



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

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CORRECTION – CMS UPDATE ON CRITICAL CARE PAYMENT

Last month I told you there had been a transmittal that would allow you to bill critical care and ER care on the same date by the same provider. CMS released a change request 5792 as follows:

“When a hospital inpatient 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. **(Note that hospital emergency department services are not paid for the same date as critical care services when provided by the same physician to the same patient.)** “

MEDICARE PAY CUT AVERTED

Short and simple; Congress did override President Bush’s veto and stopped the 10.6% pay cut for the balance of 2008. You will maintain the pay rate you have been receiving since January 2008 along with a 1.1% increase in 2009. 2010 is now the year to see if the rate will go down. At this point 2010 is set to reduce payments 21% but for now your payments will remain the same.

THERAPY CAP EXTENSION - KX MODIFIER BACK

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) was enacted on July 15, 2008. One part of this legislation extends the effective date of the exceptions process to the therapy caps to **December 31, 2009**. If you are an outpatient therapy service provider, you may now resume submitting claims with the KX modifier for therapy services that exceed the cap furnished on or after July 1, 2008.

For physical therapy and speech language pathology services combined, the limit on incurred expenses is \$1810 for calendar year 2008. For occupational therapy services, the limit is \$1810. Deductible and coinsurance amounts applied to therapy services count toward the amount accrued before a cap is reached. Services that meet the exceptions criteria and report the KX modifier will be paid beyond this limit.

Before MIPPA was enacted, outpatient therapy service providers were previously instructed not use the KX modifier on claims for services furnished on or after July 1, 2008. The extension is

retroactive to July 1, 2008. As a result, providers may have already submitted some claims without the KX modifier that would qualify for an exception.

You can read the full MedLearn Matters article dealing with the primary sections of the MIPPA here <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0826.pdf>

PQRI INFORMATION

If you are participating in the Medicare Physician Quality Reporting Initiative or thinking about participating this is a link to the CMS site where you can get more information in the form of PDF files of past educational phone conferences. Lots of information here for you http://www.cms.hhs.gov/PQRI/02_CMSSponsoredCalls.asp#TopOfPage

The Medicare Improvements for Patients and Providers Act of 2008 extended the funding for the PQRI to 2010 along with a 2% increase in 2009.

MEDICARE CROSS-OVER CLAIMS

In the past Medicare would cross-over a claim to the listed secondary carrier when the claim was approved. However, now the claim is not crossed to the secondary until the Medicare payment floor has been met. Electronic claims payment floor is 14 days while paper claims payment floor is 30 days. Keep this in mind when working your AR. To be sure the secondary has had time to receive and process the claim, wait at least one month on and electronic and two months on a paper claim. This will give the secondary plenty of time to pay the claim and save you time in making calls to the carrier before they could process the claim for payment.

ANTHEM FEDERAL EMPLOYEES PLAN

Anthem used to make payment to non-contracted providers IF the patient was referred to the specialist by the primary, contracted provider. Anthem no longer pays based on referral. If you are not contracted with Anthem BC/BS and see a referred patient, the payment will be made to the patient. It will be your responsibility to get your payment from the patient. You can determine an FEP policy by the "R" suffix in the identification number on the card.

Also there are changes in the FEP plan as to Anthem handling overpayments to providers. Before January 2008 for Indiana, Kentucky and Ohio and February 2008 for Wisconsin, Anthem would send a written request for the return of the overpayment. Now Anthem will deduct the overpayment from future remittances "to the extent provided by the contract".

You do have the option of handling an overpayment, which you find, in a couple ways. You can call the FEP Customer Service and request that they do an automatic deduction from future payments. Those phone numbers are Indiana – (800)382-5520, Kentucky – (800)456-3967, Ohio – (800)451-7602, Wisconsin – (800)242-9635. If you choose to send Anthem a refund check, mail the check along with the explanation of benefits showing the overpay to: Central Region-CCOA Lockbox, P. O. Box 73651, Cleveland, Ohio 44193-1177.

NEW ENROLLMENT RULES FOR MEDICARE

Part B News reports that effective August 26, 2008, a new enrollment appeals rule contains three areas of extreme change. This new rule allows the carriers to revoke your billing privileges and give you less time to respond to their requests for additional information.

In the past you had 60 days to respond with additional information but now you will have only 30 days. Some carriers have tried to establish the 30 limit already but if this happens to you, remind

them that the law initiating this limit doesn't go into effect until August 26. Any requests before that date still hold the 60 days response time.

