



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

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NEW HEADACHE CODES FOR 2009

If you have been denied for high-end MRI claims when the diagnosis has been the old 784.0 – Headache, there is hope on the horizon. The 2009 ICD-9 has a new series of 339.XX to cover headache syndromes. In the past, insurance companies would not pay for an MRI for 784.0 because that code doesn't tell them if this is a "take two aspirin" headache or intracranial bleeding.

As the ordering physician, it will be imperative that you give the radiologist the highest specificity in the diagnosis documentation.

Here are the new categories for headaches; **330.0X** – Cluster Headaches or trigeminal autonomic cephalgias, **339.1X** – Tension Headaches, **339.2X** – Post-traumatic headache, **339.3X** – Drug induced headache, **339.4X** – Complicated headache syndromes, 339.8X – other headache syndromes.

In addition there are 2009 changes to the migraine codes. A new and revised 5th digit applies to the **346.XX** code **0** = without mention of intractable migraine, without mention of status migrainosus. **1** = with intractable migraine, so states, without mention of status migrainosus. **2** = without mention of intractable migraine with status migrainosus and **3** = with intractable migraine, so stated, with status migrainosus.

To the existing **346.XX** code they have added **346.3X** – Hemiplegic migraine, **346.4X** – Menstrual migraine, **346.5X** – Persistent migraine aura without cerebral infarction, **346.6X** – Persistent migraine aura with cerebral infarction, and **346.7X** – Chronic migraine without aura.

ICD-9 CHANGES

There are a lot more changes this year in your ICD-9, more than any other year and much more than I can handle in the newsletter but secondary diabetes codes 249.00-249.91 are big ones. Be sure to review your new ICD-9 to see all the 5th digits applications as to whether it's controlled or uncontrolled. Also Fever codes, 780.60-780.64, these were added as part of the inpatient prospective payment system in July 31. 780.6 has been deleted and now you must use a 5th digit

code for the cause of the fever. 780.60 is for unspecified fever. Pap smears; 795.10-796.79 now requires that you indicate where you took the smear from, anus or vagina.

Here is a link to online codes www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/06_codes.asp

COMMUNITY PAN-FLU PREPAREDNESS LEGAL ISSUES CHECKLIST

CMS has sent out an alert, for healthcare providers, to a valuable resource in preparedness for a potential pandemic influenza.

http://www.healthlawyers.org/Template.cfm?Section=Public_Information_Series&Template=/ContentManagement/ContentDisplay.cfm&ContentID=55721 This link is to a *Checklist* developed during a public interest dialogue session convened by the American Health Lawyers Association (AHLA), the Office of the Inspector General and the U.S. Centers for Disease Control and Prevention.

CMS is encouraging you to review the Checklist as they consider the legal impediments and implementation challenges to community pan-flu preparedness.

The AHLA is also sponsoring a teleconference entitled “The Sneeze Heard ‘Round the World: Pandemic Influenza Preparedness Strategies to Adopt Now.” You can find out more about the teleconference here <http://www.healthlawyers.org/pi/teleconference>

BILLING EPIDURAL STEROID INJECTIONS (ESIs) AND FLUOROSCOPY

If your neurologist is doing fluoroscopy along with ESIs be sure you code for it or you risk losing \$55 to \$95 in additional payments.

Neurology Coding Alert (NCA) 2008, Vol. 10, tells us how to bill and what to look for. Start with codes 62310-62311 and read the report. If the neurologist chooses an interlaminar epidural approach, placing the medication in the epidural space, **as long as the needle is positioned in the epidural or subarachnoid space with the needle going *straight* in between the lamina use 62310-62311.**

NCA warns not to confuse single injection codes 62310-62311 with 62318-62319 which covers continuous infusion or intermittent bolus.

