



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

**Please route to appropriate staff**

**Newsletter access is also available through the help menu**

*If any of the links in this newsletter do not work, please copy and paste them into your browser.*

**CMS DELAYED THE NEED FOR TAX ID**

Effective April 6, 2009, CMS will require you to provide the last 5 digits of your Tax Identification number in addition to your NPI and PTAN, when you call to use the IVR system, or speak with a Customer Service Representative. For more information, refer to <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6139.pdf>

**MANDATORY USE OF REVISED ABN**

Effective March 1, 2009, all providers, practitioners, and suppliers paid under Part B, as well as hospice providers and religious non-medical health care institutions (RNHCIs) paid exclusively under Part A, are required to use the revised ABN in place of the General Use ABN (CMS-R-131-G) and Lab ABN (CMS-R-131-L). The revised form (English and Spanish versions) and notice instructions are now posted on the Beneficiary Notice Initiative Web page [www.cms.hhs.gov/bni](http://www.cms.hhs.gov/bni)

**MORE INFORMATION ON E-PRESCRIBING**

In October 2008, the Centers for Medicare & Medicaid Services (CMS) and 34 partner organizations hosted a meeting about the mechanics of implementing an e-prescribing program in a practice. Audiotapes and slides are now archived online for continuing education credit. The Massachusetts Medical Society and the American Pharmacist Association are pleased to provide Continuing Medical Education (a maximum of 22.5 AMA PRA Category 1 Credits) (risk management study for MA Physicians) and Continuing Education for pharmacists (up to 13.25 hours of continuing education credit (1.325CEUs)). Simply go to [http://www.massmed.org/cme/CMS\\_eprescribing](http://www.massmed.org/cme/CMS_eprescribing) to view the presentations and hear the audiotapes of the program. There are no registration or certificate fees.\*

Information on CMS: [http://www.cms.hhs.gov/PQRI/03\\_EPrescribingIncentiveProgram.asp](http://www.cms.hhs.gov/PQRI/03_EPrescribingIncentiveProgram.asp)

\*Taken from Part B Outreach, Highmark Medicare Services

**CMS MEDICARE LEARNING NETWORK INFO ON PREVENTIVE MEDICARE**

You can order, free of charge, a tri-fold brochure that will provide you with an overview of Medicare's coverage of three preventive services: the initial preventive physical examination

(IPPE), also known as the Welcome to "Medicare Physical" Exam or the "Welcome to Medicare" visit, ultrasound screening for abdominal aortic aneurysms, and cardiovascular screening blood tests. To view, download and print this brochure, please go to the CMS Medicare Learning Network (MLN). Here is a link <http://www.cms.hhs.gov/MLNProducts/>, scroll down to "Related Links Inside CMS" and select "MLN Product Ordering Page".

[http://www.cms.hhs.gov/MLNProducts/downloads/Expanded\\_Benefits.pdf](http://www.cms.hhs.gov/MLNProducts/downloads/Expanded_Benefits.pdf)  
<http://www.cms.hhs.gov/MLNProducts/>

### **ICD-10 DELAYED**

Due to so many protests, the implementation of ICD-10 has been delayed until October 1, 2013. However, per Part B News, the American Health Information Management Association urges the use of the extra time to work on the implementation and compliance. The AHIMA has criticized the additional years given to comply stating, "This further extension means more years without the data needed to make intelligent data-driven decisions related to all aspects of healthcare".

The HHS ICD-10 final rule in the Federal Register can be viewed here: [www.federalregister.gov/OFRUpload/OFRData/2009-00743\\_PI.pdf](http://www.federalregister.gov/OFRUpload/OFRData/2009-00743_PI.pdf)

### **ADVANCE PRACTICE NURSES AND PHYSICIANS ASSISTANTS WEB PAGE**

The *Medicare Learning Network (MLN)* has made available the Advanced Practice Nursing and Physician Assistants (APN/PA) Web page. This Web page is for Medicare fee-for-service (FFS) advanced practice nurses and physician assistants who provide services to Medicare beneficiaries.

You can access Medicare FFS program topics in order to keep up with policy and operational updates specific to advanced practice nurses and physician assistants.