The carriers have also been given the authority to revoke your billing privileges if they see a pattern of billing services that could not have been performed. For example if you repeatedly bill for services after the death of a patient or bill office visits when in fact the service was in an ambulatory surgery center, and a pattern is detected, the carrier can revoke your privileges.

Last but not least is the fact that Medicare requires you to revalidate your enrollment every 5 years. In the past they have said to wait until the carrier notifies you that it is time to revalidate but this new rule allows for you to voluntarily revalidate. It may be prudent to mark your calendars to remind you that it's time to revalidate. Part B News was told of a practice that received a revalidation letter that was not clear; "We had a doctor who received a letter that asked for a copy of his license and other documents," Holmes says. It did not mention form CMS-855."

You will have 60 days to appeal denial of your enrollment or revocation of your billing privileges.

Here is a link to the Federal Registry on this subject <http://edocket.access.gpo.gov/2008/pdf/E8-14440.pdf>

CMS TO RELEASE ICD-9 CODES IN OCTOBER

Part B News, April 21, 2008 issue told us that there are going to be 332 new diagnosis codes, 55 revisions and 22 deletions in the ICD-9 that is scheduled for release this year. The Federal Registry published the changes on April 30, 2008.

Fiscal 2009 ICD-9 revisions effective Oct. 1

ICD Chapter	New Codes	Revised Codes	Deleted Codes
1. infectious	22	0	3
2. neoplasms	73	28	0
3. endocrine	28	0	1
4. blood	1	0	0
5. mental	0	0	0
6. nervous	64	13	1
7. circulatory	1	0	0
8. respiratory	2	0	1
9. digestive	2	0	0
10. genitourinary	12	0	2
11. pregnancy	19	0	0
12. skin	22	9	1
13. muscle	4	0	1
14. congenital	0	0	0
15. perinatal	11	1	2
16. signs/symptoms	20	1	2
17. injury/poisoning	8	1	2
18. V codes	42	2	6
19. E codes	0	0	0

Source: Part B News analysis of new ICD-9 codes to be published in the Federal Register on April 30.

MEDICARE PAYS FOR CPAP WITH DX VERIFIED ON HOME TESTS

For dates of service on or after March 13, 2008, Medicare will allow coverage of CPAP therapy when the diagnosis of Obstructive Sleep Apnea is confirmed by a home sleep test. Previously, Medicare would only cover CPAP when the OSA testing was done in a sleep lab.

The coverage is still bound by the limits set forward in CR 6048 which basically limits the initial coverage of the CPAP to a 12 week limit. If the patient improves during the initial 12 week CPAP then continued use will be covered.

The approved diagnostic testing methods are; Polysomnogram performed in a sleep lab or unattended home sleep monitor device type II or type III or type IV, measuring at least 3 channels. This testing must be ordered and overseen by the treating physician.

A positive obstructive sleep apnea is verified by the Apnea-Hypopnea Index (AHI) or the Respiratory Disturbance Index (RDI). Medicare tells us, "The AHI or RDI must be greater than or equal to 15 events per hour or greater than or equal to 5 and less than or equal to 14 events per hour with documented symptoms of excessive daytime sleepiness, impaired cognition, mood disorders or insomnia, or documented hypertension, ischemic heart disease, or history of stroke."

Note: The AHI is equal to the average number of episodes of apnea and hypopnea per hour while the RDI is equal to the average number of respiratory disturbances per hour.

For more information see the MedLearn Matters here:
<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6048.pdf>

ALLERGY IMMUNOTHERAPY IN MEDICARE PATIENTS

There is no National Coverage Determination (NCD) on allergy immunotherapy because of the variance in treatment from area to area. In 2006 a study used helped CMS to determine that a Local Coverage Determination (LCD) is the best way to handle immunotherapy in allergic patients and that concept continues today. However, CMS encourages providers of immunotherapy to "closely follow practice parameters provided on the Joint Council of Allergy, Asthma and Immunology (JCAAI) Web site at <http://www.jcaai.org> ".

MALPRACTICE

One of a medical practice's costs and a significant cost is malpractice insurance. Having knowledge of what constitutes a malpractice claim is also a must. There are four elements to prosecute a malpractice lawsuit. Obviously there has to be an allegation by the patient of what the patient believes you have done wrong. Once there is the allegation, then the next step is looking at negligence which means a failure to meet the accepted standard of care. However, negligence is only one of four elements of a malpractice lawsuit. Below are listed the four elements:

1. **Duty of Care.** This means meeting the *standard of care* and may be different state by state but generally standard of care is the degree of skill, care and diligence exercised by providers of the same profession/specialty practicing in the light of the present state of medical science.

