



PRC MEDICAL

**Monthly Newsletter
FEBRUARY 2010**

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NEW "AI" MODIFIER

Consults being a thing of the past you now have to make sure that, if you are the admitting provider, you bill your initial visit 99221-99223 appended with modifier AI to let Medicare know that you are the admitting physician. Specialists called in that would once have billed a consultation now are allowed to bill 99221-99223 codes without the AI modifier.

Remember the telehealth services G-code consultations are still valid.

Read the revised LMN at: [MM6740: Revisions to consultation services payment policy](#).

OFFICE OF INSPECTOR GENERAL (OIG) RELEASES WORK PLAN

<http://oig.hhs.gov/publications/workplan.asp> follow this link to access the OIG Work Plan for 2010. It will give you a heads-up on what to expect in the terms of audits and review in the coming year.

2010 MEDICARE PAYMENT CONVERSION FACTOR

Thank God for "small" favors and the increase in the payment conversion factor is a very small favor and may not last long. In 2009 the conversion was set at \$36.0666 and this year it's gone up to \$36.0846! Don't you just love the way the government works? Don't get too excited though because that increase may crash by 21.3% on March 1st unless Congress steps in to stop the fall.

Part B News tells us that the increase in the conversion factor was based on a technical correction made by CMS to adjust the Malpractice RVUs in their calculations. You may or may not see an increase in your 2010 service payments based on the service and your location. The "formula" is a mix of many factors. Basically we just have to wait and see what next month brings.

TIME LIMITS FOR FILING MEDICARE

Services furnished in the last three months of a year hold the same filing date as if the service had been provided in the subsequent year. For example, a surgery done October 1 through December 31, 2009 must be filed by December 2011.

Assigned claims must be filed within one year of the date of service or your payment will be reduced by 10%



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Date of Service	Claim must be filed by
October - December 2007	December 31, 2009
January - September 2008	December 31, 2009
October - December 2008	December 31, 2010
January - September 2009	December 31, 2010

Note: If the last date to file a claim is on a Saturday, Sunday or Federal holiday, the claim will be considered timely if filed by the day after that date.

It is also important to file Medicare Secondary in a timely manner even if you don't expect payment.

ANTHEM REDUCES RADIOLOGY PRE-CERT TIMES

Anthem BC/BS has announced that they recognize the need for repeat CT and MRI exams, as frequently as once a month, in patients that have a confirmed cancer diagnosis. Your requests for these repeat exams will no longer be transferred to a registered nurse for review, as long as the clinical criteria were met at intake. This will result in faster turn around cert times.

Anthem directs you to email Central.eProvider.Rep@anthem.com with your name, TIN and contact information or visit anthem.com>Provider>Select state>Answers@Anthem for more information. The website has a radiology pre-certification/pre-notification tool.

ORDERING/REFERRING PROVIDERS GIVEN TIME TO ENROLL IN MEDICARE

Change Request 6417 will be delayed until April 5, 2010. This change gave carriers the ability to check the status of ordering/referring physicians. Basically, you have to be enrolled in Medicare to refer your patient to a Medicare provider or supplier. This delay will give those not enrolled time to enroll in Medicare. For addition information see: <http://www.cms.hhs.gov/Transmittals/downloads/R510OTN.pdf>

SEX SPECIFIC PROCEDURE OVERRIDE

There are certain procedures that are male or female specific and denied in the treatment of a transgender or hermaphrodite patient. For example, if you do a procedure that is listed gender specific to a female on a patient who is listed legally as a male you will be denied. However, you can override the automatic denial by adding the modifier KX. In this case the KX modifier is conveying, "Requirements specified in the medical policy have been met". This will alert the MAC that you are performing a service on a patient for whom gender specific editing may apply, but should be by-passed for this patient. The Common Working File will then override the gender specific edits for the code with the KX modifier thereby avoiding denial.

CMS SETS REGULATIONS FOR "MEANINGFUL USE" IN ELECTRONIC MEDICAL RECORDS

If you have yet to hear the term "meaningful use", you are sure to hear it over and over this year.

From CMS:

The public is encouraged to comment on new regulations.

The Centers for Medicare & Medicaid Services (CMS) and the Office of the National Coordinator (ONC) for Health Information Technology encourage public comment on two regulations that lay a foundation for improvement of quality, efficiency, and safety through *meaningful use* of certified electronic health record (EHR) technology. The regulations will help implement the EHR incentive programs enacted under the American Recovery and Reinvestment Act of 2009 (Recovery Act).

A proposed rule issued by CMS outlines proposed provisions governing the EHR incentive programs, including defining the central concept of *meaningful use* of EHR technology. An interim final regulation (IFR) issued by ONC sets initial standards, implementation specifications, and certification criteria for EHR technology. Both regulations are open to public comment.