If the neurologist doesn't use the “straight” approach but chooses to inject at an angle into the nerve root area outside the epidural space, this is a transforaminal injection (through the foramen). This approach bathes the specific spinal nerve as it exits the spinal cord. For this procedure you use 64479 (plus add-on code 64480) or 64483 (plus add-on code 64484) using add-on codes only if appropriate. The add-on rule; “You should report 64479 and 64483 as the primary codes for the first transforaminal injection to the cervical/thoracic or lumbar/sacral levels, respectively. Use add-on codes 64480 and 64484 for each additional injection at the cervical/thoracic or lumbar/sacral levels, respectively.

If your physician is using fluoroscopic guidance you can bill 77003 in addition to the above codes. Remind your physician that he must document that he used fluoroscopy guidance and with that documentation you can get a reimbursement roughly between \$55 to \$95 based on the Medicare Physician Fee Schedule.

The parenthetical note following 77003 in the CPT book “(Injection of contrast during fluoroscopic guidance and localization 77003 is included in623210-62319.....)” Don't let this confuse

you. This note deals specifically with the **injection of contrast** but does not apply to billing 77003 along with these epidural injection codes.

Diagnosis requirement policies exist with most Medicare carriers and some commercial payers. Check with your carriers to determine their coverage policies. NCA gives Aetna as an example stating that Aetna states therapeutic selective transforaminal epidural injections are part of a comprehensive pain management program. If more than three injections are given over six months it will be subject to medical necessity review. They are generally medically necessary when used for "identifying the etiology of pain in persons with symptoms suggestive of chronic radiculopathy, where the diagnosis remains uncertain after standard evaluation.

Some examples of ICD-9 to support medical necessity are 722.0-722.2, 722.4-722.6, 722.8x, 723.0, 724.0x, 723.4, 724.4 **Remember, the diagnosis used to bill must be documented. Never use a code based solely on what the carrier covers!**

In addition, if your practice bears the cost of the medication be sure to bill the appropriate HCPCS code: Kenalog-J3301, per 10 mg.; Celestone Soluspan-J0702; Depo-Medrol-J1020-J1040 and Aristopan-J3303 per 5 mg.

CMS EXPANDS "WELCOME TO MEDICARE VISIT"

In the past the patient who is new to Medicare has had six months to obtain their Welcome to Medicare visit and have it covered. However, in 2009 that time period has been extended to one year from their effective date on Medicare. Per Part B News it will also waive the deductible and gives CMS the ability, at its discretion, to add more new preventive services. However, the law does not state whether payment for the visit will increase with the added items.

They also state that CMS has also added to the visit an education portion on end-of-life training in the form of Advance Medical Directives. MIPPA defines end-of-life planning as verbal or written information as to the patient's ability to prepare an advance directive in the case injury or illness prevents them from making their own health care decisions and whether or not the physician is willing to abide by the patient's directives.

You can download advance directives by state at: <http://www.caringinfo.org/stateadownload>

ANTHEM BLUE CROSS AND BLUE SHIELD ON SCREENING COLONOSCOPIES

Issue 2, 2008 of the Anthem Update Newsletter reports a directive on billing screening colonoscopies that result in the surgical removal of a pre-cancerous polyp. Anthem's Lumenos members and others hold contracts that cover 100% of preventive services. It has come to Anthem's attention that these preventive colonoscopies are being billed not as a preventive with diagnosis code V76.51 but with the ICD-9 for any discovered pathology. Per Anthem's directive, if you do a screening colonoscopy you should be billing with the first diagnosis code of V76.51 and any resulting pathology code secondary.

This has resulted from complaints from patients who have 100% coverage on preventive, have scheduled a preventive service but it has not been billed as such. Anthem is directing you to bill the screening as the primary service with the pathology found listed subsequently.

If you have any questions on this contact your Anthem representative.

MEDICARE PQRI UPDATES

If you are interested or currently participating in the Physician Quality Reporting Initiative (PQRI) visit this site regularly for updates from CMS <http://www.cms.hhs.gov/PQRI/>

MEDICARE RECOVERY AUDIT CONTRACTORS (RAC)

I've read several articles on the new RAC demo program that has been run by CMS in several states. Medicare unveiled the contractors that were given the contracts for the completed program.

