



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

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FLU SEASON

It's that time of year again. Medicare advises you to start your flu injections to your patients as soon as you receive the vaccine. Here is a link to a quick access billing chart for flu, pneumonia and hepatitis http://www.cms.hhs.gov/MLNProducts/downloads/gr_immun_bill.pdf

NPI LOOK-UP

If you don't have this link bookmarked you should do it now.

<https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do> This link will take you to the NPI look-up through National Plan & Provider Enumeration System (NPPES).

You can also apply for a NPPES account and keep your particular information updated. You can correct, add, or delete information in the NPPES files by accessing their NPPES records at <https://nppes.cms.hhs.gov/NPPES/Welcome.do> and following the NPI hyperlink and then select Login. You will be required to enter your user ID and password. Required information can not be deleted but it can be updated. Some information is not accessible online and requires a paper update application. This form may be downloaded and printed here <http://www.cms.hhs.gov/cmsforms/downloads/CMS10114.pdf>

If you need to create a login to view your data and/or do updates go to

<https://nppes.cms.hhs.gov/NPPES/StaticForward.do?forward=static.npistart> and follow the directions.

PURCHASED SERVICES INDICATOR

CMS has recognized a problem with instances where Medicare is billed for the professional component of service that would involve the purchase of the technical portion. Claims are being denied as unprocessable because there is no indication that the service has not been purchased. So with Change Request 6122 to your local carriers, it will be assumed that there are no purchased services if there is nothing indicated on the claim. See the MedLearn Matters article here <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6122.pdf>

PQRI QUALIFIED REGISTRIES

If you are interested in using a qualified registry for submitting your information to the PQRI program, CMS now has a listing of those with contact information at <http://www.cms.hhs.gov/PQRI/Downloads/PQRIQualifiedRegistries.pdf>

HOME SLEEP STUDIES CHANGED BY MEDICARE FEE SCHEDULE UPDATES

First of all CMS did change its manual to cover CPAP therapy to treat obstructive sleep apnea when diagnosed with a home sleep test. This was effective for services on or after March 13, 2008. <http://www.cms.hhs.gov/transmittals/downloads/R86NCD.pdf> links to the transmittal.

On August 22, 2008 Change Request 6180, Transmittal 1580 from CMS to the Medicare Claims Processing manual clarifies the use of modifiers 26 (professional component) and TC (technical component) to Home Sleep Studies G0398 – G0400. Carrier implementation date is October 6, 2008.

G0398-G0400 now carry indicator “1” which means that the 26 or TC modifiers can be added. The code updates are retroactive to March 13, 2008 but the carriers do not have to go back and reprocess those claims unless you request them to do so.

These tests also carry status code “C” which means the carriers are given the latitude to determine how much they will pay for the services.

Local carriers may also have additional coverage rules so it's a good idea to check with your carrier before billing. *Part B News* reports that TrailBlazer Health (the carrier for Colorado, New Mexico, Oklahoma, Texas, Virginia and Indian Health) states that they will pay for the services only when the performing physician is a member of the American Board of Sleep Medicine, a “diplomat in sleep medicine by a member of the American Board of Medical Specialties,” or is a member of an accredited sleep center or lab.

I contacted PalmettoGBA and was told that PalmettoGBA is only requiring that the testing be medically necessary. The girl I talked to couldn't direct me to anything in writing except the CMS website directives which I've linked here. We will see if there are any claims problems once the billing starts for this service.

[http://www.palmettogba.com/Palmetto/Providers.nsf/files/September_2008_Medicare_Advisory.pdf/\\$File/September_2008_Medicare_Advisory.pdf](http://www.palmettogba.com/Palmetto/Providers.nsf/files/September_2008_Medicare_Advisory.pdf/$File/September_2008_Medicare_Advisory.pdf) this link will take you to the September 2008 PalmettoGBA Newsletter for more information. See the article starting on page 70 of your PDF viewer. Here is a link to the MedLearn Matters article <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6048.pdf>

HEARING TEST MODIFIER CHANGES

Comprehensive hearing test 92557 and tympanometry 92567 were also changed in CR6180. Indicator “9” was applied to these two codes making modifiers TC or 26 no longer applicable as of October 6, 2008.

