



**Professional Receivables Control, Inc.
Monthly Newsletter
February 2009**

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WELCOME TO MEDICARE PHYSICAL AND THE ECG.

In last months newsletter I told you that the ECG had been removed as a requirement from the Welcome to Medicare Physical. Per *Part B News* this has been clarified. Apparently when the ECG was a requirement it threw a “monkey wrench” in the payments for physicians who sent their patients to another provider to obtain the required ECG. Since the ECG was a requirement as part of the physical if the provider who did the ECG did not bill it correctly or the patient simply forgot to get the ECG, the physician who did do the Welcome to Medicare Physical was not paid.

The ECG is still payable as part of the Welcome to Medicare Physical but the wording in the directive was confusing and led some to believe that it had to be *medically necessary* or it could not be done. *Part B News* quotes a CMS official as saying, “the physician or other practitioner does have to decide that his or her patient should have the exam and must order it and document this in the patient’s medical record.” The official also advises you to contact your local carrier “to determine the appropriate way to bill for those exams in the future”. Remember the deductible is waived on this ECG (G0403-G0405) only during the Welcome to Medicare Physical.

If you are already discussing end-of-life planning with your patients you will have to take one more step to make this part of the Welcome to Medicare Physical. This end-of-life planning discussion is now a requirement as part of this service but will require the patient’s consent to do so. Again, the CMS official is quoted as referring you back to your local carrier to find out how they want this documented.

PalmettoGBA the carrier for Ohio and West Virginia gives you directions in their December 2008 Advisory which you can find on their website www.palmettogba.com.

MEDICAL NECESSITY TOOL

We all know that Medicare bases it’s coverage of any service on medical necessity. CMS has a tool called the *LCD Service Indication Report* that you can find at this link: http://www.cms.hhs.gov/mcd/serviceindication_criteria.asp?from2=serviceindication_criteria.asp&

Once your patient has been diagnosed, it is imperative that you know that services will be covered. You can do that by using the LCD Service Indication Report tool. You will need the precise ICD-9 code and the CPT/HCPC procedure code. If you are unsure of the correct ICD-9 code, CMS also provides a look-up tool to help you find the correct ICD-9 code for your patient's diagnosis. That may be accessed here: http://www.cms.hhs.gov/mcd/icd9_lookup.asp

Remember these tools are for confirmation only. Your chart must support any diagnosis code used. You are to NEVER pick a code just to get the claim paid if it is not supported in the chart.

COLORECTAL CANCER SCREENING

For patients over the age of 50, Medicare covers 4 services provided as "screening" procedures for colorectal cancer with time limitations. Note that this age limitation is waived for screening colonoscopy in high risk patients or barium enema as an alternative to colonoscopy in high risk patients. (See definition of "high risk" below) A G0104 flexible sigmoidoscopy is covered every 4 years or once every 10 years after having had a screening colonoscopy. A G0105 screening colonoscopy, for a high risk patient, is covered every 24 months. A G0121 screening colonoscopy, not high risk, is only covered every 10 years. A G0106 Barium enema, as an alternative to G0104 colonoscopy for high risk patients, is covered every 24 months.

"High Risk" patients are those that; 1) Have a close relative (sibling, parent, or child) who has had colorectal cancer or an adenomatous polyp; 2) A family history of adenomatous polyposis, 3) A family history of hereditary nonpolyposis colorectal cancer; 4) A personal history of adenomatous polyps; 5) A personal history of colorectal cancer; 6) A personal history of inflammatory bowel disease, including Crohn's Disease and ulcerative colitis.

If your patient requests any of the tests done more frequently than allowed have them sign an Advanced Benefit Notice. You can find the revised ABN here http://www.cms.hhs.gov/BNI/02_ABNGABNL.asp#TopOfPage

NERVE CONDUCTION STUDIES

In today's economy, a lot of practices are increasing their ancillary services. Many internists are now doing nerve conduction studies (NCS) in their offices. This can cause neurology practices some problems. For example: The internist sees the patient and performs an NCS in his office finding results that point to carpal tunnel syndrome. The internist then refers the patient to the neurologist. The neurologist doesn't want to treat a condition unless he verifies the test results himself but the insurance will not pay for another NCS.

