Professional Receivables Control, Inc.
Monthly Newsletter
February 2008

Please route to appropriate staff

REMINDER: PQRI 2007 DEADLINE

Deadline for submitting PQRI claims for 2007 is February 29,2008.

FYI

Any primary insurance that goes electronically is also able to be sent electronically as a secondary insurance.

Information Regarding the New 2008 Medicare Physician Fee Schedule Amounts Released 1/11/2008 from Palmetto GBA

In previous messages, the Centers for Medicare and Medicaid Services (CMS) indicated that the Medicare, Medicaid and SCHIP Extension Act of 2007 replaced the scheduled 10.1 percent reduction in the Medicare Physician Fee Schedule (MPFS) conversion factor with a 0.5 percent increase for dates of service beginning January 1 through June 30, 2008. CMS has received a number of inquiries asking whether physicians need to take any special action to get paid at the rates required by the statute. ***Physicians do not need to take any additional action in order for their MPFS claims to be paid at the new rate that reflects the 0.5 percent increase in the conversion factor.*** Medicare contractors are able to process claims for services paid under the MPFS that contain dates of service January 1 and after with the new 2008 rates. No adjustments should be necessary. Your Medicare contractors have been instructed to process, beginning January 7, all claims with dates of service January 1, 2008, and after, that contain MPFS services.

Read the rest of the story at:
http://www.palmettogba.com/palmetto/palmetto.nsf/(News)/956F7868898DDDB3852573CD007073F0?OpenDocument

CELEBRATE NEW PERCUTANEOUS JEJUNOSTOMY CODE

Per ***Radiology Coding Alert*** Vol. 10 No. 3 2007:

CPT 2008 **deletes** 43750 (*Percutaneous placement of gastrostomy tube*) and **replaces** it with three new codes that help radiologists more precisely describe insertion of gastrostomy (49440), duodenostomy or jejunostomy (49441), or cecostomy or other colonic (49442) tubes:

- **49440** — Insertion of gastrostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report
- **49441** — Insertion of duodenostomy or jejunostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report

• **49442** — Insertion of cecostomy or other colonic tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report.

All of the above insertions take place “under fluoroscopic guidance including contrast injection(s), image documentation and report,” and you therefore would not report this service separately.

STAY ALERT: CPT 2008 also introduces three new codes for gastrostomy tube replacement:

• **49450** — Replacement of gastrostomy or cecostomy (or other colonic) tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report
• **49451** — Replacement of duodenostomy or jejunostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report
• **49452** — Replacement of gastro-jejunostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report.

FINALLY, YOU CAN LOOK UP NPI INFORMATION
At last you can look up the National Provider Identifier (NPI) of physicians who send patients to your office. The lookup is available online at:
https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do

MORE from *Radiology Coding Alert* Vol. 10 No. 2 2007:
Report Lymphoma PET Scans? Code Changes Bring a Double Whammy
78811-78816 descriptor revisions could lead to increased coverage
Your ICD-9 lymphoma options have already changed, and CPT has PET scan code changes in store for 2008. Here’s what you need to know when you report your next lymphoma PET scan.
In 2007, you probably turned to 202.80 (*Other lymphomas; unspecified site, extranodal and solid organ sites*) for many of your lymphoma claims, but you have multiple new options as of Oct. 1:

- marginal zone lymphoma (200.30-200.38)
- mantle cell lymphoma (200.40-200.48)
- primary central nervous system lymphoma (200.50-200.58)
- anaplastic large cell lymphoma (200.60-200.68)
- large cell lymphoma (200.70-200.78)
- peripheral T-cell lymphoma (202.70-202.78).

Reporting unspecified code 202.80 less often is a benefit, but all of these new lymphoma codes may cause some problems of their own, says **Erin Goodwin, CPC, CMC,** reimbursement and coding professional with a South Carolina clinic.
Documentation must offer the details you need to choose among these new codes. The trick is finding the middle ground between the physician not documenting enough information and making his documentation so specific that you have a hard time choosing the most appropriate diagnosis code.

HELP DESK HINT….
In the Receipt Book, you are now able to print the comments for a specified date range. When you have clicked on the Receipts by Date button and enter in the date range, a box will appear asking Print Receipt Comment/Message? If you want the comments to print you will click on the Yes button and if you do not need the comments, click on the No button. This is also available for the Receipts by Att-Dr feature.

NEWS FLASH:

Act Now or Miss Out on Your Rightful MRI Contrast Dollars

CMS says Q9952 has a spot on imaging claims

In all the excitement of CPT and ICD-9 2008 changes, don't let this 2007 reimbursement change slip under your radar.

