



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

Please route to appropriate staff

Newsletter access is also available through the help menu

HELP DESK HINT

Many features are available in the ELF by right clicking on an account, a visit or a transaction. Here are some new ones that were just added:

To see all Private Pay Payments posted to an account as entered in the Visit List right click on a visit and select View As-Entered Patient Pmts. This is also available in the Claims Statistics screen.

To view the Work Request history for the account or the visit, in the Claim Statistics screen right click on a visit and select View Work Reqs for Acct or View Work Reqs for Visit.

NEW MODIFIER FOR UNUSED PORTION OF DRUG

If you are billing Medicare for Part B drugs other than those in the Competitive Acquisition Program you may be required to use the modifier JW to signify that you are billing the unused portion of a single vial dose. **The carriers were given the ability to choose to use this modifier or not to use it. Check with your local carrier to see if they are requiring the JW modifier.**

The directive to your local carrier is available at:
<http://www.cms.hhs.gov/transmittals/downloads/R1478CP.pdf>

The associated *MLN Matters* article is available at:
<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5923.pdf>.

NPI DEADLINE FOR REFERRED SERVICES

As of May 23, 2008, Medicare tells us that they, "will no longer pay for referred or ordered services or items; unless the fields for name and NPI of the ordering, referring and attending, operating, or other, or service facility providers are completed on claims."

It is the submitter's responsibility to use the ordering, referring and attending, operating, other, service facility providers, or purchased service providers NPIs for claims. However, **if you make every effort to obtain the referring providers NPI but fail, you may report your own name**

and NPI in the ordering/referring/attending/operating/other/service facility provider/purchased service provider fields of the claims.

SUBSEQUENT HOSPITAL VISITS AND DISCHARGE DAY

Following a surgery, during the global surgery period subsequent visits codes 99231, 99232, and 99233 are NOT billable. This applies to both physicians and NPPs and even when the billing is fragmented due to a staged procedure. **Never bill subsequent days during the global period.**

Hospital Discharge Management codes 99238 and 99239 represents face-to-face service between the attending physician and the patient. **Only the attending physician of record, or a physician acting on behalf of the attending, may report Hospital Discharge Management.**

Physicians and NPPs who provide concurrent care, not managed by the attending physician, should bill Subsequent Hospital Care codes 99231, 99232, or 99233 for their final visit.

Remember only one Discharge Management is allowed per hospital stay and that should be billed as stated above, by the attending or a covering physician acting on the attending physicians part. However, if the Discharge Management Services (DMS) are provided the day before the patient actually leaves the hospital, you can still bill DMS but you must use the date that the service was provided. Remember, if you see the patient again on the date the patient leaves the hospital you may not bill a subsequent day after the date that you billed the DMS.

You may also bill DMS and a nursing home admission on the same day but both of these services must be face-to-face services at both facilities.

For more information on Discharge Management see CMS Manual at <http://www.cms.hhs.gov/transmittals/downloads/R1460CP.pdf>

As covered in last months newsletter, if the patient is admitted and discharged on the same date the Observation or Inpatient Care Services should be billed.

In the case of patient death, only the physician who personally performs the pronouncement of death should bill the face-to-face Hospital Discharge. Per CMS, "The date of death pronouncement shall reflect the date of service on the calendar date it was performed even if the paperwork is delayed to a subsequent date."

SMOKING AND TOBACCO CESSATION COUNSELING CODE UPDATES

For all services after December 31, 2007 HCPCS codes G0375 and G0376 have been replaced by 99406 – Smoking and tobacco-use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes; and 99407 – Smoking and tobacco-use cessation counseling visit; intensive, greater than 10 minutes.

NEW THORACENTESIS CODES FOR 2008

Two new codes were initiated in 2008; 32421 – thoracentesis and 32422 – thoracentesis with insertion of tube.

32421 can be billed with the following imaging codes: 76942 – ultrasound guidance for needle placement, 77002 – fluoroscopic guidance for needle placement, and 77012 computed tomography guidance for needle placement.

Do not bill 32422 with the following surgery codes: 19260, 19271, 19272, 32503, or 32504.

BREATHING CAPACITY BILLING HINTS

If you are billing 94200 – maximum breathing capacity, maximal voluntary ventilation (MVV) this is considered a component of 94010, 94060 and 94070. Do not bill 94200 separately with any of these codes. However, if you perform a 94200 separately on the same date as another MVV or spirometry, be sure to append modifier 59 and bill both.

