



**Professional Receivables Control, Inc.  
Monthly Newsletter  
June 2007**

**Please route to appropriate staff**

**PHYSICAL QUALITY REPORTING INITIATIVE (PQRI)**

Medicare is now paying bonuses through their PQRI program. For more information see [www.cms.hhs.gov/PQRI](http://www.cms.hhs.gov/PQRI) for the final list of 74 PQRI measures. At that link see a list of codes and guidelines at [www.cms.hhs.gov/PQRI/Downloads?Specifications\\_2007-02-04.pdf](http://www.cms.hhs.gov/PQRI/Downloads?Specifications_2007-02-04.pdf). On the AMA website there is more information at [www.ama-assn.org/ama/pub/category/4837.html](http://www.ama-assn.org/ama/pub/category/4837.html)

**MODIFIER HELP**

If modifiers confuse you, Palmetto GBA has come to the rescue with an easy access to the complete definitions and guidelines for usage on their website. Go to [www.palmettogba.com](http://www.palmettogba.com) and click on *Modifier Lookup*. This is only one of the new **Cool Tools & Top Links** that are provided on the Palmetto site.

**MEDICARE SECONDARY WHEN PRIMARY HAS A COPAY**

In the April 2007 Medicare Advisory they tell us that you must **not** collect the primary copay amount from the patient at time of service if the patient has Medicare as secondary payer. You must bill Medicare, after the primary pays and only collect from the patient after the claim has been processed through Medicare. Medicare's eob will tell you if the patient is responsible for any balance.

**PROSTATE CANCER SCREENING**

Medicare will pay for Digital Rectal Exam (DRE) and Prostate Specific Antigen (PSA) once a year if at least 11 months have passed following the month in which the last tests were performed. Medicare will cover these tests for all male patients age 50 or older (coverage begins the day after the patient's 50<sup>th</sup> birthday). Use the following codes G0109 for the digital exam and G0103 for the PSA and use Dx. code V76.44 Special Screening for Malignant Neoplasms, Prostate.

**BILLING MEDICARE FOR COLON CANCER SCREENING TESTS**

**Fecal occult blood test (FOBT)** Medicare covers one FOBT for patients 50 and older. Use 82270 (FOBT, 1-3 simultaneous determinations) Note that these tests are sent home with the patient and to be returned for evaluation. Do not bill Medicare until you receive the cards back. If the patient fails to complete the cards and return them, you can not bill Medicare. So it is advisable to avoid billing for the tests until they are returned.

**Screening flexible sigmoidoscopy (SFS):** Medicare covers this test once every 4 years on patients 50 and older. If the patient had a screening colonoscopy in the last 10 years, then the next SFS won't be covered until 119 months have passed following the last colonoscopy.

**Screening colonoscopy:** This is covered on patients 50 and older based on **risk**. Patient's not considered to be high risk for developing colorectal cancer; Medicare will pay for 1 screening colonoscopy every 10 years, but not within 47 months of a screening flexible sigmoidoscopy.

For high risk patients, Medicare will pay for 1 screening colonoscopy every 2 years regardless of age.

**Screening barium enema:** Medicare pays for this test as an alternative to the screening flexible sigmoidoscopy under the same requirements but this is an either/or situation. Medicare will not pay for both.

Medicare will also pay for a barium enema as an alternative to the screening colonoscopy for high risk patients under the same requirements but again it's an either/or situation and Medicare will not pay for both.

Starting January 1, 2007 there is no deductible applied to these screening tests and the patient will be responsible for only his 20% co-payment amount. However, the deductible will be applied if the test changes from screening to diagnostic, that is if there is a biopsy or removal of a lesion or growth during the sigmoidoscopy or colonoscopy.

There was a change in the patient copay amount from 20% to 25% if the services are performed in a non-outpatient prospective payment system hospital outpatient department or an ambulatory surgical center.

Use the following codes: 82270 for the fecal occult blood test, 3 single cards or a single triple card for consecutive collection. G0104, flexible sigmoidoscopy, G0105 colonoscopy, high risk. G0106 barium enema as an alternative to the G0104 sigmoidoscopy. . G0120 barium enema as an alternative to the G0105 colonoscopy. G0121 colonoscopy, not high risk. G0122 barium enema (not covered). You will want to bill this to Medicare when a patient is requesting a BE to screen to get the Medicare denial to then be billed to secondary carrier. Remember Medicare only covers a BE in lieu of covered screening sigmoidoscopies or colonoscopies. The patient is liable for the non-covered barium enema. G0328 colon cancer screening; fecal occult blood test, immunoassay.