“Widespread adoption of electronic health records holds great promise for improving health care quality, efficiency, and patient safety,” said, National Coordinator for Health Information Technology David Blumenthal, M.D., M.P.P. “The Recovery Act’s financial incentives demonstrate Congress’ and the Administration’s commitment to help providers adopt and make meaningful use of EHR technology so they can give better care and their patients’ experience of care will improve. Over time, we believe the EHR incentive program under Medicare and Medicaid will accelerate and facilitate health information technology adoption by more individual providers and organizations throughout the health care system.”

“These regulations are closely linked,” said Charlene Frizzera, CMS Acting Administrator. “CMS’s proposed regulation would define and specify how to demonstrate ‘meaningful use’ of EHR technology, which is a prerequisite for receiving the Medicare incentive payments. Our rule also outlines the proposed payment methodologies for the Medicare and Medicaid EHR incentive programs. ONC’s regulation sets forth the standards and specifications that will enhance the interoperability, functionality, utility and security of health information technology.”

CMS and ONC worked closely to develop the two rules and received input from hundreds of technical subject matters experts, health care providers, and other key stakeholders. Numerous public meetings to solicit public comment were held by three federal advisory committees: the National Committee on Vital and Health Statistics (NCVHS), the Health IT Policy Committee (HITPC), and the Health IT Standards Committee (HITSC). HITSC presented its final recommendations to the National Coordinator in August 2009. These recommendations, along with all other input, were considered to help inform the development of the regulations.

The IFR issued by ONC describes the standards that must be met by certified EHR technology to exchange healthcare information among providers and between providers and patients. This initial set of standards begins to define a common language to ensure accurate and secure health information exchange across different EHR systems. The IFR describes standard formats for clinical summaries and prescriptions; standard terms to describe clinical problems, procedures, laboratory tests, medications and allergies; and standards for the secure transportation of this information using the Internet.

The IFR calls for the industry to standardize the way in which EHR information is exchanged between organizations, and sets forth criteria required for an EHR technology to be certified. These standards will support *meaningful use* and data exchange among providers who must use certified EHR technology to qualify for the Medicare and Medicaid incentives.

Under the statute, HHS is required to adopt an initial set of standards for EHR technology by Dec. 31, 2009. The IFR will go into effect 30 days after publication, with an opportunity for public comment and refinement over the next 60 days. A final rule will be issued in 2010. “We strongly encourage stakeholders to provide comments on these standards and specifications,” Dr. Blumenthal said.

The Recovery Act established programs to provide incentive payments to those eligible professionals and hospitals that not only participate in Medicare and Medicaid but also adopt and make “meaningful use” of certified EHR technology.

Incentive payments may begin as soon as October 2010 to eligible hospitals. Incentive payments to other eligible providers may begin in January 2011.

The proposed rule would define the term "meaningful EHR user" as an eligible professional or eligible hospital that, during the specified reporting period, demonstrates *meaningful use* of certified EHR technology in a form and manner consistent with certain objectives and measures presented in the regulation. These objectives and measures would include use of certified EHR technology in a manner that improves quality, safety, and efficiency of health care delivery; reduces health care disparities; engages patients and families; improves care coordination; improves population and public health; and ensures adequate privacy and security protections for personal health information.

The proposed rule would define *meaningful use* for the Medicare EHR incentive programs. It proposes one definition that would apply to eligible professionals participating in the Medicare fee-for-service and the Medicare Advantage EHR incentive programs as well as a proposed definition that would apply to eligible hospitals and critical access hospitals. These definitions also would serve as the minimum standard for eligible professionals and eligible hospitals participating in the Medicaid EHR incentive program. The rule proposes that states could request CMS approval to implement additional *meaningful use* measures, as appropriate, but could not request approval of fewer or less rigorous *meaningful use* measures than required by the rule.

This rule proposes a phased approach to implement the proposed requirements for demonstrating meaningful use. This approach would initially establish reasonable criteria for *meaningful use* based on currently available technological capabilities and providers’ practice experience. CMS will establish stricter and more extensive criteria for demonstrating meaningful use over time, as anticipated developments in technology and providers’ capabilities occur.

CMS provides a 60-day comment period on the proposed rule. “The definition and requirements for demonstrating meaningful use of EHR technology are proposals. CMS welcomes and will give serious consideration to comments that improve our proposal while achieving the goals Congress established for the EHR incentive programs,” Frizzera said.

The CMS proposed rule and fact sheets may be viewed at:

http://www.cms.hhs.gov/Recovery/11_HealthIT.asp.

ONC’s interim final rule may be viewed at <http://healthit.hhs.gov/standardsandcertification>.

In early 2010, ONC intends to issue a notice of proposed rulemaking related to the certification of health information technology.

Additional Web sites for information:

• The Recovery Act Health IT page is:

http://www.cms.hhs.gov/Recovery/11_HealthIT.asp.

• Direct link to CMS regulation:

http://www.federalregister.gov/OFRUpload/OFRData/2009-31217_PI.pdf.

