



**Professional Receivables Control, Inc.  
Monthly Newsletter  
April 2008**

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**NPI DEADLINE WAS MARCH 1 FOR FEE FOR SERVICE PROVIDERS**

As of March 1, 2008 all claims to Medicare must have the NPI or NPI/Legacy combination in the primary provider fields. Per CMS:

- If you have been submitting claims with your NPI and PTAN combination, nothing will change.
- If you have been successfully submitting claims with your NPI only, nothing will change.
- If you have not already begun submitting claims to your local carrier with your NPI, these changes affect you.

If your claims are rejected (electronically through GPNet, or if you are notified on your Remittance Advice) for NPI related reasons on or after this date, please have a copy of your reject message and a copy of your NPPES file (your NPI credentialing information, filed with the NPI Enumerator) available before calling your local Medicare carrier. This will allow us to research your issue thoroughly and help you as quickly as possible.

The same holds true for Railroad Medicare. You must register through the state carrier offices and they will turn that registration information over to Railroad Medicare. You do not have to register directly with Railroad Medicare.

**Additionally for claims submitted on May 23 and after, in addition to rejecting claims that contain ONLY a PTAN, Medicare carriers will also begin rejecting claims that contain a PTAN and NPI combination. All claims submitted on or after May 23 can contain the NPI only.**

***In order to test NPI only submission of claims in your practice, you must do the following:***

- 1. Enter NPI numbers for all of your referring physicians***

## **2. Notify carriers of your NPI numbers**

**3. Contact PRC to turn on NPI only submission. This can be done by insurance carrier (i.e. Anthem, MMO, MC)**

**We strongly urge you to start testing now. The deadline for submitting NPI only to ALL INSURANCE CARRIERS is 5/23/08. At that time, all practices will be switched to NPI only, whether you have tested NPI only submission or not.**

**Test now to prevent a cash flow interruption later.**

## **IDENTIFYING YOUR PATIENT'S MEDICARE PLAN**

Did you know that you can access your patient's coverage information by using the Web site which is the official government site for people with Medicare? Especially at the beginning of the year when the patient's may have changed their plans and still don't have their cards or forget to bring them this is very helpful. You can also get plan information from the Provider Call Center but if that line is busy try looking on the website.

The site is [www.medicare.gov](http://www.medicare.gov) and there is some information you will need from your patient to find out what plan they have signed up for. First you must have their Medicare Health Insurance Claim Number (for most patients this will be their social security number with an alpha suffix which you will find on their original red, white and blue Palmetto GBA Medicare card (Ohio) or appropriate card for your state). You must also have their Part B effective date from that card and the patient's last name and date of birth and zip code. Now you are ready to go to the website [www.medicare.gov](http://www.medicare.gov).

Once on the site, go to "Medicare Prescription Drug Plans – 2008 Plan Data" from the middle area of the page. Click on "Find & Compare Plans". Now "Begin Personalized Search". Complete the form with the patient's information described above.

The site will identify your patient as being enrolled in a specific Medicare Advantage (MA) plan, or HMO. With this information you can now file your claim with the correct HMO.

If you get a negative response it may mean that the site only carries information on the patient's RX coverage and they have other carriers for their Medicare. If this happens you can get information through the Medicare Plan Provider Call Center. For Palmetto GBA that number is 1-877-567-9232.

If you get a "Plan details unavailable" it may be a data entry error. Check the patient information for accuracy and try again.

## **SHARING CRITICAL CARE CODES AND NEW PAYMENT POLICIES**

Per CMS; two physicians can combine the time they spend caring for a patient in critical care if they have the same specialty but a physician can not combine time shared with a Non-Physician Provider (NPP).

Critical care codes are based on time spent with the patient; 99291 is 30-74 minutes with add-on code 99292 for each additional 30 minutes. Per *Part B News, January 14, 2008, Volume 22, Issue 2*; if one physician sees the patient in the morning, providing only 20 minutes of critical care and another physician in the practice sees the same patient later in the day for 20 minutes they can combine their time equaling 40 minutes and bill the 99291.

If the physician sees the patient for 20 minutes in the morning and then the patient is seen by the NPP later in the day for 20 minutes neither can bill the 99291 because the physician can not combine his time with the NPP's time and neither spent enough time alone to bill the 99291. The only code billable would be with one unit of the subsequent hospital code range 99231 – 99233.

If the NPP had met the 30 minute minimum time requirement for the 99291 the NPP can bill the critical care independently. However, if two NPPs share the critical care they are not permitted to combine their time as the physicians are permitted to do. NPPs can perform critical care but are paid at a reduced rate of 85%, while the physician receives the full 100%.

