



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

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INCIDENT-TO UPDATE

The Centers for Medicare & Medicaid Services has notified Medicare contractors that change request 5288, transmittal 87BP, titled "Incident to Policy Update" has been rescinded and it will not be replaced at this time.

BILLING SELF-REFERRED MAMMOGRAMS

In the past, Medicare fiscal intermediaries told providers to use the surrogate UPIN of SLF000 in the Attending Physician UPIN field on the institutional claim form. On a self-referred mammogram, you are now instructed to use your own NPI in that field as no attending/referring physician NPI is available. *You must make a good effort to try to get the referring NPI.*

JULY UPDATE TO MEDICARE PHYSICIAN FEE SCHEDULE DATA BASE

Effective July 1, 2008 Medicare payments changed how they are calculated. There is no longer a geographic adjustment and the conversion factor is now \$34.0682 resulting from a 0.899 update. For more information go to:

[http://www.palmettoqba.com/palmetto/providers.nsf/\(Docs\)/A1231BC02DCDCBE98525745E005CCEE0?OpenDocument](http://www.palmettoqba.com/palmetto/providers.nsf/(Docs)/A1231BC02DCDCBE98525745E005CCEE0?OpenDocument)

OUTPATIENT THERAPY CHANGES EFFECTIVE JULY 1, 2008

The Balanced Budget Act of 1997 enacted financial limitations to outpatient therapies; physical therapy, occupational therapy, and speech-language pathology services in all settings except outpatient hospital services. The 2006 Deficit Reduction Act put further exceptions on those limits, through June 30, 2008.

As stated in *MLN Matters* article, MM5871, exceptions to the \$1810 outpatient therapy caps were allowed from January 1, 2008, to June 30, 2008, for medically necessary services that were appropriately billed with modifier **KX**. **On or after July 1, 2008**, the exceptions to therapy caps are restricted to those medically necessary services billed by the outpatient departments of hospitals. **Use of the modifier KX will not be effective on or after July 1, 2008.**

If, on July 1, 2008, a cap has already been reached, a beneficiary, who is not a resident in the Medicare certified part of a skilled nursing facility, will be able to have medically necessary

services, that exceed the cap, only when the services are billed by the outpatient department of a hospital. A beneficiary in a Medicare certified skilled nursing facility is restricted, by consolidated billing rules, from coverage of services that are billed by a hospital.

Here is the link to the *MLN Matters special edition article* [SE0815](#) .

CRITICAL CARE AND NEONATAL INTENSIVE CARE

If you don't follow the *Medicare MedLearn Matters* here is another example of the benefit of reading them. As of July 7, 2008 Change Request 5993 was implemented. The MLM article explains the definition of critical care and how to bill for them. It discusses medical necessity, full physician attention, counting the hours of critical care billing. There is a lot more information in the article. Here is a link so you can read the whole article <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5993.pdf>

Part B News also tells us that Transmittal 1530 to the Medicare Processing Manual completely replaces the section on critical care and neonatal intensive care. It updates references to the new 2008 blood draw code 36591. Most of the transmittal deals with clarifications that they now cover with clinical examples and documentation examples which previously were only given general definition. For example you can now bill both critical care and an E/M code if a patient presents to the ER and you do an E/M service that shows no specific problem but you order the patient to stay for observation. Later that day the patient goes into cardiac arrest. Under the new law you can bill both the E/M and the critical care given later due to the arrest.

Here is a link to Transmittal 1530: <http://www.cms.hhs.gov/transmittals/downloads/R1530CP.pdf>

PROPER CODING FOR DIABETIC NEUROPATHY

If you are a neurologist and treating a patient for neuropathy, you need to report the diagnosis codes in the proper place and order.

Neurology Coding tells us three steps to use the right coding.

First: Code Diabetes First. For diabetic neuropathy, code 250.6x (Diabetes with neurological manifestations) with the appropriate 5th digit depending on the patient's condition and use that code as the primary diagnosis. Whether you use 337.1 (Peripheral autonomic neuropathy in disorders classified elsewhere) or 357.2 (Polyneuropathy in diabetes) depends on which meets the ICD-9 requirements for coding to the highest specificity. Diabetes often causes neuropathy, a general term for damage or destruction of the peripheral nerves. Adhere to these coding combinations: Polyneuropathy (357.2 can only be paired with diabetes (250.6x). But you can list neuropathy (337.1) with a primary diagnosis of diabetes 250.6x) or amyloidosis (277.30-277.39).

