



**Professional Receivables Control, Inc.  
Monthly Newsletter  
FEBRUARY 2007**

**Please route to appropriate staff**

**NEW PROBLEM VERSUS OLD PROBLEM**

You are seeing a patient for the first time, and the patient has an established diagnosis. When considering your level of care do you use this as a new problem or an old problem?

You may believe that it's a new patient for you so you would treat this as a new problem, but you would be wrong. According to the questions and answers portion of the October 2006 Advisory, the term "new problem" is one identified as undiagnosed and may or may not require and additional work-up. For the purpose of scoring E/M documentation, a new problem is one that is new to the patient, not to the provider.

**CLIA WAIVED TEST PRODUCTS**

If you just started using a new lab product and need to know if it's a waived test, use this website <http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfClia/testswaived.cfm> from the FDA. Book mark it for future use.

**EATON CORP RETIREES NEW INSURANCE**

Eaton Corporation changed their retirees from Medicare primary with a First Health secondary plan to a new Medicare Managed Plan called **Advantra Freedom**. This is not a secondary plan but a Medicare replacement. The insurance code in the system for in house clients is **ADVFREE**.

**SECURE HORIZONS 2007 CARDS**

If you are having problems determining Secure Horizons Medicare products, I have a copy of the new cards for 2007. Contact me and I'll send them to you. (Phone and email listed at the end of this newsletter).

**MEDICARE AND PART A COVERED SKILLED NURSING FACILITIES**

This is an area of confusion so I'm going to attempt to clarify. If you see a patient who is residing in a Medicare Part A covered SNF stay, and you provide services other than the E/M or Professional services, the SNF is billed for the technical portion of the service. Example: Patient has an office visit and requires an EKG. You should contact the SNF and prearrange for them to pay you for the technical portion of the EKG. Establish how they want billed, HCFA or Statement and how much they will pay you along with when you can expect payment once they receive the billing.

The above situation is the ideal. However, we know that many times the doctor fails to ask and doesn't realize the patient is living in a SNF level of care covered by Medicare. So you bill the global EKG to Medicare and it's denied. At this point I suggest you split the billing into professional and technical. Re-file the professional portion to Medicare. Bill the technical portion to the SNF.

Often the SNF will refuse to pay you because you have no prearrangement but according to the Medicare directives the SNF is still responsible for that service as they are being paid a lump sum for all medically necessary services to the patient.

It is the SNF responsibility to educate the patient and family upon admission to the restrictions of services being sought outside their facility. It is also your responsibility to know where your patient is residing and make the prearrangement. However, it plainly states that if there is no prearrangement, the SNF is still responsible to pay you.

This link [http://cms.meridianksi.com/kc/main/kc\\_frame.asp?kc\\_ident=kc0001&loc=5](http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5) will take you to the online education for CMS. Choose Web Based Training Courses and then the Skilled Nursing Facility Consolidated Billing Course. You have to register but the course is free and there is a section on prearrangement.

**There is also a Web Based Training Course for front desk personnel. Choose Front Office Medicare. You may want to have your front desk personnel take the course. There is a test at the end and when they complete the test they can print out a completion certificate.**

### **COVERAGE ISSUES**

The number one reason for denials seems to be coverage issues. Make sure your front desk personnel are checking the identification cards carefully. We often get denials from Medicare because PalmettoGBA has been put in as primary with another insurance as secondary. When I receive the denial, I find that the insurance listed as secondary is, in fact, the Medicare carrier. These Part C carriers do put some reference on the card as to the coverage, for example, United Healthcare **Medicare Complete**, is on the card. This is the Medicare coverage, not secondary. Anthem Senior Advantage is plainly marked, this is their Medicare plan. SummaCare Secure Care is a Medicare Plan. If the patient presents both cards, PalmettoGBA and another, if you can't determine by looking at the card, ask the patient if the other insurance is a Medicare Plan. Some may know, of course, some have no idea what they have so it's up to us to make that determination. Review the cards carefully, if you truly can't determine, then enter MC primary and the other secondary and I will handle it when the denial comes through. However, know that this will delay receipt of payment for the doctor's services.

**This link will take you to a listing of the Medicare carriers by State. Scroll down to Ohio and they are listed. <http://www.medicarehmo.com/mclist.htm>**

### **KAISER PERMANTE AND BILATERAL PROCEDURES**

As of January 1, 2007 Kaiser is requiring bilateral procedures to be billed on one line, quantity = 1 with modifier 50. If you bill two lines your claim will be denied.