Old way: Medicare included payment for contrast in certain MRI practice expense (PE) relative value units (RVUs).

New way: Medicare will pay separately for contrast media for services on or after Jan. 1, 2007, and will no longer include the contrast cost in MRI PE RVUs.

What to do: In addition to the CPT code for the MRI, you should report the appropriate HCPCS code for the contrast medium (typically Q9952-Q9954) for all services after Jan. 1, 2007.

Medicare payers won't be searching their files to offer you payment retroactive to the Jan. 1 effective date, but you can appeal relevant claims.

Find out more in MLN Matters article MM5677:
www.cms.hhs.gov/MLNMattersArticles/downloads/MM5677.pdf

REVISED GUIDANCE FOR COMPLETING FORM CMS-1500

Providers note the changes in Chapter 26 of the *Medicare Claims Processing Manual* that impact the Form CMS-1500 boxes 32a and 32b.

Box 32a: If known, enter the National Provider Identifier (NPI) of the service facility.

Box 32b: If known, **enter the legacy Provider Identification Number (PIN)** of the service facility preceded by the **ID qualifier 1C**. There should be one blank space between the qualifier and the PIN. This instruction affects Physicians, Non-Physician Practitioners and Ambulance.

Read the complete article at:
http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5749.pdf

REMINDER FROM PALMETTO GBA: Clarification on NPI Enumerator's Responsibilities

The topics with which the NPI Enumerator can assist providers are listed below:

- Status of an NPI application, update, or deactivation
- How to apply, update, or deactivate
- Forgotten/lost NPI
- Lost NPI notification
- Trouble accessing NPPES
- Forgotten password/User ID
- Need to request a paper application

Healthcare providers should not contact the NPI Enumerator for questions other than those related to the above topics. A new MLN Matters article clarifies the specific responsibilities of the NPI Enumerator. This article is located at http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0751.pdf on the CMS Web site.

CORRECT CODING INITIATIVE (CCI) EDITS, Version 14.0:

Effective January 1, 2008 is available at:
www.cms.hhs.gov/NationalCorrectCodInitEd

<u>PQRI</u>: an early start will earn the 1.5% bonus
From ***Part B News:***
"The PQRI bonus is now fixed at 1.5% of allowable charges in 2008 the same as last year, says Brian Whitman, a policy analyst at the American College of Physicians in Washington. Before the new law, the 2008 bonus was "an unknown figure based on participation." He says. That means the bonus would be lower if more physicians participate.

> **<u>TIP</u>:** "Start now and you won't have to try to catch up, Whitman says. If practices start in the second or third week of January, they'll be all right. But if they start pushing back to February or March, it will be hard to hit that 80%."

"Look out for deletions, new opportunities
Practices that participated in PQRI in 2007 need to make sure the measures they reported have not been removed from the '08 list.

> **<u>TIP</u>:** "This year, you will have 119 PQRI measures to choose from, a 60% increase from last year. Some specialties, including dermatology, gastroenterology, and ophthalmology lost favorite measures this year. If your 2007 measures have been stricken from the list, look to the new structural measures, which apply broadly across specialties.

"CMS introduced two new structural measures this year targeted at electronic medical records, and e-prescribing. These measures are appealing, because they can be reported by any specialist who uses the technology. However, in its current form, the reporting could be intrusive, says Whitman, because it requires the submission of the quality indicator with each claim that uses the EMR. Whitman says CMS has a lot of authority to decide how to implement these measures, and could revisit implementation strategies this year."

<u>NEW CODES FOR SMOKING CESSATION + PQRI</u>
Per ***Part B News:***
Smoking cessation counseling has two new codes:
99406, 3 – 10 minutes ($12.13) and **99407,** more than 10 minutes ($23.12) - these codes replace the temporary G-codes. If the counseling occurs during a separately identifiable E/M visit then you will bill it with a **25** modifier.
Remember Smoking cessation counseling is only billable if the patient has a disease caused by smoking, such as COPD.

<u>"TIP</u>: If you spend time counseling you health patients to quit, you can see a modest reward by using the new PQRI measure 115, 'advising smokers to quit.' The sweeping denominator for the measure – all patients age 18 or older- will require you to report G-codes on a lot of your claims. This burden could deter some practices from choosing the measure because you even have to report when patients don't smoke, using codes **G8456** (current smokeless tobacco user) or **G8457** (tobacco non-user). " C. Weaver

Sue Shafer, RHIT