distinct reason as to why the primary procedure is distinct from the secondary.

The default is to have this option turned off, and we recommend that users not enable this option unless they have a comprehensive understanding of how the CCI edits work, the goal of edits, and meaning of the our unbundling edits.