- A copy of the ONC regulation is available at:
<http://healthit.hhs.gov/standardsandcertification>.
- The HHS press release is available at:
https://www.cms.hhs.gov/apps/media/press_releases.asp.
- The CMS fact sheets are available at:
https://www.cms.hhs.gov/apps/media/fact_sheets.asp.

CMS HCPCS UPDATES

If you bill with HCPCS codes you will want to bookmark this CMS site http://www.cms.hhs.gov/HCPCSReleaseCodeSets/02_HCPCS_Quarterly_Update.asp where you will find all current updates.

CARDIOLOGY CODE CHANGE

Part B News offers this tidbit on diagnostic nuclear cardiology coding:

Fact: Codes 78465, 78478, 78480 and 78481 have been combined into a single diagnostic nuclear cardiology code: 78452. In the process, 78465, 78478 and 78480 will be deleted, as of Dec. 31, 2009.

New code 78452 includes multiple studies of myocardial perfusion imaging, tomographic (SPECT), with qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, at rest and/or stress.

TIP: You will still be able to bill separately for your stress (93015-93018 series), as well as the radioactive isotopes and stressing agent, if used. However, you will be restricted to just one radiology code for the tests.

THERAPY CODE CHANGES

Effective January 1, 2010, the following updates are being done to the therapy code list for calendar year 2010:

- 92520 (Laryngeal function studies (i.e., aerodynamic testing and acoustic testing)) is being added to the “sometimes therapy” list and requires the use of a therapy modifier
- 95992 (*Canalith repositioning procedure[s], [e.g., Epley maneuver, Semont maneuver], per day*) is being removed from the therapy code list

Here is the link to the MLN Matters article [MM6719](#).

HIPPA VERSION 5010

CMS is now actively working on the conversion of the Health Insurance Portability and Accountability Act (HIPAA) to the new 5010 version.

Version 5010 includes many improvements in structural, front-end matter, technical and data content such as improved eligibility responses and better search options. You will see many improvements in clarifying rules, corrections, and reversals, refunding processes, and how they recoup payments. The new claims transactions standards will improve how you report clinical data, enabling the new ICD-10-CM/PCS diagnosis and procedure codes, and distinguishes between principal diagnosis, admitting diagnosis, external cause of injury, and patient reason for visit codes.

Some important dates in the implementation process are:

- Level I Compliance (Medicare contractors) by: **December 31, 2010**

- Level I compliance means a covered entity, in this case Medicare contractors, can demonstrably create and receive compliant transactions, resulting from compliance of all design/build activities and internal testing.
- Level II Compliance (all others) by: **December 31, 2011**
- Level II compliance means a covered entity (e.g., Medicare providers, software vendors, clearinghouses, etc.) has completed end-to-end testing with each of its trading partners, and is able to operate in production mode with the new version of the standards.
- **All covered entities must be fully compliant on: January 1, 2012**

Educational information:

CMS has many HIPAA 5010 educational resources Web pages designed to increase national awareness of the healthcare industry at large. The pages listed below also assist in implementation of HIPAA version 5010, including links to transcripts from national provider calls.

- http://www.cms.hhs.gov/Versions5010andD0/40_Educational_Resources.asp

Medicare Learning Network (MLN) Special edition article SE0904

An Introductory Overview of HIPAA 5010

- <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0904.pdf>

Additional information concerning HIPAA 5010, this web page includes links to transaction side-by-side comparisons with the current version 4010A1.

- www.cms.hhs.gov/ElectronicBillingEDITrans/18_5010D0.asp

Frequently-asked questions (FAQs)

- Visit the [CMS HIPAA 5010 FAQ](#) page.

More information:

Listed below are additional resources identified for HIPAA 5010:

- [Electronic transactions and code sets regulations](#) – Here CMS discusses the final rules and regulations which established the need for the HIPAA 5010 standards.
- [Ingenix 5010 Prepared Web site](#) -- Ingenix is a publisher of Current Procedural Terminology (CPT) manuals. Their web site contains additional resources, news, and solutions to help you transition to 5010, with FAQs and the ability to contact 5010 experts.
- [HIPAA 5010 and ICD-10 Compliance Examples](#) -- Progress/Data Direct Web site provides the latest healthcare tutorials with a cut & paste code to get software and compliance entities a jump start working on HIPAA 5010 compliance.
- [X12 Store](#) -- Here you can purchase HIPAA 5010 Implementation Guides.

FACET JOINT INJECTION CHANGES

The CPT codes for facet injections prior to January 1, 2010 were 64470-64476. The guidance (e.g., fluoroscopic or CT) should have been reported in addition to the facet injection codes, if in fact it was performed.

Beginning January 1, 2010 new codes are now assigned for facet injections (CPT 64490-64495), guidance; fluoroscopic or CT, is now bundled into these codes and therefore are not reported separately.

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