



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

**Please route to appropriate staff**

**IT'S THAT TIME OF YEAR AGAIN!**

The New ICD-9-CM Diagnosis & Procedure Codes will be effective on Oct. 1, 2007. As you already know, Medicare no longer grants a 90-day grace period to submit discontinued ICD-9-CM Diagnosis Codes. There are 142 new or amended ICD-9-CM codes that become effective for Date of Service October 1, 2007. This is a good time to review the updates. A number of codes have been expanded with a 5<sup>th</sup> digit. **Some** examples of changes are in: **787.2x** Dysphagia, **789.5x** Ascites, **233.3x** Carcinoma in situ and **389.2x** Hearing Loss. There are new cancer codes in category **200**. We also have 39 new or amended Procedure codes.

As of July 2, 2007, several J-Codes have been deleted and replaced with Q-Codes for Immune Globulin. For more information go to:

<http://www.cms.hhs.gov/transmittals/downloads/R1261CP.pdf>

Also changes in the Asthma medication codes, see that information at:

<http://www.cms.hhs.gov/transmittals/downloads/R1260CP.pdf>

**HELP DESK HINT...**

When sending questions to PRC's Help Desk please be specific and give enough details to help us troubleshoot the problem more efficiently. The following are a few examples of what will help.

- What practice you are with?
- Where were you (which screen) in the ELF when the problem occurred?
- Do you know if anyone else is experiencing the same problem?
- If it pertains to a specific account, please give the acct # and visit #.
- Contact name, phone #, fax # and/or email address so we can contact you with any questions or when the problem has been corrected.

You can contact the Help Desk via phone at 1-800-589-9004 x4357, via fax at 330 493-7123 or via email at [helpdesk@prcontrol.com](mailto:helpdesk@prcontrol.com).

**MEDICARE EXPANDS COVERAGE OF ULTRASOUND DIAGNOSTIC PROCEDURES**

Per CMS: "CMS was asked to reconsider our current national coverage determination (NCD) on ultrasound diagnostic procedures. CMS has determined that there is sufficient evidence to conclude that esophageal Doppler monitoring of cardiac output for ventilated patients in the ICU and operative patients with a need for intra-operative fluid

optimization is reasonable and necessary under Section 1862(a)(1)(A) of the Social Security Act, and therefore, we are removing the past national non-coverage of cardiac output Doppler monitoring.

“CMS will amend the NCD Ultrasound Diagnostic Procedures at section 220.5 of the NCD manual by adding “Monitoring of cardiac output (Esophageal Doppler) for ventilated patients in the ICU and operative patients with a need for intra-operative fluid optimization” to Category I, and deleting “Monitoring of cardiac output (Doppler)” from Category II.” For more information go to:

<https://www.cms.hhs.gov/mcd/viewdecisionmemo.asp?id=196>.

### **CLARIFICATION OF SCOPE OF PORTABLE X-RAY BENEFIT**

The wording in the manual section states that "**skeletal films involving arms and legs**" are covered services under the portable x-ray benefit. The language has been changed slightly to "**skeletal films involving extremities**". This means the inclusion of wrist, hand and fingers and ankle, foot and toes. There is also an inclusion of diagnostic mammograms with certain requirements. See the website for more details.

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5536.pdf>

### **Implementation of the Carrier Jurisdictional Pricing Rules for All Purchased Diagnostic Service Claims**

Check out the revisions to Implementation of the Carrier Jurisdictional Pricing Rules for All Purchased Diagnostic Service Claims which become effective Oct. 1, 2007, See the details at:

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5543.pdf>

### **PQRI**

On 7/11/2007: “The Centers for Medicare & Medicaid Services announced today that all participating physician groups improved the clinical management of diabetes patients in the first year of the three-year Medicare Physician Group Practice (PGP)

Demonstration. This demonstration rewards providers for coordinating and managing the overall health care needs of Medicare patients with chronic conditions. These physician groups have redesigned care to improve clinical quality and to create more efficient and effective delivery systems. As a result, in addition to the quality improvements across all groups, two groups – Marshfield Clinic and University of Michigan Faculty Group Practice – earned performance payments for quality and efficiency of \$7.3 million as their share of the \$9.5 million in savings to the Medicare program. Additional groups had lower Medicare spending growth rates than their local markets but not sufficiently lower to share in savings.” Read the rest of the story at:

[http://www.cms.hhs.gov/apps/media/press\\_releases.asp](http://www.cms.hhs.gov/apps/media/press_releases.asp)

Have you done all you can to receive your 1.5% bonus using PQRI? Per CMS “Prompt submission of claims with quality measures is imperative as the claims will only be included in the PQRI analysis (and the associated bonus payment calculation) if received by Medicare’s National Claims History (NCH) file on or before February 29, 2008.” Please be sure to read the Reporting section of the PQRI on CMS Website for all the requirements of the program. Also on the CMS website is the new **PQRI TOOL KIT** with worksheets for each of the 74 Quality Measures. Check out the following Fact Sheets from the Medicare Learning Network:

[http://www.cms.hhs.gov/PQRI/Downloads/2007\\_pqri\\_fact\\_sheet.pdf](http://www.cms.hhs.gov/PQRI/Downloads/2007_pqri_fact_sheet.pdf)

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5640.pdf>

## **UHC's NEW POLICY**

According to *The Coding Institute* Vol. 7, No. 6, UHC is requiring physicians to refer their patients to a Network Lab or face fines of \$50, "change eligibility in carrier Premium Designation and Practice Rewards program, a decreased fee schedule or termination of network participation." This became effective March 1, 2007.