How do you get your testing covered? Look for EMG. If the preliminary NCS at the internist was 95900, 95903 or 95904 none of these include an EMG. Some carriers won't cover any NCS without an EMG. You should not have a problem being paid as long as your NCS includes an EMG and the required diagnoses. *Neurology Coding Alert*, gives an example of United HealthCare reimbursing for NCS (95900, 95903, 95933-95934, 95936-95937) and EMG (92265, 95860-95861, 95863-95870, 95872) when you use diagnosis codes listing in the Nerve Conduction Studies/Electromyography Policy that went into effect November 2006.

For Medicare make sure you refer to CPT Appendix J for the reasonable number of studies for a physician to arrive at a diagnosis in 90 percent of patient with that final diagnosis, in our example, carpal tunnel syndrome. The table indicates for unilateral CTS, maximum number of studies on three motor nerves, four sensory nerves and single-needle EMG study is reasonable.

Basically what you have to define is the difference between the “screening” test done by the internist and your “diagnostic” testing. The internist may conduct his screening with a machine that tests sensory and/or mixed nerve latencies but not motor NCS. These machines do not include the EMG. There is another machine that tests amplitude of response at sensory roots as an indication of source radicular pain. However, neurologists test motor and sensory nerves, distally and proximally, along with watching motor reflexes through the spinal cord. This is clearly diagnostic, not screening.

(Information taken from Neurology Coding Alert, Vol. 10, Issue 11.)

MEDICARE SCREENING PELVIC EXAM

Back in 1997 Medicare Part B included coverage for screening pelvic exams including a clinical breast exam. Remember that this exam, with or without specimen collection for smears and cultures, must include at least seven of the following eleven points:

- Inspection and palpation of breasts for masses or lumps, tenderness, symmetry, or nipple discharge; and
- Digital rectal examination including sphincter tone, presence of hemorrhoids, and rectal masses.
- External genitalia (for example; general appearance, hair distribution, or lesions);
- Urethral meatus (for example; size, location, lesions, or prolapse);
- Urethra (for example; masses, tenderness, or scarring);
- Bladder (for example; fullness, masses, or tenderness);
- Vagina (for example; general appearance, estrogen effect, discharge, lesions, pelvic support, cystocele, or rectocele);
- Cervix (for example; general appearance, lesions or discharge)
- Uterus (for example; size, contour, position, mobility, tenderness, consistency, descent, or support);
- Adnexa/parametria (for example; masses, tenderness, organomegaly, or nodularity); and
- Anus and perineum.

END STAGE RENAL DISEASE – CMS OFFERS NEW RESOURCES

CMS has developed an ESRD Center at <http://www.cms.hhs.gov/center/esrd.asp> . You can view the question and answer section by clicking on the **FAQ ESRD Rollout Final** on that page. You can also access the crosswalk of former conditions vs. revised conditions at <http://www.cms.hhs.gov/CFCsAndCoPs/downloads/ESRDConditionsCrosswalkFINAL080408.pdf>

MEDICARE PHYSICIAN GUIDE

You can download the latest physician guide here <http://www.cms.hhs.gov/MLNProducts/downloads/physicianguide.pdf>

CMS OFFERS DIRECTIVE ON MUE

In the CMS Question and Answer section one office asked how to bill a service that is reasonable and necessary but in excess of the Medically Unlikely Edit (MUE)?