From a Palmetto GBA release, there has been a Change Request 5792 that makes some changes in the payment policies for E/M services and Critical Care services provided on the same day.

- When a hospital inpatient (or emergency department or office/outpatient) evaluation and management (E/M) service is furnished on a calendar date at which time the patient does not require critical care and the patient subsequently requires critical care, both the critical care services (Current Procedural Terminology (CPT) codes 99291 and 99292) and the previous E/M service may be paid for the same date of service.
- During critical care management of a patient those services that do not meet the level of critical care should be reported using an inpatient hospital care service with CPT Subsequent Hospital Care using a CPT code in the 99231-99233 range.
- Physicians and qualified NPPs may report both critical care services and an inpatient hospital care service for the same patient on the same calendar date when during critical care management of a patient the services do not meet the level of critical care services.
- Physicians and qualified NPPs are reminded that both Initial Hospital Care codes (CPT codes 99221-99223) and Subsequent Hospital Care codes are “per diem” services and may be reported only once per day by the same physician or physicians of the same specialty from the same group practice.
- Physicians and qualified NPPs are advised to retain documentation for discretionary Medicare carrier or A/B MAC review in case claims are questioned. The retained documentation must support why the same physician or physicians of the same specialty in a group practice submitted claims for both critical care services and other E/M services for the patient on the same date of service.

**Additional:**

You may see the official instruction (CR 5792) issued to your Medicare A/B MAC or carrier by going to <http://www.cms.hhs.gov/Transmittals/downloads/R1473CP.pdf>.

If you have questions, please contact their office at 1-877-567-9232.

**BONE MASS MEASUREMENT (BMM) BILLING REQUIREMENTS**

CMS has clarified how BMM must be billed to qualify for payment. Certain BMM tests to screen patients for osteoporosis are covered but subject to frequency standards which are detailed here [http://www.cms.hhs.gov/mcd/viewlcd.asp?lcd\\_id=6926&lcd\\_version=46&show=all](http://www.cms.hhs.gov/mcd/viewlcd.asp?lcd_id=6926&lcd_version=46&show=all).

Medicare contractors will pay BMM for screening when coded: 77078 through 77081, 77083, 76977 or HCPCS G0130. The claims must contain valid ICD-9 diagnosis codes indicating the reason for testing is postmenopausal female, vertebral fracture, hyperparathyroidism, or steroid therapy.

Medicare contractors will deny 77078, 77079, 77081, 77083, 76977 and G0130 if there is no diagnosis code for the above mentioned reasons. (77080 is detailed below.)

Dual-energy x-ray absorptionmetry tests are covered when used to monitor FDA approved osteoporosis drug therapy but subject to the 2 year frequency standard.

Medicare contractors will pay 77080 if one of the following diagnosis exists; 733.00, 733.01, 733.02, 733.03, 733.09, 733.90, or 255.0 as long as one of the aforementioned diagnosis (postmenopausal female, etc.) is also included.

You can view additional information here [www.cms.hhs.gov/transmittals/downloads/R1416CP.pdf](http://www.cms.hhs.gov/transmittals/downloads/R1416CP.pdf). You can save this file for future reference.

You are urged to use the Advanced Benefit Notice to inform your patient of their rights and let them make the decision to have the test, if there is any concern that Medicare will deny the claim.

### **CMS ISSUED A NEW ADVANCED BENEFIT NOTICE (ABN)**

Mandatory use of the new ABN isn't until September 1, 2008 but it is available to use now.

Firstly, the name has been changed to Advance Beneficiary Notice of Non-coverage. It will still be shortened to the familiar ABN.

Familiarize yourself with the changes in the forms. It is now a consolidation of the two existing ABN forms, the ABN for general services that you are familiar with and the ABN for lab services. The new ABN replaces both. The new ABN can be used instead of the NEMB (notice of Exclusion of Medicare Benefits). It also contains a field that must be filled out with the estimated cost of services; this is mandatory and necessary to stay compliant. There is also a new option that allows the patient to choose to pay for the service without having a claim submitted to Medicare.

You are not permitted to make any changes to the new ABN. According to Part B News, there is a Spanish version in the making but CMS has not released it yet. Once that Spanish ABN is available you must complete it in Spanish. Some practices have combined the ABN with the office financial policy, one on each side of a single paper. You will no longer be able to do that as it is considered altering the ABN which is forbidden. You must keep the ABN on a separate sheet of paper but you can print it on your letterhead. Part B News tells us that you may also pre-print a single procedure that you use repeatedly on the new ABN.

You will find the new ABN on CMS's website at [www.cms.hhs.gov/bni](http://www.cms.hhs.gov/bni)

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