



Professional Receivables Control, Inc.
Monthly Newsletter
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MEDICARE 2008 PREMIUMS AND DEDUCTIBLES

Your Medicare patients will have increases as follows to their premiums and deductibles for the new year. Part B Premiums are up from \$93.50 in 2007 to \$96.40 in 2008. The deductible went up from \$131.00 in 2007 to \$135.00 in 2008.

IMPORTANT DATES FOR NPI

After May 23, 2008, legacy identifiers will not be permitted on any inbound or outbound Medicare transactions. This includes inbound claims, crossover claims, both paper and electronic remittance advices, the 276/277 claims status inquiries/replies, NCPDP claims and the 270/271 eligibility inquires/replies.

To stay on top of the NPI updates visit <http://www.cms.hhs.gov/NationalProidentStand/> regularly.

CMS stopped assigning Unique Physician Identification Numbers (UPINs) on June 29 2007 but will continue its UPIN look-up at <http://www.upinregistry.com> until May 23, 2008.

REGISTRATION TO ACCESS CMS ONLINE COMPUTER SERVICES NOW AVAILABLE

In the near future, the Centers for Medicare & Medicaid Services (CMS) will be announcing new online applications that will allow Medicare fee-for-service providers to access, update, and submit information over the Internet. Details of the provider applications will be announced as they become

available. Even though these new Internet applications are not yet available, CMS recommends that providers set up their online account so they can access these applications as soon as they are available. The first step is for the provider, or appropriate staff, to register for access through a new CMS security system known as the Individuals Authorized Access to CMS Computer Services – Provider Community (IACS-PC).

A MLN Matters article, the first in a series on IACS_PC, discusses questions and answers about the registration process and may be found on the CMS Website at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0747.pdf>

NEW THERAPY CODE ADDED TO MEDICARE PAYABLE LIST IN 2008

Medicare has added code 96125 which will be used for standard cognitive performance testing per hour of a qualified health care professional's time, both face-to-face with the patient and time interpreting test results and preparing the report. This is an *always therapy* code so no matter who performs the service it must carry one of the therapy modifiers GN, GO or GP.

ABN AND NEMB NOTICES

When you provide a service to a patient that you know will not be covered by Medicare and you have no signed Advanced Benefit Notice (ABN) you must use the modifier GZ. This modifier can not be used on items that are statutorily excluded.

Statutorily denied services should be modified with the GY modifier. In this instance you may offer the patient the Notice of Exclusion for Medicare Benefits (NEMB) but this is optional. A copy of the NEMB can be accessed at http://www.cms.hhs.gov/BNI/11_FFSNEMBGeneral.asp

An example of NEMB services would be routine physicals and lab tests in the absence of signs or symptoms, and hearing aids. The patient may have a secondary policy that will cover these items but requires the Medicare EOB before it will process the claim. Therefore, you must file Medicare first, with the appropriate modifier and then file the secondary carrier.

In a case where you are filing a non-covered service, other than the services that are statutorily excluded and you do have the signed ABN on file, you must use the GA modifier. This will cause Medicare to then send the statement of benefits to the patient telling them that they have signed a waiver and accepted responsibility for payment of the non-covered services.

REDETERMINATION TIME LIMITS

Remember that you have only 120 days, from the date of the claim denial, to get your redetermination request to Medicare. That means that from the date on the electronic explanation of benefits, or standard explanation of benefits, you have 120 days to get your request in to Medicare. Medicare must receive your request within that 120 day window. If you mail your request on the 118th days and it doesn't arrive until the 121st day, you have lost your ability to file a redetermination request.

However, there are some instances where Medicare will extend the 120 day limit but those are limited to "carrier error". Therefore you must point out and prove that, through Medicare's error, your claim was denied. Carrier error is the only reason that PalmettoGBA will extend the 120 day limit.

BONE MASS MEASUREMENTS

To minimize claim denials on Bone Mass Measurements (BMM), it is important to verify Medicare coverage to make sure the patient has not had a BMM within the last 2 years. Once this has been

established then you have avoided making further mistakes. If the BMM is routine, it is limited to the once in 2 year time limit.

If *medical necessity* exists to perform the BMM more often than the 2 year limit, then you must accompany your claim with additional documentation. The initial claim for 77080, dual energy x-ray absorptiometry, you must give additional information in the Medicare documentation record.