Second: Polyneuropathy = Peripheral Mononeuropathy. Memorize this phrase before deciding on your diagnosis. Equate polyneuropathy with peripheral mononeuropathy. AHA's ICD-9 *Coding Clinic* lists 250.6x and 357.2 as the codes for peripheral (or cranial) neuropathy (see fourth digit 6: 250.6x in the 1991 third-quarter issue).

Third: Watch for Digit Pain, Body Problems. Focus on patient symptoms and E/M service details for clues to identify peripheral neuropathy (polyneuropathy) (PN) versus autonomic neuropathy (AN).

Symptoms are different for PN versus AN. **Peripheral neuropathy – digit pain.** Symptoms for peripheral neuropathy include pain and numbness in hands and feet. Patient's will typically describe this as tingling or burning and complain of a loss of sensation akin to wearing a thick

stocking or glove. (Mayo Clinic (www.mayoclinic.com/health/peripheralneuropathy/DS00131)).

Causes: Peripheral neuropathy can have multiple causes, traumatic injuries, infections, metabolic problems and toxins. Commonly, diabetes is a cause for peripheral neuropathy. The symptoms of peripheral neuropathy often go away once the underlying condition is resolved. **Action:** If the physician only indicates peripheral polyneuropathy with no other specificity, the coder must look to the 357.x (Inflammatory and toxic neuropathy...) code range depending on the underlying disease. For instance use 357.2 for diabetes. **Autonomic neuropathy – body function.** Autonomic neuropathy (AN) is damage to nerves regulating involuntary body functions. AN results in faulty communication between the brain and part of the body that the autonomic nervous system serves. To treat AN, the physician treats the underlying cause, if possible, and manages the signs and symptoms. If the physician documents that the peripheral neuropathy involved the autonomic nervous system, look at 337.1 as the code to use.

ALTERNATIVE SIGNATURES OK'D FOR HOSPICE CERTIFICATIONS

CMS has reversed its requirement for handwritten signatures on Hospice certifications. *Part B News, April 7, 2008 issue*, reported that CMS Transmittal 248 to its Program Integrity Manual reversed its directive that handwritten signatures were required. The information was released on March 28 and must be implemented by carriers by April 28 but there is a retroactive implementation date of September 3, 2007.

Medicare carriers have now released this information also, not only will they accept an electronic signature but they will accept any facsimile signature also (stamp, etc.)

There is a requirement that a hard copy of the electronic signature be kept in the patient's file. This may cause some problem in offices that have gone completely to electronic medical records. However, it is a requirement, so if you use the electronic certification on a Hospice patient, be sure to keep a hard copy on file.

BILLING UNATTENDED OXIMETRY

Medicare will pay for oximetry, unattended, when provided in a certified sleep-lab. They will not cover unattended oximetry in the patient's home nor in a mobile facility. Here is some guidance in billing from *MedLearn Matters*:

When billing for this service, CPT code 94762 most appropriately represents the continuous overnight oximetry trend study.

For a limited group of payers, continuous overnight oximetry is considered medically necessary when done for one of the following circumstances: 1) The patient has a condition for which intermittent arterial blood gas sampling is likely to miss important variations (e.g., sleep apnea); and 2) The patient has a chronic condition resulting in hypoxemia, and there is a need to assess supplemental oxygen requirements and/or a therapeutic regimen.

Continuous overnight oximetry is considered investigational and not medically necessary for the following: 1) As the sole diagnostic test for sleep apnea syndrome in lieu of polysomnography or for routine screening for sleep apnea in the absence of any of the above conditions; and 2) In the home for asthma management.

The requirements as far as the oximetry unit used; the unit must be preset and sealed so it can't be adjusted by the patient. Also the unit must produce a printout with an adequate number of sampling hours, the percent of oxygen saturation and group of results. It is not necessary to send the printout with the initial claim but keep a copy in case you are asked for it upon review. Be sure

to document in the patient's chart that the unit was issued to the patient and the length of time it was used. You must also document in the patient's chart the treating physicians request for the services.

ANTHEM BC/BS POLICIES AND COVERAGE

Are you starting a new procedure and want to know if Anthem covers it? Try going to Policy Search on their website and research before providing the service to one of Anthem beneficiaries. http://www.anthem.com/cptsearch_shared.html bookmark this site and use it. If your procedure isn't covered, you will know in advance and make payment arrangements using an ABN or prepayment.