BACK TAXES AND YOUR MEDICARE PAYMENTS

Effective October 1, 2008, if you owe the IRS back taxes you may see your Medicare payments being withheld. If this occurs you will see a “WU” code on your Medicare remittance advice. See more information here

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6125.pdf>

CORRECT CODING HOSPITAL CARE

The following charts provided by PalmettoGBA the Medicare intermediary for Ohio and West Virginia but this applies to all carriers.

The correct CPT codes to use when inpatient hospital care is less than 8 hours on the same calendar date, when a patient is admitted and discharged on a different calendar date, and when admitted for 8 hours but less than 24 hours on the same calendar date; and identifies medical record documentation requirements.

Palmetto GBA has developed a tool sheet to assist providers in determining the appropriate service to bill. Remember you must still meet the E/M requirements for the code you bill and sign all your entries as well as personally document the admission and discharge including the number of hours the patient was in inpatient care. This holds true for observation care as well.

Day One	CPT Code(s)
Admitted less than 8 hours – discharged same calendar date	Initial hospital care: CPT codes 99221-99223 (Do not report CPT 99238 or 99239)
Admitted 8 hours but less than 24 hours – discharged same calendar date	Inpatient Care (includes admission & discharge): CPT codes 99234-99236 (Do not report CPT codes 99238 or 99239)
Admitted 24 hours: first calendar day	Initial Hospital Care: CPT codes 99221-99223
Day Two and Beyond	CPT Code(s)
Discharged on second calendar date and beyond	Hospital Discharge Service: CPT code 99238 or 99239
Remains in hospital on second calendar date and beyond	Subsequent Hospital Care: CPT codes 99231-99233

The following chart addresses Observation Care:

Day One*	CPT Code(s)
Admitted less than 8 hours (discharged same calendar date)	Initial Observation Care: CPT codes 99218-99220 (Do not report CPT code 99217)
Admitted 8 hours but less than 24 hours (Discharged same calendar date)	Initial Observation Care: CPT codes 99234 - 99236 (Do not report CPT code 99217)
Admitted 24 hours (First calendar date)	Initial Observation Care: CPT codes 99218 - 99220

Day Two and Beyond *	CPT Code(s)
Discharged on second calendar date and beyond	Observation: CPT code 99217
Remains in observation on second calendar Date and beyond	Established Patient Office/Outpatient CPT codes 99211-99215

If a patient is admitted from observation care, you charge only the initial hospital care code.

Note the following key points with regard to payment, per the CMS change request CR 5792. To view the complete CR 5792 go to: <http://www.cms.hhs.gov/Transmittals/downloads/R1473CP.pdf>

- When a hospital inpatient (or emergency department 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.
- During critical care management of a patient those services that do not meet the level of critical care should be reported using an inpatient hospital care service with CPT Subsequent Hospital Care using a CPT code in the 99231-99233 range.
- Physicians and qualified NPPs may report both critical care services and an inpatient hospital care service for the same patient on the same calendar date when during critical care management of a patient the services do not meet the level of critical care services.
- Physicians and qualified NPPs are reminded that both Initial Hospital Care codes (CPT codes 99221-99223) and Subsequent Hospital Care codes are “per diem” services and may be reported only once per day by the same physician or physicians of the same specialty from the same group practice.
- Physicians and qualified NPPs are advised to retain documentation for discretionary Medicare carrier or A/B MAC review in case claims are questioned. The retained documentation must support why the same physician or physicians of the same specialty in a group practice submitted claims for both critical care services and other E/M services for the patient on the same date of service.

RESPIRATORY BILLING COMPONENT CODES

CCI notes the following codes to be components of 94060/94010 (spirometry), 94200 (maximal voluntary ventilation), 94375 (respiratory flow volume loop), 94640 (non-pressured inhalation treatment), 94664 (aerosol inhalation), and 94770 (CO₂ by infrared). The CCI indicates that the spirometry procedure 94060 is a component of 94070 (post-exposure bronchospasm evaluation), and the pulmonary stress-testing procedures 94620 and 94621.

BILLING TWO MRIs ON THE SAME DAY

The scenario is that you do an MRI without contrast and during that procedure you see something that requires a second MRI with contrast. How do you bill? *Radiology Coding Alert* tells you to first be sure that you meet the Medicare requirements for ordering. If you have an order for MRI without contrast only, make sure a second order was requested and received for the second MRI with contrast. The full requirement can be viewed at <http://www.cms.hhs.gov/Transmittals/Downloads/R80BP.pdf>.

For this scenario you would use the 70553-MRI, brain (including brain stem); without contrast, followed by contrast.