One thing to keep in mind is you can fight a negative audit report. These contractors job is to review paid claims and get back overpayments made on claim processing errors. However, during the demo program there were a lot of percentages of reversals on appeals thrown out but there were enough reversals to support the ability of appeals to allow you to keep your payments. So do not be afraid to appeals RAC determinations.

To be successful in your appeal be sure you can support. Do not get defensive upon request for records. Respond timely and give the RAC all requested information. They have the legal authority to gather the information so don't be argumentative at the beginning.

If the RAC decision is against you then you can appeal just like any other claim processing segment. Do your homework and make sure you can support your side of the appeal. Write an appeal letter and find out the specifics of their denial and go from there in a detailed manner. **Medicare can not require a refund of overpayments if the time period passed is more than three years past the date of service.**

MEDICARE OVERPAYMENTS

In the past, if Medicare told you that you had been overpaid, even if you disagreed, you had to return the monies paid and then send in your rebuttal. That meant that even if you won your appeal, you lost that income for the period of time it took to fight the overpayment decision. MIPPI changed the way this is now handled. It requires that when the first or second level appeal is received from a provider on an overpayment, subject to certain limitations, CMS and its contractors may not recoup the overpayment until the decision on the redetermination and/or reconsideration has been rendered.

Note that you have 15 days from the date of the notice of a recoupment action to send in your rebuttal. These rebuttals occur before any appeals process and are separate from the requirement of limitation on recoupments. See the full MedLearn Matters article MM6183 revised here <http://www.cms.hhs.gov/MLNMArticles/downloads/MM6183.pdf>

Part B News gives us a good time table on handling overpayment requests:

Recoupment timetable and provider action

Timeframe: Contractor - Provider

Day 1 Date of demand letter/date letter mailed. Provider receives notification by first class mail of overpayment determination.

Day 1-15 Deadline for rebuttal requests day 15. No recoupment occurs during this time. Provider must submit a rebuttal within 15 days from the date of demand letter.

Day 1-40 No recoupment occurs during this time. Provider can appeal and limit recoupment from occurring.

Day 41 Recoupment begins if no appeal is filed. Provider can still appeal and stop recoupment.

Day 60 After revised notice of overpayment following redetermination. Reconsideration request is stamped in mailroom, or payment received from the revised overpayment notice. Provider must pay overpayment or submit request for second level appeal.

Day 61-75 No recoupment occurs. Provider appeals or pays.

Day 76 and after Recoupment begins or resumes. Provider can still appeal. Recoupment stops on date receipt of appeal.

Source: CMS, Transmittal 141

You still have 120 days to get your appeal into Medicare but they will start recoupment in 41 days. CMS says the Medicare contractor can not start recoupment while an appeal is requested but overpays will accrue 12.5% interest during that time.

To read more see CMS Transmittal 141 here
<http://www.cms.hhs.gov/transmittals/downloads/R141FM.pdf>

You may want to keep this for reference if you get into this situation.

CMS CLARIFIES SIGNATURE REQUIREMENTS

CMS has found problems of noncompliance with, “existing statutes, regulations, rules and other systemic problems relating to standards of compliance for valid physician’s signatures..”

Signature stamps are prohibited on any medical record. Medicare will accept hand written, electronic signatures or facsimiles of original written or electronic signatures.

