

# Continuous Glucose Monitor Coding May Change

BY JOYCE FRIEDEN  
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LAKE BUENA VISTA, FLA. — Endocrinologists who want to put Medicare patients with diabetes on continuous glucose monitors may soon have a more updated CPT code to use, according to Dr. Eric Orzeck.

The current reimbursement code for continuous glucose monitoring (95250) covers “ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for up to 72 hours; sensor placement, hook-up, calibration of monitor, patient training, removal of sensor, and printout of recording.” A companion code (95251) covers physician interpretation of the monitor’s printout.

But Dr. Orzeck, who presents proposed coding changes to the CPT Editorial Panel on behalf of the American Association of Clinical Endocrinologists (AACE), said the panel proposed that the code should accommodate the continuous glucose monitoring system staying in place for a minimum of 72 hours, rather than the current “up to 72 hours.” Dr. Orzeck said he was optimistic about the panel’s revision being published. “I have a feeling it’s going to be accepted because it’s just an editorial revision. It doesn’t have to go to another step,” he said at the AACE annual meeting.

Another piece of good news was that “there was no change in the laboratory platform,” so endocrinologists can continue to use their in-house labs for testing and can bill Medicare, said Dr. Orzeck, an endocrinologist at Baylor College of Medicine, Houston. “This was definitely resisted by the [commercial] lab people.” Of course, in-office testing requires a CLIA (Clinical Laboratory Improvement Amendment) waiver or certification to be paid, he added. One proposed change that is currently on appeal would allow other technology—such as nerve conduction studies—in the office, he added.

Dr. Orzeck urged endocrinologists to look carefully at their billing processes. He said endocrinologists often do not code properly. “We tend to undercode. It has to do with our training and the fact that we’re a much more cognitive specialty.”

Dr. Orzeck and his colleagues recently

looked at the frequency of billing codes used by endocrinologists, as compared with oncologists—another specialty that’s primarily cognitive.

“If you look at curves of coding, endocrinologists tend to have a spike at the ‘4s,’ with 45%-50% of their coding being for either 99204 or 99214, for office visits for new or established patients involving problems of moderate to high severity. On the other hand, he said, oncologists have a “very nice ramp up with 3s, 4s, and 5s, with their coding being at the 55% level for 99215,” which is a higher-complexity office visit code.

Dr. Orzeck stressed that he is not urging people “to upcode just because other groups do it. I’m advocating that you look at time spent and the complexity of what you do and code appropriately. You are the final [arbiter] of your services. You know what it took to do what you did, and therefore you know best how to code. [But] don’t be afraid to bill for the time that you actually expend, taking into account the complexity of the visit.”

Dr. Orzeck also stressed the importance of using modifiers. “You have to know how to use them and your biller has to know how to bill them,” he said. Otherwise, “you’re going to be leaving a lot of money on the table, and you’re not going to realize exactly what the potentials are. It’s the means by which we tell the insurance company that a certain procedure had to be performed, but it was different from what the standard coding manuals said would be performed on a regular basis.”

He reviewed the following codes and modifiers that endocrinologists can use to help them get paid appropriately:

► **99354.** This is a time-based, not a complexity-based, code and can be added on to a regular office visit. The code is defined as “prolonged physician service in the office or other outpatient setting requiring direct (face-to-face) patient contact beyond the usual service.” For instance, suppose you’re discussing radioactive iodine treatment with a hyperthyroid patient. “The pa-

tient read somewhere that it causes sterility and she desires a pregnancy somewhere down the line. You’re not going to convince her or even have the ability to tell her what the issues are and what your thoughts are in an 8- to 10-minute visit,” he said. “So you can then bill [at] a 4 level, for example, and then add 99354 for prolonged services above the time for the initial service.” With a visit lasting more than 30 minutes, report the evaluation and management code, then add 99354 for up to 1 hour and 14 minutes, he suggested.

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► **90774.** This code applies to one of the few procedures endocrinologists do perform: thyrotropin-releasing hormone injection for follow-up of thyroid cancer patients. The 90774 code is for an intravenous push,

Dr. Orzeck said. If you buy the medication yourself, use the appropriate J code (J2725) to bill for it, he said, noting that the medication must be billed in units of 250 mcg.

► **90765.** This code is used for an intravenous infusion, such as that used for zoledronic acid. That drug now has its own J code (J3488), said Dr. Orzeck, who is a member of AACE’s socioeconomic committee. “If you do provide [Reclast], the quantity is only 1 mg for that J code,” he warned. “So if you don’t bill ‘times 5’ for the 5 mg that you administer to the patient, you will not be paid for the whole cost; you’ll only be paid at the rate of 1 mg. ... This is one of the areas that we as physicians often don’t get paid for doing what we do, when the money is there and we just didn’t get it done.”

