



**PRC MEDICAL**

**Monthly Newsletter  
DECEMBER 2009**

Please route to appropriate staff

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**HAPPY HOLIDAYS FROM PRC MEDICAL**

**2010 MEDICARE FEE SCHEDULE CHOPS 21.2%**

The 2010 Medicare Physician Fee Schedule eliminates consultation codes while setting the conversion factor at \$28.4061. *Part B News* reports that there was a swift reaction by medical groups. "Access to care and choice of physician for seniors, baby boomers and military families are at serious risk – and Congress must fix the payment formula once and for all this year," said AMA president J. James Rohack, MD, in a statement released immediately after the fee schedule was posted online at the *Federal Register* Oct. 30.

Here is a link to view a copy of the final rule with comment period:

[www.federalregister.gov/inspection.aspx#special](http://www.federalregister.gov/inspection.aspx#special) CMS will accept comments on designated provisions of the final rule until December 29, 2009.

More internet information: [www.federalregister.gov/OFRUpload/OFRData/2009-26502\\_PI.pdf](http://www.federalregister.gov/OFRUpload/OFRData/2009-26502_PI.pdf)

**BCBS FRAUD AND ABUSE TRAINING (FWA)**

BCBS of Texas is offering its Medicare Provider FWA training that is required by CMS on line at: <http://www.nmchili.org/2004/Conference04/ConfPlan.htm>

Anthem BCBS offers one at:

<http://www.courses.learnsomething.com/scripts2/content.asp?r=WelcomePage&a=559&WLBS=2009111122922>

Most Medicare Advantage carriers are offering this training through their sites. I have given you two above.

**The deadline for completion of CMS required training is December 31, 2009.**

**ANTHEM UPDATE ON OUTPATIENT DIAGNOSTIC PREAUTHS**

Anthem added the following cardiac imaging services to the list requiring preauthorization effective September 1 of this year:



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Stress Echocardiography (SE): 93350, 93321\*, 93351, 93325\*, 93320\*, 93352\*

Resting Transthoracic Echocardiography: (TTE) 93303, 93308, 93304, 93320\*, 93306, 93321\*, 93307, 93325\*

Transesophageal Echocardiography: (TEE) 93312, 93317, 93313, 93320\*, 93314, 93321\*, 93315, 93325\*

\*Denotes an add-on/secondary code included in the grouper, but not requiring review.

I have the complete cardiac listing from Anthem. If you want it email me and request the "Anthem Dx Cardiac Pre-Auth List" and I will email it to you.

### NATIONAL DRUG CODES (NDC)

Any time you file a claim for a drug or radiopharmaceutical that is not otherwise classified or unlisted you must include the NDC number, name and dosage in the documentation record for that visit. Most of the time your drug supplier has those numbers but you can look them up here on the FDA website:

<http://www.accessdata.fda.gov/scripts/cder/ndc/default.cfm>. This is one you might want to bookmark if you use many of these unclassified drugs.

### CONSULTS ARE GONE IN 2010, ARE YOU READY?

You have a month left to adjust your thinking to the fact that there are no consults left in the Medicare 2010 fee schedule. Practices that billed a lot of low level in hospital consults 99251 will have to replace it with low level initial hospital visits 99221. The biggest difference is that 99221 require more work on the part of the provider. 99221 require the history and examination at detailed or comprehensive levels as compared to the 99251 that only required problem focused history and exam.

Remember there were 5 consult codes and now there are only 3 initial visit codes to choose from so there is no way to crosswalk from one to the other. CMS states they are aware of this but they say it's still possible to determine which of the 3 initial visits codes to use based on the basics of those code's guidelines which has not changed. So check your CPT books and make sure that the providers know they have to "ramp-up" their exams, having said that, another thing that remains the same with Medicare is **medical necessity**. Ultimately, was the level of care provided medically necessary?