One of the educational resources featured on this Web page is the "Advanced Practice Nurse/Physician Assistant Web-based Training Program. This interactive Web-based training program:

- provides definitions of the advanced practice nursing/physician assistant provider types
- outlines the qualifications of the advanced practice nursing/physician assistant provider types
- describes collaboration/supervision requirements for advanced practice nursing/physician assistant Medicare reimbursements
- lists the Medicare billing requirements for advanced practice nursing and physician assistants
- identifies links to Medicare manuals and other resources.

This Web page is updated on a regular basis, so check it often for timely and reliable information from *MLN*.

For more information, visit the Web page on the CMS site at [http://www.cms.hhs.gov/MLNProducts/70\\_APNPA.asp#TopOfPage](http://www.cms.hhs.gov/MLNProducts/70_APNPA.asp#TopOfPage)

### **CAN YOU BILL A PATIENT IF THEY LEAVE BEFORE COMPLETION OF THE VISIT?**

Yes and No. Both answers are correct depending on the situation. Let's say a patient arrives at your office and vitals are taken but you are delayed due to an emergency with another patient. The patient leaves due to your delay. In this situation you can not bill. However, if your nurse performed any testing, let's say the nurse does a Stat-Strep swab but the patient leaves before you can interpret and treat, you can bill for the cost of the test but not for the E/M service. In a

*Part B News* article they discuss your medical responsibility to finish the service over the phone. Call the patient with the results but even doing this doesn't allow you to bill an E/M because of the E/M requirement that the, "medical decision making was not made in the presence of the patient, and the diagnosis was not given to the patient face-to-face.

*Part B News* also stated that there are instances where a patient may walk out through no fault of yours, such as in the case of a patient who is just trying to obtain drugs and once they know you are not going to write the prescription may just leave. It was suggested that you can bill the patient for the level of E/M provided. My feeling is that this sounds doable on paper but in reality you may never be able to collect from that type of patient. Legally, you can bill.

As a management issue, I would say "walkouts" can be avoided by communication. Be sure your staff is aware of the delay and someone is talking to the other patients to explain what is going on. Walkouts are or should be rare but can be handled with prompt communication with the patients. Also in the case where you are able to bill for the cost of a test, I would suggest that any copay amount should be written off. You already have an angry patient, good public relations dictates not "pouring salt in an open wound" by billing the patient for any portion not covered by the insurance.

### **DETERMINING A "NEW" DIAGNOSIS**

When you are evaluating a patient visit to determine the level of the E/M is a condition considered a new diagnosis based upon the patient's or your physician's knowledge of the condition?

Answer: If a patient presents with a history of a condition, already diagnosed, that has never before been treated or diagnosed by your physician, the diagnosis is established, NOT NEW. For the purpose of E/M documentation a new condition is one that is new to the patient, not new to the physician.

### **BILLING THE NEW 64 LEAD ECG**

The new 64-lead ECG has been found to detect some heart attacks that might be missed by the 12-lead ECG. ST elevation myocardial infarction can be found in the 64-lead information in waveforms and 3-D color images which identifies possible ischemia and/or infarct. The 12-lead only views the anterior portion of the heart. The 64-leads are attached to the chest area, front and back, in the form of a vest covering the entire chest area resulting in a 360-degree view.

CMS has assigned payment amounts for the 3 new codes developed by the AMA for the 64 Lead ECG. 0178T – with interpretation and report, 0179T – tracing and graphics only, without interpretation and report, and 0180T – interpretations and report only. However, some third party payers may still consider this procedure as investigational. Be sure to contact the payer for their policies prior to performing this procedure.

### **NEW ECHOCARDIOGRAPHY CODES**

If you have been getting denials on your echocardiographic procedures it may be due to the code changes. The error may be yours in not using the codes or it has been found that some carriers failed to enter the new codes into their systems.

Effective January 1, 2009 a full Echo with Doppler and Color Flow add-on procedures should be coded with the new 93306 (previously you would have used 93307 plus add-ons 93320 for the Doppler and 93325 for the Color Flow). A Stress Echocardiogram should now be coded 93351 (which is inclusive of both the stress test 93015 and the echo 93350).

If you have been using these new codes 93306 and 93351 and are being denied for services after January 1, 2009, contact your carrier. If the 120 day time limit to have the claim reviewed has passed, you can still have these claims reviewed. Medicare carriers will overlook the timely filing limit on the review due to "carrier error".

