



**Professional Receivables Control, Inc.
Monthly Newsletter
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Please route to appropriate staff

PALMETTOGBA TELEPHONE REOPENING

If you haven't been using this department for your corrections, you will soon find your claims being denied as duplicates, if you just add a modifier and re-file the claim. You should be calling **866-308-5441** with your claim corrections. As long as the denial code MA130 is not on the claim. For instance, you get a denial because the patient was on hospice and requires a modifier, DO NOT ADD THE MODIFIER AND RE-FILE. Call the above phone number and they will add the modifier for you and re-open the claim for payment. In the past, Medicare let it slide, if you added the modifier and re-filed. Now you will see those claims being denied as duplicates based on the original denial.

The above number is open from 9 am to 12 pm and 1 pm to 4 pm. You can correct 3 claims on each call.

REGISTER YOUR NPI WITH ANTHEM

Anthem has two online locations for registering your NPI. For a single NPI go to: <https://npi.wellpoint.com/npi/online/onlinesubmit.jsp> For multiple NPI go to: [http://www.anthem.com/wps/portal/ahpfooter?content_path=shared/noapplication/f0/s0/t0/pw_ad081886.htm&label=National%20Provider%20Identifier%20\(NPI\)%20Registration](http://www.anthem.com/wps/portal/ahpfooter?content_path=shared/noapplication/f0/s0/t0/pw_ad081886.htm&label=National%20Provider%20Identifier%20(NPI)%20Registration)

CCI EDIT LINK

If you are reading this on the computer the following is a directive link to the Physicians NCCI Edit look-up on the CMS Website. Just click and save it to your favorites for future reference. <http://www.cms.hhs.gov/NationalCorrectCodInitEd/>

If you are reading a printed copy, you can type the above address into your browser and then save to your favorites.

This tool is extremely helpful with "bundling" issues and tells you when you can use modifier 59.

CAN A TEACHING PHYSICIAN BILL FOR READING AND EKG?

If the resident does the EKG and the interpretation and he is the only one signing the report, the teaching physician can not bill for the interpretation. However, if the teaching

physician reviews the image and the resident's interpretation **and indicates he has done so**, and signs the report, then the teaching physician can bill the interpretation. Remember just co-signing the report doesn't prove you reviewed the images and the resident's interpretation, you have to document that you did both and sign the report.

MAMMOGRAM, SCREENING OR DIAGNOSTIC?

You have a patient that has had a proven benign lesion in her breast. Do you schedule a diagnostic or screening mammogram to recheck the patient?

Per Medicare Medlearn Matters, "According to the ACR Standard of Diagnostic Mammography, a diagnostic mammogram is appropriate. Also, in the December 8, 1995 Federal Register, CMS expanded its definition of diagnostic mammography to include a personal history of biopsy-proven breast disease, thereby allowing the attending physician and the patient the opportunity to determine whether a screening or a diagnostic mammogram is performed."

MEDICARE ADVANTAGE PLANS

Remember years ago when the private Medicare plans started and we all called them HMO Medicare? Well, that term isn't true any more. The plans have morphed into many different plans. The title Medicare Advantage Plans was adopted a while ago by CMS. Under that title there still exists HMO plans and these plans are the more restrictive, assigning a primary "gatekeeper" provider and require pre-authorizations from that provider before a specialist can provide service. The HMO plans are *managed* plans.

There are also Private Fee-For-Service Plans (PFFS) that provide a more liberally managed health plan. Basically, these plans allow the patient to receive health care from any provider who is state licensed, has a Medicare billing number or be eligible to obtain one.

There are some if, ands, and buts, about these plans that you should know. There are terms and conditions that providers must follow to provide services to these participants. At a minimum there terms and conditions will specify: 1) The amount the PFFS organization will pay for all services; 2) Provider billing instructions, and 3) The amount the provider is permitted to collect from the enrollee; and whether the provider must obtain advance authorization from the PFFS organization before furnishing a particular service.

They refer to the providers as "deemed". This is because you don't have to have a legal contract to treat these patients but you do have to know and understand the terms and conditions before providing the services to be a deemed provider. How do you do this?