CMS’s response, “Since each line of a claim is adjudicated separately against the MUE value for the code on that line, the appropriate use of Current Procedural Terminology (CPT) modifiers to report the same code on separate lines of a claim will enable a provider/supplier to report medically reasonable and necessary units of service in excess of an MUE value. CPT modifiers such as -76 (repeat procedure by same physician), -77 (repeat procedure by another physician), anatomic modifiers (e.g., RT, LT, F1, F2), -91 (repeat clinical diagnostic laboratory test), and -59 (distinct procedural service) will accomplish this purpose. Modifier -59 should be utilized only if no other modifier describes the service.”

Part B News tells us that CMS has released some of its MUEs but stopped short, withholding most information “so it would not tip its hand to those abusing the Medicare system”. You are cautioned not to overuse the modifiers.

MEDICARE APPEALS PROCESS CHART

Appeals	Time Limit	Minimum Amount in Controversy	Notes
Redetermination (initial appeal)	120 days from the date of the initial claim determination notice	None	You must file a Redetermination Request before filing a Reconsideration Request with the QIC.
Reconsideration - Qualified Independent Contractor (QIC)	180 days from receipt of the redetermination	None	Please include a copy of the redetermination notice with any QIC request. The address for the QIC is located on the form.
Administrative Law Judge (ALJ)	60 days from receipt of the QIC decision	At least \$120 remains in controversy for requests made on, or after January 1, 2008. For request made before January 1, 2008, at least \$110 remains in controversy.	The QIC decision letter will provide the HHS OMHA office to which an ALJ request is mailed.
Departmental Appeals Board Review (DAB)	60 days from the date of the ALJ decision or dismissal	None	
Federal District Court Review	60 days from the date of the Departmental Appeals Board decision	At least \$1,180 remains in controversy for requests made on, or after January 1, 2008. For request made before January 1, 2008, at least \$1,130 remains in controversy.	

MIPPA – WHAT IS IT?

MIPPA = **M**edicare **I**mprovements for **P**atients & **P**roviders **A**ct. Enacted on July 15, 2008 this act includes:

- Amends Social Security Act to allow additional preventive services
- Places limitations on certain sales and marketing activities under the Medicare Advantage plans
- Gradual elimination of the 50% co-insurance on outpatient mental health services
- Revises requirements and extends the quality reporting system. (PQRI)
- Provides for incentives for electronic prescribing
- Extends increased Medicare payments for ground ambulance services
- Delays full implementation of DMEPOS competitive bidding program until after 2011
- Reinstated the therapy cap exception process

You have seen some of the results of the above items already, the implementation of a 1.1 percent increase in the conversion factor for the 2009 MPFS. For more information go to

<http://www.cms.hhs.gov/PhysicianFeeSched/>

E-prescribing – a five year plan of incentive payments to eligible professionals who are “successful electronic prescribers” (Those who either report applicable electronic prescribing measures established under the PQRI; or those who electronically submit prescriptions under Medicare Part D at a level determined by CMS)

The major benefits to e-prescribing are:

- Elimination of the possibility of errors caused by illegible handwriting.
- Reduces confusion, resulting in fewer contacts for clarification by the pharmacy.
- Aids the physician in prescribing drugs that are covered and affordable to the patient.
- Incentive payment to eligible professionals: 2% in 2009 & 2010; 1% in 2011 & 2012; and .5% in 2013.

Note: In 2012 those eligible professionals who are not e-prescribers will receive a reduction in payment (Exemptions on a case-by-case basis for those where compliance would result in significant hardship).

PQRI – Eligible professionals will be paid 2% incentive of estimated allowable charges for the 2009 reporting period (Up from 1.5% in 2007 and 2008). Charges must be submitted no later than 2 months after the end of the reporting period (Audiologists are excluded).

The CMS PQRI web page is a good starting point for more information: <http://www.cms.hhs.gov/pgri>. Registry-based reporting is an option in both 2008 and 2009. For those of you already reporting you can access your PQRI reports by first registering for a CMS IACS user ID in order to obtain your reports through the PQRI portal: <http://www.qualitynet.org/pgri> For assistance with IACS registration, call the CMS External Users Service (EUS) Help Desk at 1-866-484-8049, Monday through Friday, 7:00 am till 7:00 pm EST) or via e-mail at eussupport@cgi.com . The help desk number for the PQRI portal is 1-866-288-8912, or e-mail gnetsupport@ifmc.sdps.org .