### **MEDICARE QUICK REFERENCE CHART AVAILABLE**

The *Quick Reference Information: Medicare Immunization Billing* chart is now available in hardcopy or as a download from the Medicare Learning Network. This two sided laminated chart gives Medicare fee-for-service physicians, providers, suppliers, and other health care professionals, quick information to assist with filing claims for influenza, Pneumococcal

Polysaccharide (PPV), and Hepatitis B (HBV) vaccines and their administration. To download, view and print the chart go to [http://www.cms.hhs.gov/MLNProducts/downloads/gr\\_immun\\_bill.pdf](http://www.cms.hhs.gov/MLNProducts/downloads/gr_immun_bill.pdf) or a hardcopy of the chart can be ordered through the Medicare Learning Network Product Ordering Page at [http://cms.meridianksi.com/kc/main/kc\\_frame.asp?kc\\_ident=kc0001&loc=5](http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5)

### **MEDLEARN MATTERS COMPLIANCE QUESTION OF THE WEEK**

What steps can providers take to ensure they meet medical necessity standards?

Answer:

Compliance involves several proactive steps, including the following:

Comprehensive documentation from providers is at the very top of the list. Along with a valid order, providers (those who treat patients) must designate the ICD-9-CM diagnosis code or diagnostic information that sufficiently describes the reason for the diagnostic test or service.

Before the service is provided, staff must verify that valid orders have been submitted. This is done by checking the submitted order with existing national coverage determination (NCD) or local coverage determination (LCD) policies, and validating that the proposed care is medically necessary, and, therefore, a covered service.

If a NCD or LCD does not indicate coverage, the physician, ideally, or his/her assistant will present an advance beneficiary notice (ABN) to the patient for consideration and signature. This allows the provider to collect payment from the individual if the insurer does not make payment.

### **MEDICARE CODING AND REIMBURSEMENT UPDATE**

At the beginning of each year, Medicare puts out a new Coding and Reimbursement Update. This publication holds a lot of important coding information. For example, it lists all T-codes. T-codes are those that have a value IF no other service is performed at the same time, but T-codes will always be denied “not paid separately” and bundled in with any other service provided and paid for the same date of service. Example: 94760 and 94761 Pulse Oximetry. Also it lists all the N-codes. These are codes that are subject to denial as not covered and appropriate to use an Advance Benefit Notice to advise your patient that they are responsible for the cost. You can find this document in the *Advisory* area of the Palmetto Website. Filter to Part B Ohio and go into *Advisories*. Choose 2007 and view the attachment. If you need assistance getting there you can call Medicare at 1-800-567-9232 or me at 330-564-2645 and we will be glad to help you access the document.

### **ADDENDA TO MEDICAL RECORDS**

Medicare requires that all medical records be done in a timely manner and be complete and accurate. However, we all know that every once in a while, a fact is omitted that must be entered at a later date. Palmetto GBA has set up the following criteria to add information to an existing medical record:

- The addendum must be added to the medical record in a timely manner – within a few days of the original entry.
- The addendum must contain individualized, patient-specific clinical information for each date of service amended. Medicare does not except blanket statements, declarations or attestations.
- The addendum should be chronological in the original medical records. (If the addendum is voluminous; you may refer in the progress notes, to the addendum

information found elsewhere in the records.)

- Each addendum must be legible, signed, and dated by the person making the entry.
- The addendum should address additional clinically relevant information; not information just to meet a regulatory requirement or to later validate a CPT code that was initially down coded due to lack of supporting documentation.

### **KAISER PERMANENTE BILLING CHANGE FOR BILATERAL PROCEDURES**

Effective January 1, 2007 Kaiser Permanente changed the billing requirement for bilaterally procedures to coincide with the CMS guidelines.

*Bilateral Procedures* are surgeries performed on both sides of the body during the same operative session or on the same day.

*Rule Justification:* When performed bilaterally, the same surgical procedure should not be billed twice. Kaiser Permanente's reimbursement requires the code to be billed on one line with a bilateral modifier.

If you bill two codes and both carry modifier 50, Kaiser will pay one line and deny the other.

If you have any questions contact your representative at (216) 623-8765 or (800) 441-9742 at Kaiser Permanente.

### **HELP DESK HINT**

The **Edit Visit** screen in the **Visit List** has been updated to allow for diagnosis corrections and the deletion of any unnecessary diagnosis.

**To make a correction/deletion**, click on the diagnosis that is to be edited from the edit visit screen. You will see a split screen. The top section allows you to make the correction under the New Visit Diagnosis heading. The bottom section will display the current diagnosis codes.

**To change the diagnosis**, type in the correct code, or you can click on the magnifying glass, or press **F2**, and select the correct diagnosis from the patient's personal diagnosis list, in the numbered field, that needs corrected.

**To remove a diagnosis**, click on that diagnosis box and clear out the diagnosis code by using the delete key, space bar, or backspace key. If the diagnosis has been used on a charge line, a warning will appear that the diagnosis is used on a transaction and can not be deleted. If this is the diagnosis that needs to be removed, the charge will need to be adjusted off using the CPE adjustment code. Then you will have to re-enter a new visit with the correct diagnosis code.

**Please remember that nothing is updated until you click the Accept button.**