PRC MEDICAL

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CERT ERRORS IN ORDERING DIAGNOSTIC TESTS

I've discussed this topic before but due to reading many articles about CERT finding continued errors due to lack of physician orders, let's go over this again.

An "order" is communicated in 3 ways; 1) A written document signed by the treating physician/practitioner, which is hand-delivered, mailed, or faxed to the testing facility; 2) A telephone call by the treating physician/practitioner or his/her office to the testing facility; and 3) An electronic mail by the treating physician/practitioner or his/her office to the testing facility.

The tricky one is number 2. If a phone order is given there MUST be documentation at both ends. The ordering physician/practitioner must document his intent to have the testing done in the patient record. Of course the testing facility must document receipt of the phone order in their patient records. Even though this method is allowed it can lead to further audit and confirmation of records. You must NEVER add documentation after the fact. By this I mean if you fail to document the patient record at the time the service is requested and find that error upon request of medical records, do not alter the record. This constitutes fraud. So if phone orders are given and I would add this should be the last resort, make sure both parties document the patient medical records.

FACET JOINT INJECTIONS

If you are injecting both sides of the spine at a single level you should be using modifier 50 and billing with the appropriate CPT code. If you are doing multiple bilateral procedures be sure to use the modifier 50 with each appropriate code.

The OIG published a report this year showing that physicians incorrectly billed with add on codes when in fact they were doing bilateral procedures.

If you are injecting multiple levels you should be using the add on codes. See the chart below:

Table: Facet Joint Injection CPT Codes and Descriptions

CPT Code	Description

64470	Injection; anesthetic agent and/or steroid, paravertebral facet joint or facet joint nerve; cervical/thoracic; single level
64472 (add-on)	Injection; anesthetic agent and/or steroid; paravertebral facet joint or facet joint nerve; cervical/thoracic; each additional level
64475	Injection; anesthetic agent and/or steroid; paravertebral facet joint or facet joint nerve; lumbar/sacral; single level
64476 (add-on)	Injection; anesthetic agent and/or steroid; paravertebral facet joint or facet joint nerve; lumbar/sacral; each additional level

See the CMS Manual at: http://www.cms.hhs.gov/Transmittals/downloads/R1786CP.pdf

INCIDENT-TO AND THERAPY SERVICES

Can services of a physical therapy assistant be billed "incident to" a doctor's services?

Answer: For a service to qualify as "incident to," an initial encounter must have occurred between the patient and the doctor, a course of treatment established, and all "incident to" requirements fulfilled. However, physical therapists have their own benefit category and may provide services without direct supervision and bill Medicare directly for services within the scope of their licensure.

Source: CMS Internet-only Manual (IOM) Pub. 100-02 Medicare Benefit Policy Manual, Chapter 15 "Covered Medical and other Health Services", Section 60 "Services and Supplies Furnished Incident to a Physician's/NPP's Professional Service". http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf

CRITICAL CARE REQUIRMENTS

Critical care is a time reported service. You must devote full attention to the patient, record the time in the medical record and remember that critical care time is spent in direct contact with your patient or time spent on the unit or floor. You can include the time you spend speaking with the patient's family as long as that time is spent related to your medical decision making such as obtaining history, review conditions and/or prognosis and discussing limitations. Do not count time spent outside the critical care unit or floor; do not count any activity that does not contribute to the patient's treatment.

Total Duration of Critical Care	Procedure Code
Less than 30 minutes	Report appropriate E&M
30 - 74 minutes	99291 (1)
75 - 104 minutes	99291 (1) and 99292 (1)
105 - 134 minutes	99291 (1) and 99292 (2)
135 - 164 minutes	99291 (1) and 99292 (3)
165 - 194 minutes	99291 (1) and 99292 (4)
195 minutes or longer	99291 (1) and 99292 as appropriate

Included in Critical Care:

- 36000 – Introduction of needle or intracatheter, vein
- 36410 – Venipuncture necessitating physician's skill for diagnostic or therapeutic purposes
- 36415 – Routine venipuncture
- 36600 – Arterial puncture