### **CONSULTS AND SPLIT/SHARED VISITS**

Under Medicare policy you can not share a consult, a critical care service or procedures. See Palmetto GBA April 2007 Advisory, page 58.

### **PHYSICIAN QUALITY REPORTING INITIATIVE SPECIFICATIONS**

CMS has released specifications for the 74 measures included in the 2007 PQRI. This program provides financial incentives for health care providers who participate in the voluntary reporting program. You can find the specifications at [http://www.cms.hhs.gov/PQRI/Downloads/Specifications\\_2007-02-04.pdf](http://www.cms.hhs.gov/PQRI/Downloads/Specifications_2007-02-04.pdf) General information on this program can be found at [www.cms.hhs.gov/PQRI](http://www.cms.hhs.gov/PQRI)

## **MEDICARE INITIAL PREVENTIVE PHYSICAL REMINDER**

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 provides for an initial preventive physical examination (IPPE), including a screening electrocardiogram (EKG) for eligible NEW beneficiaries. This is a once-a-lifetime benefit for the beneficiary.

### **Applicable HCPCS codes are:**

**G0344** - Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first six months of Medicare enrollment.

**G0366** - Electrocardiogram, routine ECG with 12 leads; performed as a component of the initial preventive examination with interpretation and report.

**G0367** - Tracing only, without interpretation and report, performed as a component of the initial preventive examination.

**G0368** - Interpretation and report only, performed as a component of the initial preventive examination.

**1. A beneficiary is eligible when he *FIRST* enrolls in Medicare Part B and only payable if the IPPE is performed *WITHIN* the first 6 months of coverage.**

2. The IPPE examination must be performed by a doctor of medicine or osteopathy as defined in Section 1861 (R) (1) of the SSA or by a qualified non-physician practitioners (NPPS).

3. If the physician or qualified NPP is not able to perform both the examination and the screening EKG, an arrangement may be made to ensure that another physician or entity performs the screening EKG and reports the EKG separately using the appropriate HCPCS G code. The primary physician or qualified NPP shall document the results of the screening EKG into the beneficiary's medical record to complete and bill for the IPPE benefit. **NOTE:** Both components of the IPPE (the examination and the screening EKG) must be performed before the claims can be submitted by the physician, qualified NPP and/or entity.

4. Refer to CMS IOM Manual, Pub 100-04, Chapter 12, and Section 30.6.1.1 for complete details for submitting these services:

<http://www.cms.hhs.gov/manuals/downloads/clm104c12.pdf>

### **INCIDENT-TO BILLING**

If you are having trouble deciphering Incident-To billing, Medicare has come to the rescue.

<http://www.palmettogba.com/palmetto/providers.nsf/44197232fa85168985257196006939dd/85256d580043e754852571e9005ba112?OpenDocument> this link will take you to an online learning course that takes about 20 minutes and should help you shift through all the information and how to use it.

### **BILLING FOR A DECEASED PROVIDER WHO DID NOT GET AN NPI**

Hopefully, no one will have to deal with this situation but if there is an instance where you have a provider who is deceased and you bill for services after May 23, 2007 and Medicare hasn't been notified of his death, you will have to file hardcopy. There is a process already in place where each State notifies Medicare of the death of a provider.

However, some States do this quarterly. So if this is the case, the representative of the provider's estate must contact the processing contractor, i.e. Palmetto GBA, and in turn Palmetto will notify you that you must file any remaining claims on a HCFA and note on the HCFA that the provider is deceased in Item 19.

**HELP DESK HINT**

CMS has announced that it will be disseminating NPI numbers. The target date is June 28, so watch for that being announced.

However, in the ELF you will find a "Master NPI List" to assist our clients. This list is located in Maintenance, View Only, and Master NPI List. This information is for reference only and used to access "missing" NPI #'s that are needed for claim submission. Please feel free to contact the Help Desk or go to [www.palmettogba.com](http://www.palmettogba.com) to learn more about NPI #'s and how to use them.

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