- The type of osteoporosis drug therapy that the patient is receiving that requires the more frequent BMM.
- The date that treatment was initiated.
- If the patient is not receiving drug therapy for osteoporosis, include the name and daily dose of the drug therapy the patient is receiving that might adversely affect bone density.

Palmetto GBA will not reimburse codes 77078, 77079, 77081, etc. for bone density studies when the reason for the study is to monitor osteoporosis drug therapies.

See Medicare Advisory from July 2007 for more information.

ANCILLARY STAFF LIMITATIONS

CMS has limits on what ancillary staff can do in the course of the patient's visit. You can use ancillary staff to document only 1) Review of systems, 2) Past family and social history and 3) Vitals. Then the physician or NPP, who is performing the evaluation and management service, must notate that the notes were reviewed and corrected or additions were made. Only the physician or NPP may perform the history of present illness as well as the exam and decision making.

If ancillary staff is accompanying the physician or NPP and documenting the exam as dictated, the physician or NPP must review that documentation and note any additions and sign the notes. Also the staff person who did the documentation must be plainly identified.

GUIDELINES FOR TEACHING PHYSICIANS, INTERNS AND RESIDENTS

The guidelines Fact Sheet (July 2007) which provides information about payment for physician services in teaching settings and general documentation guidelines, is now available in the downloadable format from the Centers for Medicare & Medicaid Services Medicare Learning Network at <http://www.cms.hhs.gov/MLNProducts/downloads/gdelinesteachgresfctsht.pdf>

HELP FOR NEW EMPLOYEE FROM MEDICARE

If you have new providers, billers, or medical assistants in your practice, PalmettoGBA now offers help through the following link:
[http://www.palmettogba.com/palmetto/providers.nstf/\(Docs\)CCCB85B07921E2F08525738E0070AD52?OpenDocument](http://www.palmettogba.com/palmetto/providers.nstf/(Docs)CCCB85B07921E2F08525738E0070AD52?OpenDocument)

CLIA WAIVED TEST LISTING

If you do even one lab test in your office, you are required to have a CLIA waiver. Over the years the list of tests that you can perform under your CLIA waiver certification has continued to grow. Here is a link where you can see all the CLIA approved tests for your waiver
www.cms.hhs.gov/CLIA/10_Categorization_of_Tests.asp#TopOfPage

ANTHEM UPDATES

Diagnosis of Sleep Disorders – This medical policy was revised to add acoustic pharyngometry as investigational/not medically necessary.

NPI numbers – this will be the only identifier accepted by Anthem as of May 23, 2008 per Anthem Network Update, Issue 3, 2007. If you continue to use both legacy and NPI after May 23, you claims may be rejected.

MEDICARE HELP WITH EVALUATION AND MANAGEMENT DOCUMENTATION

The number one problem found in Medicare billing reviews is the documentation to support the level of evaluation and management billed. PalmettoGBA now offers some assistance with E&M documentation on their website. Go to www.palmettogba.com and filter down to Ohio Part B or West Virginia home page, in the right side drop down menu **Quick Links**. Then in **Articles** find **E/M Help Center**.

From the E/M Help Center, you can access:

- CMS's E/M Documentation Guidelines
- Frequently Asked Questions related to E/M services
- Peer comparison graphs that show aggregate claim submission data by specialty
- Tips for E/M coding by specialty
- PalmettoGBA seminar handouts for E/M services
- Sample E/M "score sheets"

RADIOLOGY NATIONAL PAID CLAIMS ERROR RATES

Medicare posted the following errors in Radiology related claims:

Radiological Procedures Common Documentation Errors

- Radiological results are not present in the medical record.
- Independent radiology providers must maintain documentation of physician orders for radiology services, including ICD-9 codes, even if the orders were verbal.
- Ordering providers must supply the ICD-9 code that represents the reason for the radiological service that is ordered.
- The medical necessity of the radiology services is not supported by documentation.
 - Valid diagnosis and/or description of the reason for the test ordered.
 - Use of valid code. General V-codes are not acceptable
 - Valid diagnosis must support medical necessity based on NCD, LCD (if one exists) or reasonable clinical judgment.