There is also more information in the January 2009 Medicare Advisory which you can access on the www.palmettogba.com website.

Note: E-prescribing measures have been removed from PQRI for 2009 reporting period due to the separate e-prescribing incentive.

DMEPOS – This competitive bidding program has been delayed and for now can be supplied by any Medicare-enrolled DMEPOS supplier.

Note: All DMEPOS suppliers must still be accredited by September 30, 2009.

THERAPY CAP EXTENSION – This was reinstated and will continue through December 31, 2009 allowing the continued use of modifier KX if the service meets the criteria. Physical therapy and speech language pathology combined have a limit of \$1810. Occupational therapy has a limit of it's own of \$1810. For more information: www.cms.hhs.gov/TherapyServices/ .

ICD-10 INFORMATION AVAILABLE

The CMS Medicare Learning Network has made available to you in print format the ICD-10-Clinical Modification/Procedure Coding System Fact Sheet. This fact sheet provides general information about the new ICD-10 including benefits of adopting the new system, structural differences between ICD-9CM and ICD-10-CM/PCS along with recommendations for

implementation planning. Go to http://www.cms.hhs.gov/MLNProducts/01_Overview.asp and scroll down to *Related Links inside CMS* and select *MLN Product Order Page*.

CMS has delayed the use of ICD -10 until October 1, 2013.

BILLING FOR OUT OF JURISDICTION PURCHASED SERVICES

If you bill for screening mammograms or other diagnostic services that you purchase from a provider outside your Medicare contractor's jurisdiction you must use your NPI as the billing provider and also use your NPI as the performing provider but list the name, address and ZIP code of the actual performing provider.

BILLING QUANTITY IN INJECTIONS AND INFUSIONS

Palmetto GBA accepts up to 4 digits in the QB (quantity billed) field. However, if you use 4 digits the 4th is representing **tenths**. 100 = one hundred but 1009 isn't one thousand nine. 1009 = 100.9

If you record a tenth you must add the leading zeros. Example 0.1 would be entered as 0001 (not 01 which would be interpreted as "1") 90.9 would be entered 0909 (not 909, which would be interpreted as nine hundred and nine)

A single injection with a quantity up to 999.9 (entered as 9999) must be submitted on one line. If multiple injections of the same drug/infusion are injected on the same date and the total dose is up to 999.9 this must also be submitted on one line.

If the total dosage is up to 999.9 but split into more than one line, the first will pay and the rest will deny as duplicates.

If the total dosage is over 999.9 use the fewest possible lines. Example: 3000 mgs. of J9263 **(for which the billing unit is 1 mg.)**

INCORRECT would be to bill J9263 quantity of 3000.

CORRECT would be to bill J9263 quantity 9999 (meaning 999.9)

Next line J9263 quantity 9999

Next line J9263 quantity 9999

Next line J9263 quantity 0003 (meaning 0.3)

Palmetto reminds us that we are reporting UNITS of a drug as defined by CMS ASP drug files, and these units may not always be 1 mg. Therefore, using the 3000 mg example, if the billing unit for the drug or biological is 100 mg, 3000 mg would be reported as "30" units (30 units of 100 mg each) and reported on only ONE line.

If you are billing unclassified drugs J9999, J3490 or J3590, the drug name, the National Drug Code (NDC) number and total dosage must be reported in the Medicare documentation field. Remember the correct number of units for these not otherwise classified codes is always 1 (one). Your reimbursement will be based on the dosage indicated in the narrative field.

Tip: Watch your charge field in ELF because the charge increases with quantity billed and you may have to manually alter the charge amount.

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