### WHEN TO BILL MEDICARE PART B FOR DRUGS

There is only one instance where Medicare Part B will pay for drugs and that is oral anti-emetic drugs used as a full therapeutic replacement for IV drugs post chemotherapy. There are certain requirements. The drugs must be administered or prescribed by a physician to be used immediately before chemo, during chemo, or within 48 hours of chemo. There is also a specific required drug combination: 1) Aprepitant (Emend is the Registered name), 2) A 5-HT3 antagonist (e.g. granisetron, ondansetron, or dolasetron) and 3) Dexamethazone (a corticosteroid)

Read the press release here:

<http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=1307&intNumPerPage=10&checkDate=&checkKey=2&srchType=2&numDays=0&srchOpt=0&srchData=part+d&keywordType=All&chkNewsType=1%2C+2%2C+3%2C+4%2C+5&intPage=&showAll=1&pYear=&year=0&desc=false&cboOrder=date>

You can also read more about the details of drugs, administration, etc. in the [www.palmettogba.com](http://www.palmettogba.com) July 2009 Advisory.

### AMERICANS WITH DISABILITIES ACT AND YOUR OFFICE



I think most offices are aware of the directives in the Americans with Disabilities Act that became effective in 1992. Your parking lots have designated parking for disabled patients. You have ramps that allow wheelchair bound patients to enter your buildings. But did you know that if a patient is deaf and requests a sign language interpreter you must provide that interpreter at no cost to the patient or their insurance?

Basically the law allows an arrangement that is agreed to by the patient. If the patient agrees, you can have someone type out your communications so the patient can read them or maybe the patient can read lips but if the patient wants a sign language interpreter, you must provide a qualified interpreter at no cost. You can not bill the patient for the cost of that interpreter nor can you bill any insurance for the cost.

If you are a Medicare and/or Medicaid provider you must also provide a language interpreter if you are treating patient's who can not speak English. This is also at your cost and can not be billed to the patient or any insurance carrier.

To read more go to: <http://www.ada.gov/q%26aeng02.htm>

See this link for sign language interpreters in your area: <http://interpreterconnections.com/>

### **COMPLIANCE FOR DURABLE MEDICARE EQUIPMENT CONSIGNMENT**

From Medlearn Matters MM6528:

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6528.pdf>

“Medicare allows Medicare enrolled DMEPOS suppliers to maintain inventory at a practice location owned by a physician or non-physician practitioner for the purpose of DMEPOS distribution when the following conditions are met by the DMEPOS supplier and verified by the NSC-MAC:

- The title to the DMEPOS shall be transferred to the enrolled physician or non-physician practitioner's practice at the time the DMEPOS is furnished to the beneficiary.
- The physician or non-physician practitioner's practice shall bill for the DMEPOS supplies and services using their own enrolled DMEPOS billing number.
- All services provided to a Medicare beneficiary concerning fitting or use of the DMEPOS shall be performed by individuals being paid by the physician or non-physician practitioner's practice, not by any other DMEPOS supplier.
- The beneficiary shall be advised that, if they have a problem or questions with the DMEPOS, they should contact the physician or non-physician practitioner's practice, not the DMEPOS supplier who placed the DMEPOS at the physician or non-physician practitioner's practice.
- The NSC-MAC shall verify that no more than one enrolled DMEPOS supplier shall be enrolled and/or located at the same practice location. (Note: This prohibition does not exist for one or more physicians enrolled as DMEPOS suppliers at the same physical location.) A practice location shall have a separate entrance and separate post office address, recognized by the United States Postal Service.

- The NSC-MAC customer service personnel shall respond to direct provider and/or supplier questions concerning compliance with this policy. The responsibility for determining compliance with these provisions is the responsibility of the DMEPOS supplier, physician, or non-physician practitioner.”

If you have questions, please contact the Medicare NSC-MAC at their toll-free number which may be found at <http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.

The official instruction, CR 6528, issued to the Medicare NSC-MAC regarding this change, may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R300Pl.pdf> on the CMS website.

### **RACs CAN NOT DISREGARD LCD TO TAKE BACK**

CMS has ruled that RACs can not override LCDs for overpayments and take backs. They can use the LCD in a review if the result is in your favor. It's doubtful that you will see a take back tied to the LCD but it pays you to review the applicable LCD in any take back to make sure. And IF you find one you have a great chance of winning an appeal.

### **E/M DOCUMENTATION**

Would your E/M documentation stand up in an audit? Maybe it will or maybe it won't and this is one area where "words" carry maximum weight. CMS has put out an Evaluation and Management Services Guide at [http://www.cms.hhs.gov/MLNProducts/downloads/eval\\_mgmt\\_serv\\_guide.pdf](http://www.cms.hhs.gov/MLNProducts/downloads/eval_mgmt_serv_guide.pdf) that helps you make sure your wording won't result in down coding your services.