### **MEDICARE TIME FILING LIMITS**

This is old information but worth going over. Medicare accepted assignment claims, by law, must be filed within one year from the date of service or the payment will be reduced 10%. There are exceptions. If the service is provided during the last 3 months of the year the end filing date is the same as the next year. If you see a patient from October 1, 2008 through December 31, 2008 you have until the end of 2009 to file those claims. If the last filing date is a, "non-workday or legal holiday the claim will be considered timely, if it is filed on the next workday", per PalmettoGBA.

Per PalmettoGBA the same filing limits apply to Medicare Secondary Payer and they suggest you file those claims promptly even if you don't expect payment.

### **WILL MEDICARE PAY FOR POWER WHEELCHAIRS?**

Absolutely and they will also pay for power scooters but there are several requirements to get this done for your patients. Some companies, that sell these items, will supply you with a form and tell you everything that is needed is covered on that form giving the impression that all you need to do is fill out their form and keep a copy in the chart. There are no specific prohibitive restrictions on the use of a form to keep a record but it must be a complete and comprehensive record of your face-to-face examination of your patient. In an audit the form alone does, "not provide sufficient documentation of a comprehensive assessment of a patient's mobility needs", per Ohio Medicare carrier, PalmettoGBA.

Here is what is needed:

1. There must be an in-person physician-patient encounter.
2. The physician must perform a medical examination for the specific purpose of assessing the beneficiary's mobility limitation and needs. The results of this exam must be recorded in the patient's medical record.
3. The prescription must only be written AFTER the in-person visit has occurred and the medical evaluation is completed. This prescription has seven required elements.
4. The prescription and medical records documenting the in-person visit and examination report must be sent to the equipment supplier within 45 days of the completion of the examination.

For more detailed information to assure you document all the necessary information go to Palmetto's site:

<http://www.palmettogba.com/palmetto/providers.nsf/DocsCat/Providers~Ohio%20Part%20B%20Carrier~Articles~DMEPOS~Power%20Wheelchairs%20and%20Power%20Operated%20Vehicles%20-%20Documentation%20Requirements?opendocument>

### **NEW CLAIM REOPENING GUIDELINES FROM CMS**

CMS has changed the claims reopening requirements with Change Request 6157 issued January 16, 2008 becoming effective and assigned the same implementation date of February 16, 2009.

According to the CR 6157 "a contractor may reopen an initial determination made on a claim between 1 year and 4 years from the date of the initial determination when good cause exists.

“Good cause” is defined as when there is new and material evidence or there was an error on the face of the evidence used to make the initial determination.

For more information here is the link to CR-6157

<http://www.cms.hhs.gov/transmittals/downloads/R1671CP.pdf>

### **LACK OF INTEROFFICE COMMUNICATION CAN LOSE INCOME**

In today's electronic office we file our claims as quick as we can enter the information into the computer. One area that can cause you problems is failure to let your front office staff know that you are sending a patient from your office to the hospital for admission. If the office bills the office visit you will not be able to bill for your *initial hospital visit* on the same date. Once you have submitted the claim you can't go back and change it either. This is your mistake and Medicare doesn't allow it to be appealed. However, if you see a patient on one date and then the patient is admitted the next date (note that I am saying date not day) even if it's not a full 24 hours from the time you first saw the patient, you can bill both and be paid for both.

### **MEDICARE PREPARES FOR AN INFLUENZA PANDEMIC EMERGENCY**

CMS has made available a dedicated Pandemic Flu Web page at [http://www.cms.hhs.gov/Emergency/10\\_PandemicFlu.asp](http://www.cms.hhs.gov/Emergency/10_PandemicFlu.asp) . This page contains all the information providers need to know in the event of a flu pandemic.

What will trigger a “pandemic” situation? The decision to implement an emergency situation would occur if; “1) The President declares an emergency or disaster under the National Emergencies Act or the Stafford Act; and 2) The Secretary of the Department of Health and Human Services declares – under chapter 319 of the Public Health Service Act – that a public health emergency exists; and 3) The Secretary elects to waive one or more requirements of the Title XVIII of the Social Security Act (Act) pursuant to chapter 1135 of such Act.”, stated in PalmettoGBA January 2009 Advisory.

If a “pandemic” is declared or any other national emergency, CMS will issue communications to Medicare Providers to specify which policies and procedures will be implemented.

There are additional CMS influenza policy documents at:

<http://www.cms.hhs.gov/Transmittals/downloads/R4040TN.pdf> ;

<http://www.cms.hhs.gov/Transmittals/downloads/R4020TB.pdf> ;

<http://www.cms.hhs.gov/Transmittals/downloads/R4030TN.pdf> ;

and <http://www.cms.hhs.gov/Transmittals/downloads/R4110TN.pdf> .