OUTPATIENT THERAPY CAPS FOR 2008

Wow, hang on to your wallets! If you are providing physical therapy, speech therapy and occupational therapy in your office you have been given a whopping \$30.00 increase in your CAP amount.

As you know, the CAP is combined for physical and speech therapies and was \$1,780.00 in 2007 and for occupational therapy another \$1,780.00. For 2008 your CAP amounts have been raised to \$1,810.00. Be sure to watch you patients closely and add the modifier KX, if the patient's diagnosis qualifies for the extension, once the \$1,810.00 CAP is reached.

IMPACTED CERUMEN REMOVAL

You can bill Medicare for both an E/M and earwax removal as long as the earwax removal is not related to the E/M and requires, for medical reasons (danger of laceration or infection), that the wax removal is done by a physician or non-physician practitioner.

You must document why it was necessary for you to remove the cerumen as stated above and modifier your E/M code with a 25 and use the 69210 for the cerumen removal.

Per *Part B News*, Medicare will not pay for routine earwax removal (with softeners and swabs) as it is part of the office visit.

Audiologists are not permitted to bill earwax removal.

RECOVERY AUDIT CONTRACTOR (RAC)

We are all familiar with Medicare Carriers and Advance Med (CERT Program) requesting records from us to check the validity of our claims but there is a third entity on the horizon that will be asking for records to determine if there has been an underpayment or overpayment and then pursue the overpayment from you. For underpayments the contractor will notify your local carrier to process additional payment to you.

RAC was tested in three states, California, Florida and New York from May of 2005 through March of 2008. They are evaluating the cost effectiveness of the program but it looks like it will be implemented by 2010 in all 50 states.

As with the others, you will have a venue to protest any finding.

For more information go to www.cms.gov/rac/

CONSULTS CARRIER HIGH ERROR RATE

One out of every five consultations review in the Comprehensive Error Rate Testing Program failed to meet the documentation requirements to support the level of consult billed.

From Palmetto GBA, the Ohio Medicare Carrier: Tips for Correct Coding:

- All consultations require documentation of the level of history, physical examination, and medical decision making. These are the key components of Evaluation and Management (E/M) services, including consultations.
- For all consultations submitted to Medicare, documentation in the patient's medical record must meet or exceed the level of service for all three of these three key components, as specified in Current Procedural Terminology (CPT). If any one of the three key components is not documented at the specified level, select the CPT code that encompasses the lower level of service.
- Documentation in the patient's medical record for consultations must also include a documented request from the referring physician for opinion or advice, evidence of the opinion rendered by the consulting physician, and a written report from the consulting physician to the referring physician or healthcare practitioner.

What You Can Do:

- You are encouraged to conduct self-audits on claims submitted to Palmetto GBA. You may use any one of a number of privately developed "scoring" tools or Palmetto GBA's E/M Score Sheet (available on their Web site).
- Ensure that new staff in your office understands the E/M Documentation Guidelines. Palmetto GBA offers periodic workshops designed to familiarize office staff and clinicians with these guidelines.
- If you submit claims to Palmetto GBA for consultations, they may contact you to ensure that you understand the documentation guidelines associated with these services. Again, it is important to note that their goal is to assist you in filing accurate claims.

References:

- E/M Documentation Guidelines, developed by the Centers for Medicare & Medicaid Services (CMS) and the American Medical Association (AMA): http://www.cms.hhs.gov/MLNEdWebGuide/25_EMDOC.asp
- The Palmetto GBA E/M Help Center includes E/M "frequently asked questions," educational resource materials, and the Palmetto GBA E/M Score Sheet. The E/M Help Center is located under "Articles" on the Ohio and West Virginia home pages:
 - Ohio: <http://www.PalmettoGBA.com/boh>
 - West Virginia: <http://www.PalmettoGBA.com/bwv>
- For a schedule of upcoming Palmetto GBA E/M workshops, refer to our Education Web pages, under "workshops":
 - Ohio: <http://www.PalmettoGBA.com/boh/education>
 - West Virginia: <http://www.PalmettoGBA.com/bwv/education>
- Read more about the CERT program on the CMS Web site: <http://www.cms.hhs.gov/cert>

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