The reasoning is that if you use 70551-without contrast and then add 70552-with contrast the CCI edits bundle the non-contrast with the contrast study. You can use a modifier to override the edit but often payers won't reimburse for both. "You can expedite your paying by billing for a single without-and-with-contrast exam, 70553"

Note: you can bill the second, with-contrast MRI without an order if you can't reach the treating physician and you feel a delay would harm the patient. In a hospital setting, the hospital may allow the radiologist to order new tests but some fiscal intermediaries may deny claims.

Medicare now allows you to report the contrast with MRIs (Q9951-Q9954). That transmittal 1339 can be viewed here: <http://cms.hhs.gov/Transmittals/downloads/R1339CP.pdf>. (source: Radiology Coding Alert/2008, Vol.10, No.8).

ANTHEM BLUE CARD CONTACT NUMBERS

Claims Status

- Indiana-Kentucky-Ohio — 866-594-0521 - This is the number a PROVIDER would call for CLAIMS STATUS on claims FILED AFTER 12/15/07.
- Missouri – Wisconsin - 866-791-2292 – This is a number that a Missouri or Wisconsin PROVIDER would call for CLAIMS STATUS on claims FILED AFTER 12/15/07.
- Indiana - 888-800-2160 - This is the number an INDIANA PROVIDER would call for CLAIM STATUS on claims FILED BEFORE 12/15/07.
- Kentucky - 800-383-2538 - This is the number a KENTUCKY PROVIDER would call for CLAIM STATUS on claims FILED BEFORE 12/15/07.
- Ohio - 800-213-4908 - This is the number an OHIO PROVIDER would call for CLAIM STATUS on claims FILED BEFORE 12/15/07.
- Missouri- 800-875-1039 - This is a number that a Missouri PROVIDER would call for CLAIMS STATUS on claims FILED BEFORE 12/15/07.
- Wisconsin - 800 -242-7164 - This is a number that a Wisconsin PROVIDER would call for CLAIMS STATUS on claims FILED BEFORE 12/15/07.

Eligibility and Benefits

- 800-676-BLUE - This is the number a PROVIDER would call regarding patient ELGIBILITY & BENEFITS.

Locating a Provider

- 800-810-BLUE - This is the number a PATIENT would call to find an In/Network PPO Provider.

Anthem Switchboard

- 800-331-1476 - This is the number for the ANTHEM CORPORATE SWITCHBOARD.

If you have any questions, please contact Provider Inquiry or your local Network Management representative.

HOW DO YOU RATE THE MEDICAL CARE YOU PROVIDE?

As a physician I'm sure that you feel you provide top of the line medical care to all your patients and this is probably true. However, patient's perception of your practice may be based on much more than the actual care you provide. *Medscape Business of Medicine* in a June 19th article report that patients view your practice based on seven perceptions; "1) ratings of the overall quality of care provided by respondents' regular physicians or other health care providers; (2) wait times for medical appointments; (3) whether physicians spent enough time with respondents; (4) whether physicians listened carefully to respondents; (5) whether physicians explained things in a way that respondents could understand; (6) whether respondents had problems communicating with their physicians; and (7) whether there has been a time when respondents felt uncomfortable asking questions of physicians. Taken together, these measures are seen as giving a broad picture of the perceived quality of the physician-patient interaction.

This was part of a report on how ethnic groups view the care they received compared to white patients. The study reported results from the 2007 Harvard School of Public Health/Robert Wood Johnson Foundation survey of fourteen minority ethnic subgroups as they perceived the quality of care they were receiving.

The complete report is too detailed to cover here but know that patients judge the physician care they receive not just on the medical treatment but on the practice as a total from the time they call for an appointment, walk in the front door, the actual time you spend with them and how you treat them communicating your findings. Every person in your office is a reflection of what is perceived by your patients and every interaction you have with the patient, no matter how insignificant in your mind, reflects on that perception also.

HELP DESK HINT

The Comment (Ctrl M) button on the Transaction Entry screen allows the User to link a comment to a particular visit. There are three types of comments: Free Form, Deductible and Coinsurance. Free Form allows the User to create their own comments to be used again on another visit/account or by entering 999 in the Com Code field the User can enter in a one time message. The Deductible and Coinsurance types allow the User to specify the amount that the insurance has applied to these. Under the Help menu option there is a Quick Card that further explains this ELF feature.

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