## **MORE COMMON BILLING ERRORS FROM PALMETTO GBA**

1. "Item 32 indicates the place where the service was rendered to the patient including name and address – including a valid ZIP code – unless rendered at the patient's home. Please be advised that any missing, incomplete, or invalid information recorded in this required field will result in the claim being returned or rejected in the system as unprocessable. Any claims received with the word "SAME" in Item 32 indicating that the information is the same as supplied in Item 33 are not acceptable. (**NOTE:** *References to an item number, such as item 32, refer to paper claim forms. However, note that whenever an item number is used in this article, the related concept and information required also applies to equivalent fields on electronic claims.*)"
2. "Evaluation and management (E&M) procedure codes and the place of service do not match. An incorrect place of service is being submitted with the E&M procedure code. (Example: CPT code 99283, which is an emergency room visit, is submitted with place of service 11, which is office)."

**<http://www.palmettogba.com/palmetto/providers.nsf/44197232fa85168985257196006939dd/85256d580043e7548525729c00695129?OpenDocument>**

## **REVISED INFORMATION ON PET SCAN CODING**

"Note: This article was revised on August 1, 2007, to correctly list HCPCS code A4641, instead of A4691, in two places within the article and to correct one code shown in Table 2 related to physicians/practitioners billing for CPT 78491 and 78492. All other information remains the same." Implementation Date is January 7, 2008. There are several updates in CPT codes and HCPCS codes for the tracers, for complete information please see the article at:

**<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5665.pdf>**

**LABORATORY AND RADIOLOGY:** Adjustment to Medicare System Common Working File (CWF) Duplicate Claim Edit for the Technical Component (TC) of Radiology "Effective with implementation of CR5675 on October 1, 2007, claims with dates of service on or after April 1, 2007, **will be paid that provide** radiology and pathology services to Medicare beneficiaries on **the day of admission and the day of discharge during an inpatient hospital stay.**" For more information go to:

**<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5675.pdf>**

## **VACCINE ADMINISTRATIONS IN 2008**

Per CMS: "Remember that, effective January 1, 2008, physicians can no longer bill Medicare Part B for the administration of Medicare Part D-covered vaccines, using the special G code (G0377). Instead, you will need to bill the patient for the vaccine and its administration, and the patient will need to submit the claim to their Part D plan for reimbursement." For more information go to:

**<http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0723.pdf>**

## **TIPS FROM DECISION HEALTH:**

**"When completing your Medicare enrollment forms --**

1. Be sure you have **all required NPIs** before completing the application.
2. Where the form asks for a Medicare identification number, **use your PIN**, not UPIN.
3. Don't skip **section 3** where the form asks about adverse legal actions. Check yes or no.

“Miss any of these seemingly small steps and your form will be returned to you as **INCOMPLETE** or **ERROR**. This could lead to a delay in your claims processing and payments. Not to mention force you to spend even more time on the process!”

**\*\*\*\*\*CORRECTION\*\*\*\*\***

**MEDICAL RECORD FEES FROM JULY NEWSLETTER**

The Ohio General Assembly controls what you are allowed to charge to copy medical records. Effective January 1, 2007, you are not permitted to charge more than has been set in House Bill Number 331 as follows:

Patient or patient representative request for records:

Data recorded on paper: \$2.67 per page for the first 10 pages;  
.55 per page for pages 11 through 50  
.22 per page for pages 51 and higher

Data recorded other than on paper: \$1.82 per page; the actual cost of postage may also be charged.

If the request is made other than by the patient or patient's personal representative, total costs for copies and all services related to those copies shall not exceed the following:

Initial fee of \$16.38 which shall compensate for records search;

Data recorded on paper: \$1.08 per page for the first 10 pages.  
.55 per page for pages 11 through 50  
.22 per page for pages 51 and higher.

Data records other than on paper: \$1.82 per page; the actual cost of postage may also be charged.

You must provide one copy without charge to the following:

The Bureau of Worker's Compensation  
The Industrial Commission  
The Department of Health and Human Services  
The Attorney General

If you have any questions Please Contact John T. Mulligan @ 216.348.5435 or [jmulligan@mcdonaldhopkins.com](mailto:jmulligan@mcdonaldhopkins.com)

Sue Shafer, RHIT