CMS tells us that "for the most part" patients will give you their insurance information before you provide service. Might I add here that this is the function of your front desk personnel? They are the "gatekeepers" for your practice and you should never have a patient in your exam room that hasn't been screened by your front desk. Now, having said that, once a patient presents the PFFS ID card it is up to you to contact the plan for information on its terms and conditions. Each card carries a website and/or phone number. The card usually holds the address where the claims are to be filed and the copay amounts, but the amount that the PFFS will pay you for a given service will have

to be determined by the phone call. Once the patient has informed you of the coverage and you provide service you are a deemed provider (even if you don't take the time to call the plan for specifics) for this patient. The process is by patient, you are deemed for this one patient. This does not mean that you are contracted for every patient with this plan.

What happens if the terms and conditions aren't met? In an instance of emergency where you treat a patient without knowledge of the patient's enrollment in the PFFS plan, you are a non-contract provider. You are guaranteed that the payment you receive from the PFFS plan, and what you are allowed to collect from the patient, will be the same as under regular Medicare.

Remember that once you have the id card which gives you knowledge of the PFFS plan, you are required to accept what they pay combined with the patient copay amount as payment in full and this amount may not be as much as regular Medicare or in some cases more. IF you choose not to make the call to find out in advance, you are still bound to accept their payment in full, along with the patient copay amount.

Your contract with regular Medicare does not require that you see PFFS enrollees, this is your decision on a case by case basis.

These plans are required, by law, to cover all services that regular Medicare would cover and pay your clean claims within 30 days of receipt.

If the service is denied as "non-covered" you may collect from the patient. For example, if the plan doesn't pay for hearing aides, you collect from the patient.

Unicare is one of these plans and the card plainly states that you should not bill regular Medicare and tells you to call the plan for complete copay and coverage information.

I am seeing that patients are presenting both the Palmetto GBA Medicare card and the PFFS cards and the office is entering the PFFS plan as secondary. Please READ the ID cards that are presented and enter accordingly.

E/M SERVICES REST HOMES OR NURSING HOMES

If you see a patient in a "rest home" this is signified as domiciliary, rest home or custodial care services in the CPT codes. For new patient use range 99324-99328 and established patient use range 99334-99337 with place of service 33. Remember these are viewed as the same level of care provided in a home visit, this is not a facility that provides nursing level care, so you have "new" and established".

If you see a patient in a nursing facility, use range 99304-99306 for initial services and 99307-99310 for subsequent services with place of service 32. This is viewed as initial and subsequent like in the hospital, differing from the new and established services provided in the rest home setting.

CONTINUOUS AEROSOL TREATMENT

If you are providing inhalation therapy for a period of an hour or more you should be using 94644 for the first 60 minutes and if the treatment continues for an additional 60

minutes you also use the add on code 94645. Remember that 94645 requires a complete and total addition of 60 minutes to be billed so if you gave 2 hours of treatment you bill 94644 and 94645. If the treatment is under an hour, use 94640. The 94640 describes small treatments several times a day at short intervals (usually at 10 minutes). The 94644 and 94645 is administered for longer periods of time and then discontinued. This provides a higher dose of medication and requires different equipment.

NON-PHYSICIAN PROVIDERS AND HPI

There are many practices using NPPs in today's market and I have copied below the exact question and answer from Medicare's Question and Answer section for your information:

Can the Physician Assistant (PA), Medical Assistant (MA), or Registered Nurse (RN) document the HPI and the physician/NPP refer to what the PA, MA, or RN documented? For example, "agree with above note."

Answer: Recently, Palmetto GBA received clarification from CMS on the answer to this question. Per the 1995 and 1997 E/M documentation guidelines the ONLY portion of the history that may be PERFORMED by ancillary staff of the physician (e.g., employed RN, LPN, CNA etc.) are the Review of Systems and Past/Family/Social History and it MUST be reviewed by the physician or NPP who MUST write a statement that it is reviewed and correct or add to it.

Only the physician or NPP who is conducting the E/M visit can PERFORM the History of Present Illness (HPI). This is physician work and not relegated to ancillary staff. The exam and medical decision making are also physician work and not relegated to ancillary staff.

If ancillary staff are present he/she could document what is dictated and performed by the physician or NPP in the HPI but the ancillary staff CANNOT PERFORM the HPI.

It is very important to convey whether you are addressing documenting or performing.

Resources:

CMS 1995 & 1997 E/M Guidelines -
http://www.cms.hhs.gov/MLNEdWebGuide/25_EMDOC.asp

- Palmetto GBA Web site - <http://www.PalmettoGBA.com/boh/Guide> (Ohio) or <http://www.PalmettoGBA.com/bwv/Guide> (West Virginia), and select Evaluation and Management Guidelines, Documentation & Coding Tips.

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