This is a legal concept, not a clinical concept but it is based on clinical care. Keep in mind that standard of care is not the same in all cases. There is no blanket of care. It depends on the individual patient needs and the fact that different providers will have different approaches to the same patient problem. As you all know, a physician can provide the proper standard of care and have a bad outcome so the bad outcome alone does not meet the requirement for a lawsuit. All four elements must exist.

2. **Breach of Duty.** This element means that the care you provided fell below the standard of care; negligence. At this stage, even though the physician's care was below standard, it was accidental and the physician did not mean to cause harm. Negligence without damage to the patient does not meet the requirement for a lawsuit.

3. **Damages.** Damages alone do not constitute a malpractice lawsuit but is only one of the required four elements. As stated above, a bad outcome alone doesn't support a malpractice lawsuit. There must be damages and negligence. For example: You give a patient a certain medication and the patient has an allergic reaction. This is not negligence unless you knew or should have known that the patient had a specific allergy to that particular medication.

4. **Proximal Causation.** This is based on the patient proving that you should have foreseen that your action would cause the patient damage but negligence on your part caused you to proceed.

The above information was taken from a *Medscape.com* article on Risk Management.

ANTHEM CHANGED POLICY ON AFTER-HOURS SERVICES

If you haven't noticed the change yet, Anthem changed its policy on paying for after-hours services. They announced, "Effective May 1, 2008, Anthem in Ohio, Kentucky, Missouri, Indiana and Wisconsin will allow additional reimbursement for 99050 only in the place of service office (place of service 11). Codes 99051-99060 will be considered part of the primary service and will not be reimbursed separately in any place of service. Anthem recognizes that additional reimbursement is needed when services don't occur during regularly scheduled office hours. However, services that are provided during regular office hours or in 24-hour facilities are considered a normal course of business and are part of the reimbursement for the actual services provided."

BILLING MEDICARE FOR ENDOVENOUS ABLATION THERAPY

Per *Part B News* there are four criteria you must document and rules you need to follow. You already know that Medicare will not pay for this as a cosmetic procedure. In order to avoid denials you need to document:

- Physical signs of varicose veins or venous insufficiency (pigmentation, stasis dermatitis, ulceration)
- Symptomatic pain, including swelling, itching, bleeding, nighttime cramping
- Results of an ultrasound scan showing reflux in the vein
- Failure of conservative therapy measures (i.e. compression hose)

The fourth item is imperative; you must try conservative measures before moving on to ablation.

Part B News also directs the use of modifier 50 with the CPT code if the procedure is done on both legs during the same session. If a second vein is treated on the same leg, on the same day use 36476, endovenous laser, vein add-on or 36479, endovenous laser, vein add-on for the appropriate procedure.

The following DX codes are appropriate for the above procedures 454.0 – with varicose ulcer, 454.1 – with inflammation, 454.2 – with ulcer and inflammation and 454.8 – with pain, swelling or other complications.

CMS PROCEDURE/DIAGNOSIS HELP

CMS offers help when matching procedure to proper diagnosis codes. Save this link to your favorites for future use:
http://www.cms.hhs.gov/mcd/serviceindication_criteria.asp?from2=serviceindication_criteria.asp&

Here are some tips for using this site:

Step1: Enter the CPT or HCPCS procedure code.

Step 2: Enter the ICD-9-CM diagnosis code, using the highest level of specificity. Or, if you don't have the code readily available, click the "code lookup" link and describe the patient's condition. Click "next" to obtain a list of possible codes and select the one that best fits.

Step 3: There are several options available; the quickest return is provided if you select "contractor"; then choose "First Coast Service Options, Inc. (00590, Carrier)" from the pull-down list:

The results returned indicate if the procedure/diagnosis combination you entered supports medical necessity requirements; if it does, you can select the link provided to access the pertinent local coverage determination(s).

QJ MODIFIER FOR INCARCERATED PATIENTS

Medicare will not pay for services provided to a patient who is incarcerated. The Social Security Administration provides the incarceration dates to the local carriers. During a period of incarceration Medicare will not pay for any medical care unless it is the local or state government's policy to make the patient financially responsible for their medical care. Basically, CMS presumes that the local or state government is paying for the medical care while incarcerated unless otherwise notified.

If you see a patient while incarcerated and you have confirmed that the patient is going to be responsible for the bills, then you must use the QJ modifier in either the first or second modifier placement.

Important: If you see a patient over a period of time when the patient is incarcerated and then not incarcerated do not bill them together. Split the not incarcerated dates out and bill them separately. If the patient states he was not incarcerated during a specific time that Social Security says he was incarcerated, it is up to the patient to contact Social Security to clear up that error.

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