Watch for updates in your carriers advisories or if you have questions contact your Provider Call Center.

### **ANTHEM MAKES SOME COVERAGE CHANGES**

Effective April 15, 2009 Anthem Blue Cross/Blue Shield will not pay any additional amount for anesthesia services provided by the operating surgeon. The reimbursement for the anesthesia service will be part of the global amount paid for the surgery and not reimbursed separately.

In addition, April 15, 2009 is also the date that Anthem will consider chest x-rays incidental to E&M services. Per Anthem, “diagnostic radiology will be incidental to evaluation and management services when billed by the same provider. A radiologist officially interprets and writes the final report that is placed into a patient's chart, whether the services are performed in an inpatient or an outpatient setting. Anthem will only reimburse the radiologist who performs the official

interpretation and report and not another physician who does an interpretation but does not write the final official report.”

### **OHIO AUTOMATED RX REPORTING SYSTEM (OARxRS)**

OARxRS is a program that collects RX data from licensed pharmacies in Ohio (including mail-in pharmacies). This data is kept in a secured database. The information is in a patient specific format to prescribers and pharmacists for use in treating patients. You must be registered to use this service. The information is not guaranteed to be complete as it is based on data entered by dispensing pharmacies in Ohio. You are advised to contact the dispensing pharmacy for more information on any listed prescription. For more information on OARxRS contact OARxRS staff by E-Mail at [info@ohiopmp.gov](mailto:info@ohiopmp.gov); by phone at (614)466-4143; or fax at (614)644-8556.

### **AMOUNT IN CONTROVERSY CHANGED FOR FEDERAL DISTRICT COURT APPEALS**

As of January 1, 2009 the dollar limit requirement for **Federal District Court** review went up from \$1,180.00 for requests prior to 1/1/2009 to \$1,220.00 for after 1/1/2009. The amount for **Administrative Law Judge** requests remains \$120.00

### **MEDICARE COVERAGE FOR DIABETIC THERAPEUTIC SHOES**

Medicare will cover one pair of therapeutic shoes and three therapeutic inserts each year. Certain requirements are necessary including specific documentation. See this link for more detailed information:

[http://www.palmettogba.com/Palmetto/Providers.nsf/files/DME\\_MAC\\_Therapeutic\\_Shoes.pdf/\\$File/DME\\_MAC\\_Therapeutic\\_Shoes.pdf](http://www.palmettogba.com/Palmetto/Providers.nsf/files/DME_MAC_Therapeutic_Shoes.pdf/$File/DME_MAC_Therapeutic_Shoes.pdf)

### **GOOD INFORMATION ON E-PRESCRIBING**

Highmark Medicare Services had a “webinar” on e-prescribing and has this handout offering. <http://www.highmarkmedicare.com/calendar/partb/pdf/2009-02-17-webinar-handouts.pdf>  
This has a lot of good information on the new e-prescribing incentive program.

### **MEDICARE PAYMENT SCHEDULE**

Want to know more about how the Medicare Payment Schedule works? Check out this CMS information: <http://www.cms.hhs.gov/MLNProducts/downloads/MedcrePhysFeeSchedfctsht.pdf>

### **MEDICARE SECONDARY PAYER**

Because determining whether Medicare should be the primary or secondary payer is based on several federal laws it can be confusing. PalmettoGBA offers this tool: <http://www.palmettogba.com/palmetto/providers.nsf/DocsCat/Providers~Ohio%20Part%20B%20Carrier~Articles~General~MSP%20Lookup%20Tool?opendocument> to aid in that process.

### **ANTHEM OFFERS ONLINE COORDINATION OF BENEFITS QUESTIONNAIRE**

Anthem BC/BS in Indiana, Kentucky, Missouri, Ohio and Wisconsin has added a new online form on [www.anthem.com](http://www.anthem.com). Look under the Answers@Anthem tab titled “Anthem Blue Cross and Blue Shield Coordination of Benefits Questionnaire” and print off a few. If your patient has other insurance besides BC/BS print out this form and have the patient fill it out and mail it as soon as possible to the address on the back of their ID card. It may be beneficial to have them fill it out while in your office and mail it in yourself. This will expedite Anthem in processing your claim.

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