- 71010 – Radiologic exam, chest, single, PC
- 71015 – Radiologic exam stereo, frontal, PC
- 71020 – Radiologic exam, chest two views, PC
- 43752 – Naso- or oro-gastric tube placement
- 91105 – Gastric intubation
- 93561 – Indicator dilution studies
- 93562 – Subsequent measurement
- 94002 thru 94004 – Ventilation assist and management
- 94660 - CPAP, continuous positive airway pressure ventilation
- 94662 – CNP, continuous negative pressure ventilation
- 94760 – Noninvasive ear or pulse oximetry
- 94761 – multiple determinations
- 94762 – by continuous overnight monitoring
- 99090 – Analysis of clinical data stored in computers, e.g., ECGs, blood pressures, hematologic data
- Critical Care must be in a critical care setting such as; CCU, ICU, Respiratory care or ER, any location when care meets the definition of critical care and of course, as always, is medically necessary.

Critical Care Services are treatment of:

- Renal, hepatic, metabolic or respiratory failure
- Overwhelming infection
- Circulatory failure
- Shock-like conditions
- Post-op complications

Critical care during a global surgery follow-up period can be billed as long as the service is significant and separately identifiable from the original procedure. This applies to all global periods 0, 10, or 90 days. If the provider is the surgeon who performed the original procedure be sure to use modifier 24 or 25. The modifier is not required if the service is performed by a different provider.

Remember to document the total time spent (this is a time related service), make sure your document is legible and supports the medical necessity of the service.

Also an E/M and critical care may be paid if provided on the same day as long as they are documented as: E/M earlier in the day and critical care later, documenting two distinct face to face encounters with the patient. ER and critical care services are not payable on the same date.

If you are a teaching physician you can also bill critical care as long as you are present the total time billed. Remember to document your involvement with the patient and resident and document that you performed the key portion of the service. Both your documentation and the resident's entry must support the level of care. You may not count time spent teaching or time that the resident spent alone with the patient.

I have three critical care examples that are too long to add here but if you email me at mrscott@comcast.net and request: Examples of Critical Care (Highmark Webnar), I will be glad to send them to you.

FEES FOR MEDICAL RECORD COPIES

If you decide to charge for copies of medical records, to offset your costs, there are limitations that very from state to state.

As an example: In Ohio the following rates were set for 2009: If the records are requested by the patient or the patient's representative: $2.74 per page for the first 10 pages; 57 cents per page for pages 11 through 50; 23 cents per page for pages 51 and higher. For data resulting from an x-ray, MRI, CT-scan recorded on paper or film, $1.85 per page. You can also charge for the actual amount of postage incurred if you mail the copies.

If the request comes from someone other than the patient or their representative the total cost of the copies and all services related to those copies are limited to: Initial fee of $16.84 for the records search; $1.11 per page for the first 10 pages; 57 cents per page for pages 11 through 50 and 23 cents per page for pages 51 and higher. For data resulting from x-ray, MRI, CT-scan the fee is $1.87 per page. Again you can charge you actual postage costs if records are mailed.

You can not charge a fee to Worker's Comp., the Industrial Commission, the Department of Job and Family Services, the Attorney General; a patient or their representative if the records are being used to support a Social Security entitlement.

You can not charge for copies requested by the Medicare CERT or RAC programs. Also most insurance companies have clauses which prohibit you from billing them.

Ultimately you have to decide when and who you bill for records. I would suggest that providing copies free of charge to your patient is good provider/patient relations.

See the Ohio Revised Code here: http://codes.ohio.gov/orc/3701.741

TELEHEALTH INFORMATION

If you are considering providing Telehealth services go to this CMS link and download their informational fact sheet http://www.cms.hhs.gov/MLNProducts/downloads/TelehealthSrvcsfctsht.pdf

NEW SPECIALITY CODE FOR SPEECH LANGUAGE PATHOLOGISTS

As of June 29th if you register as a speech language pathologist (SLP) you have your own specialty code 15. As of July 1, SLPs can register as an independent provider under their own specialty code.