► **Modifier 25.** This modifier “is the one that gives us the most improvement on our billing,” he said. The CPT code book definition reads, “Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service.” This would apply, for instance, when you admit a patient to the hospital after seeing them in the office to identify that the second service needed to be performed on the same day.

► **Modifier 26.** This is used when you are

interpreting a stream of data or other information, and utilizing equipment you don’t own or control. For example, said Dr. Orzeck, “If I dose a patient with radioactive iodine, and I want to get a [follow-up] scan, the patient goes to hospital and gets scanned on their equipment and comes back to office with the scan in hand. I’m going to use modifier 26 to show that I’m interpreting data that I did not obtain on my own but is not going to be interpreted by anyone else.”

► **Modifier 51.** This modifier is appended to a secondary procedure when multiple procedures are performed on the same day, Dr. Orzeck explained. “You will not get paid for a second procedure on the same day without putting a modifier in to show that you actually did do two separate procedures at the same time on the same patient, but they were distinct and not an extension of one procedure to another.”

► **Modifier 91.** Endocrinologists should use this code more often, according to Dr. Orzeck; it’s for repeating the same test on the same patient at different times during the day. “The patient comes in and their blood sugar is 41, 58, or 396, and you say, ‘I want to see what it is in 30 minutes’ or an hour or whatever. You will not get paid for that repeat test unless you put the modifier on to explain that you’re not doing it to verify that the test is appropriate or because the sample came from a different site, but [instead] you’re doing it to look at actual information for dealing with patient management in the acute phase” of a problem, he said. With the modifier, “you will get paid for the subsequent tests at the same rate as the initial test,” he added.

► **Bundled codes.** Endocrinology does not have many “bundled” codes—which would encompass several time-consuming services usually performed as a package—but bundled codes have been proposed for certain services performed by endocrinologists. One example would be a code that comprises starting insulin, training the patient to use a meter, and instituting a new diet for a newly diagnosed type 1 diabetes patient, he said. “This is working its way through consideration, and there may be a bundled code that would incorporate the fact that the time involved is quite high in certain procedures.” ■

## IMGs Fill Coverage Gaps in Physician Shortage Areas

BY JOYCE FRIEDEN  
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ARLINGTON, VA. — International medical graduates have become an integral part of providing medical care in federally designated physician shortage areas, according to results from a recent study.

“Compared to U.S.-trained physicians, IMGs provide more primary care and more [overall] medical care to populations living in primary care shortage areas” as well as to minorities, immigrants, patients in poor areas, and Med-

icaid recipients, said Esther Hing of the National Center for Health Statistics, in Hyattsville, Md.

Ms. Hing and her colleague Susan Lin, Dr.P.H., studied 2005-2006 data from the National Ambulatory Medical Care Survey. The survey was nationally representative, and the data used by the researchers included information from 2,390 physicians in office-based practices. Surveyors performed a face-to-face interview and abstracted medical records for about 30 office visits. Ms. Hing presented the survey results at the 2008 Physician

Workforce Research Conference.

The survey showed that IMGs make up 25% of office-based physicians. They also tend to be a little older than U.S.-trained doctors, with an average age of 52 years, compared with 50 years for physicians trained in the United States. The racial and ethnic differences were more pronounced: 71% of U.S. medical graduates were non-Hispanic white, compared with 26% of IMGs. Asian/Pacific Islanders made up 32% of IMGs, compared with 5% of U.S. medical graduates. More of the IMGs than U.S. med-

ical graduates were working as primary care physicians—57% vs. 46%—a statistically significant difference, Ms. Hing noted.

IMGs also practiced more often in counties that included primary care shortage areas than did U.S.-trained physicians—87% vs. 79%. And IMGs more often saw patients during evening and weekend hours than their U.S.-trained counterparts. IMGs also were more likely to accept new patients and to accept Medicaid—nearly one-third of IMGs surveyed derived 20% or more of their incomes from Medicaid,

compared with less than one-fourth of U.S.-trained physicians.

“This study illustrates how the U.S. health care system continues to rely on IMGs to address shortages in primary care,” Ms. Hing said at the conference, which was sponsored by the Association of American Medical Colleges and Harvard Medical School. “The U.S. health care system faces challenges if the future supply . . . of IMGs is constrained by recent changes in visa policy that reduce the number of incoming [graduates]. This is an important consideration for policy makers.” ■