



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

Please route to appropriate staff

Newsletter access is also available through the help menu

NPI LOOK UP AVAILABLE

CMS has finally made available the NPI Registry. To look up provider NPI numbers go to <https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do> Besides the NPI you will find the providers Taxonomy Code, License number, address, phone, and fax. This list will be updated monthly. According to *Part B News*, some of the files do not contain the legacy numbers. However, 80% of the records hold at least one other provider identifier, 40% contain two other identifiers but very few hold more than two.

There is a downloadable file but it is extremely large and the size is prohibitive to most.

The lookup by physician name is limited to 150 results which may be limiting if you are looking for a common name.

UPIN REGISTRY WILL BE AVAILABLE TILL MAY 2008. CMS extended the availability of the UPIN directory until May 23, 2008. Medicare will accept legacy numbers until May 23, 2008 for secondary physicians only.

NPI/LEGACY COMBINATION DENIALS

Since October of 2006, you have been told to submit both your Medicare Legacy number and your NPI on claims. During that time Palmetto GBA did not penalize you if the NPI and Legacy number combination were invalid. However, beginning October 7, 2007 Palmetto GBA will begin checking the NPI against the Legacy number and if they do not match, your claim will be rejected.

What to do? First check to make sure you are using the correct NPI number. If it is correct you need to make sure that the Legacy number (we used to call this your PIN number) corresponds with what the Nation Plan and Provider Enumeration System has on file. You can check this on line at <https://nppes.cms.hhs.gov>

If you confirm that all the information is correct but you are still having problems, Palmetto suggests you may need to submit a Medicare enrollment application (CMS-855). You can also apply for NPI numbers on line at the above link. If you have need for more information please contact Palmetto at 1-866-309-5439.

DENIAL FINDER AT PALMETTO GBA

Palmetto GBA has added another great tool to their website. Denial Finder lists common denials and links to research those Denials. Let's say you get a medical necessity denial on a blood sugar test. When you open that listed denial, it gives you the denial code, the reason behind the code and links to educate yourself on the billing of a blood sugar. Go to <http://www.palmettogba.com/boh> and check it out.

TB TESTING

According to Part B News, they contacted Medicare regarding the proper way to bill for giving a patient the TB test and were told that the CPT code 86580 pays \$9.47 but this only covers the administration of the TB intradermal test. It does not cover the follow up interpretation of the test site. It is appropriate to bill a 99211 for the interpretative service when there is a face-to-face encounter to read the results. The 99211 pays \$20.09. Make sure your staff is billing both services and the chart shows the appropriate documentation.

If the test results are negative, document the site of the TB test evaluated and that the interpretation was explained to the patient. Use ICD-9 code V74.1 for the 99211. If the test is positive, but no other treatment occurs during the visit, use ICD-9 code 795.5.

Remember this must be a face-to-face interpretation. If you are using the "report card" for your patient to circle a picture on a card given to them to mark and return to you by mail, you can not bill for this service. You have to have seen the patient in person and examined the test site.

TAMPER RESISTANT RX PADS REQUIRED FOR MEDICAID PATIENTS

Due to a rise in unauthorized, altered and/or counterfeited prescriptions, CMS has set October 1 as the date that you are required to use tamper resistant RX pads when you write prescriptions for Medicaid patients in an outpatient setting. This is required for all written prescriptions even for OTC drugs given to Medicaid patients.

- To be considered tamper resistant, on October 1, 2007, a prescription pad must have at least one of the following three characteristics:
 - One or more industry-recognized features designed to prevent unauthorized copying of a completed or blank prescription form;
 - One or more industry-recognized features designed to prevent the erasure or modification of information written on the prescription by the prescriber;
 - One or more industry-recognized features designed to prevent the use of counterfeit prescription forms.

In August 2007 CMS issued letters to the State Medicaid Directors with guidance on implementing the new requirement.

Per Palmetto GBA Newsletter the key points of that letter were 1) as mentioned above, the date of October 1, 2007 was set for requiring the tamper proof pads be used on all written, non-electric prescriptions. 2) They outlined the above listed three characteristics of tamper proof pads. **No later than October 1, 2008 the States will be required to have all three characteristics on the pads instead of just one as required in 2007.**

Palmetto GBA tells us that some States already of tamper proof requirements in place and CMS has found that in these cases the State requirements exceed the above baseline requirements. Note that CMS has said that the States are free to exceed the baseline requirements. **Check with your local Medicaid office to see what they require. Some states are making free or discounted pads available to physicians because CMS has said it will reimburse states that provide pads to you.**

The tamper resistant pads are not required when the RX is electronic, faxed, or verbal. It is also not applicable when a managed care entity is paying for the prescriptions. In most situations where the drug is provided through a nursing facility or intermediate care facility for the mentally retarded, and certain other institutional and clinical facilities, the requirement is also not applied.