If you have any questions with regard to signatures contact your local Medicare Provider Call Center

DNA STOOL TEST NOT A REPLACEMENT FOR SIGMOID OR COLONOSCOPY

PreGen-Plus™, is a commercially available screening DNA stool test. However, the FDA has determined this to be a medical device that “requires pre-market review and approval prior to marketing”. This review and approval has not been obtained and CMS believes there are unresolved questions as to the safety and effectiveness of the stool DNA test. So as for now, your screening type remains sigmoidoscopy and colonoscopy. There are two transmittals with regard to this at <http://www.cms.hhs.gov/Transmittals/downloads/R93BP.pdf> and <http://www.cms.hhs.gov/Transmittals;downloads/R92NCD.pdf>

MEDICARE IMPROVEMENT FOR PATIENTS AND PROVIDERS (MIPPA)

MIPPA was passed by Congress, overriding President Bush’s veto. I’ve mentioned a few of the changes in other articles in this newsletter. Here are four more items in this act that will affect you. First, it enables the health and human services secretary to add preventive services without having to go through Congress as before. Second, the “Welcome to Medicare” initial preventive visit time allowance was extended from 6 months from date of Medicare eligibility to one year and the deductible applied in the past to this exam is now eliminated. Third, mental health outpatient services that now carry a 50% copay will, over the next six years, reach parity with other medical outpatient service copays of 20%. Last but definitely not least, MIPPA blocked the more than 10 percent pay cut and pended payment cuts through December 31, 2009. This act also put limits on cost-sharing for low-income Medicare beneficiaries. MIPPA covered more areas and if you want to look at the complete text of the bill go to <http://www.opencongress.org/bill/110-h6331/text>

ICD-10 CAUSES PROGRAM CHANGES

ICD-10 is looming on the horizon and will be incorporated over the next 3 years or so. ICD-10 will require updates in the PRC programs to accommodate the additional digits. We at PRC want you to know that we are working on those updates. We will be able to furnish our customers with the new ICD-10 codes without any problems once they are initiated.

PLACE OF SERVICE WHEN YOU'RE READING TEST RESULTS

Does your doctor go to the hospital to read tests and give results? If so what place of service are you using? The answer to this question is based on where the patient was at the time of the testing. If the patient was in-patient then you use 21 but if the patient testing was done in the outpatient department then the place of service is 22. The patient's location determines your place of service code. **Don't forget to use the modifier 26 to tell the payer that you are billing only the "professional service".**

DEACTIVATE YOUR PTAN WHEN YOU LEAVE A PRACTICE

Any provider who leaves a group practice is responsible for making sure their PTAN (formerly PIN) number with Medicare is deactivated. Otherwise, it is possible that through an error in the old practice group, services may be billed using your old PTAN. In an article in the October issue of the PalmettoGBA Advisory by Advance Med, the program safeguard contractor, they state that some practices may use an old PTAN as a stop gap practice for a new provider while awaiting the PTAN on a new provider. This isn't legal but it happens and this can be avoided by deactivating your PTAN when you leave the group.

If PRC did the enrollment for you, you can notify PRC of the provider's intent to leave the practice and his or her end date so that our staff can handle the deactivation of the PTAN for that provider.

Per Sagé Yarbrough at PRC some offices let the PTAN expire on its own which it will do in 6 months to 1 year of non-use. However, PRC is willing and able to handle the deactivation for you and will do so upon request. According to Sagé, they wait about 30 days to complete the deactivation form to make sure there isn't any overlap in service, claims, and payments, with the deactivation of the PTAN. There is a block on the form for the office designated end date. This deactivation can be done with a retro date but if any claims have been paid after the date designated, you will have to refund any monies paid.

GUIDELINES FOR BILLING FOR TEACHING PHYSICIANS

If you are billing Medicare for a teaching physician, intern or resident check here for the latest updates in billing directives
<http://www.cms.hhs.gov/MLNProducts/downloads/gdelinesteachgresfctsht.pdf>

CAPPED PAYMENTS ON IMAGING SERVICES

Back in 2005 the Deficit Reduction Act capped Medicare payments for the technical component of most imaging services at the outpatient prospective payment system rate. This cap applies to the TC-only and the TC of global services. You can find the capped and uncapped amounts here
http://www.cms.hhs.gov/PFSlookup/02_PFSSearch.asp#TopOfPage

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