You can also use http://www.anthem.com/wps/portal/ahpculdesac?content_path=medicalpolicies/noapplication/f2/s0/t0/pw_ad069675.htm&na=onlinepolicies&rootLevel=1&label=Medical%20Policies this link to their Medical Policies window and find links to "Recent Updates", "By Category", or "By Alpha" to stay informed of the Anthem Policy Updates.

NURSING FACILITY PROLONGED SERVICES

Effective for services on or after July 1, 2008, you may bill Medicare for medically necessary prolonged services for E/M visits (CPT codes 99356 and 99357) in a SNF or NF with Nursing Facility Services CPT codes (99304 – 99306, 99307 – 99310 and 99318). You may also use these prolonged services CPT codes (99356 and 99357) with Nursing Facility Services in the CPT code range (99304 – 99306, 99307 – 99310, and 99318) to bill for counseling and/or coordination of care services that are **based on time**.

Additionally, CR 5968 announces that, effective July 1, 2008, you may bill for medically necessary prolonged services for SNF or NF E/M visits (CPT codes 99356 and 99357) with Nursing Facility Services (CPT code range 99304 – 99306, 99307 – 99310 and 99318); and you may also use the medically necessary prolonged services CPT codes (99356 and 99357) to bill for medically necessary E/M visits for **time-based** counseling and/or coordination of care for Nursing Facility Services in the CPT code range 99304 – 99306, 99307 – 99310, and 99318.

Remember, whenever or wherever you bill time-based services, it is required that you chart the time spent and this must be face to face services provided to the patient. This does not include time spent reviewing charts or discussing the patient with the staff.

You can find more information here: <http://www.cms.hhs.gov/Transmittals/downloads/R1489CP.pdf>.

CMS has updated sections in the Medicare Claims Processing Manual with regard to prolonged services. This update is too extensive to review here but you can access the updated manual here <http://www.cms.hhs.gov/Transmittals/Downloads/R1490CP.pdf>

DME, PROSTHETICS, ORTHOTIC AND SUPPLIES AND COMPETITIVE BIDDING

If you refer or supply DMEPOS, to Medicare beneficiaries, your patients may be affected by this program. At this time, there are only 10 metropolitan statistical areas (MSAs) in which only contracted supplies will be eligible to provide competitive bid items and receive payment from Medicare. While these rules won't directly impact referral agents they may impact your patients.

These are the existing statistic areas and products affected:

Initial Competitive Bidding Areas (CBAs)

Effective July 1, 2008, the competitive bidding program will be implemented in the following CBAs within these 10 MSAs:

Charlotte-Gastonia-Concord, North Carolina and South Carolina;
Cincinnati-Middletown, Ohio, Kentucky, and Indiana;
Cleveland-Elyria-Mentor, Ohio;
Dallas-Fort Worth-Arlington, Texas;
Kansas City, Missouri and Kansas;
Miami-Fort Lauderdale-Miami Beach, Florida;
Orlando-Kissimmee, Florida;
Pittsburgh, Pennsylvania;
Riverside-San Bernardino-Ontario, California;
San Juan-Caguas-Guaynabo, Puerto Rico.

Product Categories

Effective July 1, 2008, the competitive bidding program will be implemented for the following product categories:

Oxygen supplies and equipment;
Standard power wheelchairs, scooters, and related accessories;
Complex rehabilitative power wheelchairs and related accessories;
Mail-order diabetic supplies;
Enteral nutrients, equipment, and supplies;
Continuous positive airway pressure (CPAP), respiratory assist devices (RADs), and related supplies and accessories;
Hospital beds and related accessories;
Negative pressure wound therapy (NPWT) pumps and related supplies and accessories;
Walkers and related accessories;
Support surfaces (Group 2 mattresses and overlays (Miami MSAs only)).

Additional areas will be added in 2009. This will affect patient who travel in and out of designated CBA areas also. If you have a diabetic patient who lives out of the CBA area but vacations in a CBA area, while in the CBA they must get supplies through the contracted supplier.

For more information on this see CMS site www.cms.hhs.gov/MLNMatattersArticles/downloads/SE0805.pdf You can download this file or print it for future reference.

Help Desk Hint

In the Claim Statistics Right Click menu options, you are able to see the work requests for the account/visit as well as send a work request through these options:

- View Work Reqs for Acct
- View Work Reqs for Visit
- Add Visit to Work Reqs.

You are also able to view the payments the patient has made on the account through the *View As-Entered Patient Payments*. To access, right click menu option in the Claim Statistics screen.

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