The letter from CMS also states that emergency fills are allowed as long as a prescriber provides a verbal, faxed, electronic, or compliant RX within 72 hours of the date on which the RX is filled. All DEA regulations on controlled substances still apply.

If you have any questions please contact Palmetto GBA at 877-567-9232.

BILLING MEDICARE PREVENTIVE VACCINES

Medicare Part B pays for three **preventive** vaccines only. **Influenza vaccine** (Preservative free – 90656 or split virus – 90658) use administration code G0008; **Pneumoccal vaccine** (90732) use administration code G0009; **Hepatitis B Vaccine** (90740 – 90747) use administration code G0010. Hepatitis B is the only one that is subject to copay and deductibles and also the only one that requires a doctor's order and administration under supervision.

Hepatitis vaccine is given in multiple doses depending on the code used. 90740 is a 3-dose vaccine for dialysis or immune depressed patients and 90747 is a 4-dose vaccine for dialysis or immune depressed patients. 90743 is a 3-dose vaccine for adolescents and 90744 is a 3-dose vaccine for pediatric and adolescent patients. 90746 is a single adult dose vaccine.

CERT ERROR RATES REVEALED

Over the past few years CMS has been reviewing records against charges to see if you are billing correctly. Now Medicare is releasing those results. Subsequent hospital visits and Consultations seem to be both areas of concern. Here is one such article from Palmetto GBA: "Under the Comprehensive Error Rate Testing (CERT) continuing errors are found with regard to cardiologists and gastroenterologists and the way they are billing consultations. Firstly, make sure the service you provide is truly a consult and not a transfer of care. Remember the three R's of consultation, Referral, Render and Report. Then if the situation really supports the consultation be sure you are performing and charting the needed service to support your level of care. Check out this Palmetto GBA article for more information [http://www.palmettogba.com/palmetto/providers.nsf/\(Docs\)/9125CBE8A73550788525734700646105?OpenDocument](http://www.palmettogba.com/palmetto/providers.nsf/(Docs)/9125CBE8A73550788525734700646105?OpenDocument)".

Note the link above is an article referencing cardiologists but the same directive applies to all consultations.

Palmetto GBA will continue to inform you of each specialty's error rates. You can keep up with these results by signing up for the Medicare Updates at the Palmetto GBA website.

ANTHEM EXPANDS PRECERT REQUIREMENTS ON RADIOLOGY

It is the ordering physician's responsibility to precertify their Anthem covered patients when they order radiology services.

Anthem has expanded their list of required precerts on radiology. They have made it easy for you to know which tests must meet this requirement. Go to www.anthem.com and enter the Provider section, in the drop down menu at the top choose OHIO. At the top you will see [Answers@Anthem](#) click on that, scroll down and you will see Radiology Services Precertification and Alpha Prefix List as well as Precertification CPT codes. There is a lot of good information on this site.

WELLCARE INSURANCE

There are two Wellcare insurances set up in the insurance file. Be sure you are using the correct one. WELLC312 is the **Medicaid** HMO and WELLPFFS is the **Medicare** HMO. Also, WELLPFFS, Medicare HMO, will not accept a claim with the patient's Medicare number or Social Security number on it. The claim must have the patients ID# in order to process.

Also be aware that Wellcare patients are given a **prescription only card**, be sure you are not taking the RX card for the insurance coverage information. If you file a medical claim with the numbers on the RX card, your claims will be denied.

HELP DESK HINT

We are beginning to submit secondary claims electronically for Anthem Blue Cross Blue Shield and those insurance carriers that go through EMDEON.

By submitting secondary insurance claims in this fashion, the primary insurance EOB adjudication information has to be "recreated" within the electronic file.

Please remember the following when posting payments and adjustments, if these are not followed, the claim will not generate correctly and will be rejected or denied by the secondary insurance carrier:

- **ALL** payments and adjustments **MUST** be posted **BY PROCEDURE!**
- When posting the Primary Insurance payment do **NOT** change the primary insurance code in the ELF for any reason.
- Enter the Primary Insurance Allowed Amount on the Payment by Procedure screen

If you have any questions, please contact the Help Desk at 1-800-589-9004 x4357 or helpdesk@prcontrol.com

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