When reporting services which may be split into technical and professional components, it is important for providers to understand the rules for billing such services. You have 3 options: global, technical component only or professional component only. Providers should review the descriptions below and ensure they are always reporting these services correctly.

A Technical service is identified by appending Modifier TC to the procedure code. A technical component of a service covers the use of equipment, supplies provided and employment of technicians. Do you own or lease the equipment and supplies used and employ a technician who performs the service?

A Professional service is identified by appending Modifier 26 to the procedure code. A professional component of a service covers interpretation and writing of a report describing the examination and its findings. Did you document a separate narrative interpretation complete with a description of the service and your findings?

A Global service includes both the technical and professional components (no modifier appended). When a provider bills a global service, he or she is submitting a claim for both technical and professional components. Submission of the global service claim indicates the provider is accountable for the technician, equipment and facility needed to perform the service as well as interpretation and report of the service. Providers who bill globally should remember to always document the written narrative report describing the examination and its findings. It is inappropriate to report globally for a service if a separate report is not documented. A short statement indicating your findings included in your E&M service does not support the professional portion of a service.

IMPORTANT REMINDERS:
1) In general, if you intend to send the procedure out for a professional interpretation by another provider, you should NOT report the professional portion.

2) If the procedure code calls for a TC or 26 modifier AND a modifier 59, the TC or 26 will always be the primary modifier because they are considered “pricing” modifiers. They immediately impact the price/reimbursement amount.

ICD-10 is Coming!
Implementation is 10/1/2014

This month I offer you a little basic education on the format of the ICD-10 book and the structure of ICD-10 codes. The ICD-10-CM book is very similar in nature to the current ICD-9 book. It is divided into the Alphabetic Index, which is an alphabetic list of terms and their corresponding codes, and the Tabular List, a numerical list of codes divided by chapter, according to condition or body system.

The Alphabetic Index as 4 sections for you to begin your look-up:
- Index of Diseases and Injury
- Index of External Causes of Injury
- Table of Neoplasms
- Table of Drugs and Chemicals

The Tabular List has 21 Chapters, each containing categories, subcategories and codes. Categories are 3 characters long and always begin with a letter (be careful about typing a zero for letter O on your keyboard). Subcategory characters may be letters or numbers. Your final code may be 3, 4, 5 or six characters in length and the final character may be either a letter or a number. And certain categories even have a seventh character extension which indicates the episode of care (initial, subsequent or sequela).

Continued Page Two-
Perhaps this image will help you understand:

The code above S52.521A indicates a Torus Fracture of the lower end of right radius, initial episode of care.

DID YOU KNOW? (Coding related snippets)

CPT changes are just around the corner. Any changes to CPT will be effective January 1, 2014; therefore, be sure you acquire a list of all CPT changes, including new codes, revisions and deletions pertinent to your specialty of practice. The AAPC has webinars available for purchase to members and non-members regarding CPT changes for 2014.

Thank you for taking the time to review this information.

If you have any questions regarding the content of this newsletter, feel free to contact Cristy Donaldson directly at 670-6177.