The old adage "If it isn't documented, it hasn't been done" still runs true in today's world of audits. Your documentation isn't just critical to your keeping the monies paid to you during an audit but they are pivotal to your patient's care. Make sure that your documentation is clear and precise to anyone who may read it at a later date. Medical auditors do have medical background but it's better to be precise than to imply and have your wording misconstrued.

*Part B News* warns that no reviewer, whether it's a RAC, MAC, CERT or an internal auditor, can read your mind. Examples given, ""Unremarkable" could actually mean a positive finding that was too minor for the provider to remark on, says Seth Canterbury, CPC, an education specialist with University of Florida Jacksonville Physicians. Or, the provider could have really meant "negative" when reviewing signs and symptoms.

Canterbury points to E/M guidelines for system examinations that state: "Specific abnormal and relevant negative findings of the examination ... should be documented. A notation of 'abnormal' without elaboration, is not sufficient." Also, "negative" and "normal" is okay when a doctor finds a system or areas are unaffected, but "an entire organ system should not be documented with a statement such as 'negative.'"

Use of "N/A" for "not applicable" is also not encouraged, Canterbury says, because it could be misinterpreted as "none available" - and again, leads to not clearly conveying the physician's thoughts.

Canterbury recommends providers use the following when they don't want to say "negative": none, or  $\emptyset$ , which is the symbol for the null or empty set.

These terms clearly convey that the provider did try to obtain a finding while performing the E/M service, but nothing was present. Stating N/A could be interpreted as the physician skipped a part of the service or didn't think it was necessary.

Physicians will document "unremarkable" because they are uncomfortable with the word "negative," Canterbury says. Using unremarkable is inadvisable, but writing non-contributory is risky too, says Dianne Wilkinson, CPC, compliance auditor at West Tennessee Healthcare in Jackson, Tenn. Writing "non-contributory" when documenting past, family and social history is not appropriate, she says. Canterbury says you'll want to avoid using "non-contributory" because it could mean either:

- the history from the patient wasn't relevant enough to the chief complaint to specifically document it, or
- the physician did not have an aspect of the patient's history, such as a past family illness, and felt it didn't contribute to the problem."

#### **NEW INTEREST RATE ON MEDICARE PROMPT PAYMENT**

Every six months CMS revises the payment rate on clean, non-periodic interim payments, Medicare claims not paid timely by Medicare carriers. The new rate of 4.875 went into effect July 1, 2009 and will hold until December 31, 2009. You can view the payment rate history at: <http://fms.treas.gov/prompt/rates.html>

#### **MRI FOR BLOOD FLOW**

As of September 2009 CMS began allowing local carriers the discretion to determine whether they would cover MRI for blood flow determination.

The following codes are being allowed:

- 75558, Cardiac MRI for morphology/function w/o contrast materials; w/flow/velocity quantification;
- 75560, Cardiac MRI for morphology/function w/o contrast materials; w/flow/velocity quantification & stress;
- 75562, Cardiac MRI for morphology/function w/o contrast materials; followed by contrast materials/further sequences, w/flow/velocity quantification; and
- 75564, Cardiac MRI for morphology/function w/o contrast materials; followed by contrast materials/further sequences, w/flow/velocity quantification & stress.

Per an article in *Part B News*, under 2010 SPT rules, all of the above codes will be deleted and replaced with a single add-on code, 75565 (cardiac MRI for velocity flow mapping). They also discuss the significantly higher pay scale for the 75560 at \$819.07 compared to the \$506.74 paid on 75559 (cardiac MRI for morph/w stress IMG). They also report that at this time the individual carrier medical directors haven't paid much attention to this change, basically because no one is billing for it. However, it's expected that in 2010 they will make a decision as to whether their local carriers will pay on it. Basically they have to decide whether the MRI for blood flow will be more valuable than the cheaper alternatives.

There are two areas where the experts say it might be covered; patients suspected of having pulmonic valve disease and patients with chest wall deformity. These two would most likely have a better MRI result than the cheaper cardiac ultrasound.

*Part B News* reports that the “bottom line” is if you have patients that would benefit medically from the cardiac MRI to measure blood flow, bill the four blood-flow codes. The worst that could happen is non-payment for the blood flow portion and payment on the other portions at the same rate you are now being paid for cardiac MRIs.

Read more on the change request 6672 at:

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6672.pdf>

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