OIG TAKING HARD LOOK AT ULTRASOUNDS

If you are doing ultrasounds, know that the Office of Inspector General is taking a long hard look at them right now. The OIG has advised CMS to monitor questionable claims and if it is determined that fraudulent claims are an issue, CMS should take steps to revoke Medicare billing numbers. If you want to see the complete report on what the OIG looked at and how they came up with their numbers go to: http://www.oig.hhs.gov/oei/reports/oei-01-08-00100.pdf

CMS DECISIONS ON CARDIAC RELATED MRI REQUESTS

CMS has ruled on a request to delete the national noncoverage of blood flow measurement from the MRI NCD Manual and permit the local Medicare contractor to decide whether to cover the blood flow measurement. There existed a contraindication between this noncoverage provision and the national coverage of MRI under the Magnetic Resonance Angiography NCD.

The same request included another request to revise the policy to permit MRI when a beneficiary has an implanted device that is designed, tested and FDA labeled for use in the MRI environment.

The result of the CMS review is two fold; 1) The blanket non-coverage of MRI for blood flow determination is no longer supported and they have removed "blood flow measurement" from the Nationally Non-covered Indications allowing Medicare contractors to have the discretion to cover or not cover this use of the MRI. 2) Use of MRI in patients with implants approved by the FDA for use in MRI was denied. CMS found no evidence that it would be beneficial to the patients and also noted that currently no such device exists.

You can read the whole article at: http://www.cms.hhs.gov/mcd/viewdecisionmemo.asp?from2=viewdecisionmemo.asp&id=228&

E/M LEVELS AND "ADDITIONAL WORKUPS"

If you are using additional testing as a ruler to bill a higher level of Evaluation and Management, be sure you understand how the carriers are going to look at it. I just read an article in "Part B News" and they warn that simple "additional workups" done the same day as the E/M, such as stat-strep and urinalysis done in the office, do not support a higher level of E/M.

Billing staff should view the charting of "additional workup" as a means to bill a higher level of E/M only if the additional testing is done outside the current visit, with results that will come back at least the next day or later. If you use incidental tests i.e.: stat-strep, etc. you are running the risk of your E/M being down coded on review.

"Part B News" does report that CMS directives on additional workup are vague leaving the definition of "additional workup" to the individual carriers and MACs so if you use this, you should request that your carrier or MAC respond in writing as to how they define and score "additional workup".

According to the "Part B News" article there are two exceptions. If you see a patient in the ER and order more testing, even though the results come during the same encounter, most carriers will allow the higher E/M level based on those tests even though they don't meet the true definition of additional workup as stated in the office setting.

The other exception is if you own x-ray machines or other diagnostic equipment. Even if you do the test and get the results during the same encounter most carriers will pay the higher E/M based on that type of additional workup.

Again, to be sure, ask for a written response from your Medicare carrier as to how they define and score additional workups.

10 THINGS YOU NEED BEFORE ACCESSING PECOS

If you are considering using the online physician enrollment PECOS you will need to gather the following information before doing so. Per MedLearn Matters SE0914 http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0914.pdf :

1) An active National Provider Identifier (NPI);
2) A National Plan and Provider Enumeration System (NPPES) User ID and password;
3) Personal identifying information, which includes the physician's or non-physician practitioner's legal name on file with the Social Security Administration, date of birth, and Social Security Number;
4) Professional license and certification information, which includes information regarding the physician's or non-physician practitioner's professional license, professional school degrees or certificates;
5) Practice location information, which includes information regarding the physician's or non-physician practitioner's medical practice location;
6) The legal business name of a solely-owned Professional Association (PA), Professional Corporation (PC), or Limited Liability Company (LLC) on file with the Internal Revenue Service and appearing on the IRS CP575 form;
7) A photocopy of the CP-575 form;
8) The NPI of the PA, PC, or LLC; and
9) Any Federal, State, and/or local (city/county) business licenses, certifications and/or registrations specifically required by that business to operate as a health care facility; and
10) If applicable, information about any final adverse action that impacts the physician or non-physician practitioner.

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