PRCMEDICAL

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PALMETTOGBA REDETERMINATION/REOPENING INTERACTIVE FORM

If you missed this in December when PalmettoGBA first sent out the link to the online Redetermination/Reopening Form here it is again: http://www.palmettogba.com/palmetto/providers.nsf/vMasterDID/7RJJFV0238?opendocument. You can access this downloadable PDF that will allow you to keep the form on your computer and type in the requested fields and then print it out. Palmetto has made some changes to the original via this update.

ICD-10 EDUCATION LINKS

CMS has several areas on their site that will help you with the new ICD-10 to avoid errors when it is implemented October 1, 2013. It's never too early to start learning.

http://medicare.fcso.com/ICD-10/159906.asp in this link you will find additional links to information related to ICD-10 clinical modification and procedure coding system, educational resources and questions and answers about ICD-10.

GETTING PATIENT INFORMATION

Getting new patient information and keeping established patient information up to date can be a daunting task. This is where your front desk personnel can be a great benefit. When the patient calls for an appointment they should first establish if the patient is new or returning. If the patient has already been established you should always confirm phone numbers and addresses. If the patient hasn't been in the office for a year or more review all key information including insurance plans. If a patient has been able to come to you in the past because you were in their plan, they may not be aware that you are not a member of the new plan. Find this out before the patient arrives and then it becomes a PR problem having to tell them you can't see them or their out of pocket is going to be higher than they expected. Sadly, we do have to keep track of patient's insurances for them.

If the patient is new, be sure to get an email address and confirm that they have a printer with their computer. This is a great way to send the patient a patient information form along with the instructions to bring all medications and insurance cards and the completed form with them to their appointment. This is a much better way to keep your waiting room moving. If you are used to instructing new patients to come in early to complete the necessary forms, you will find that having them arrive at their appointment time complete with all necessary information will greatly improve patient waiting time.

One thing to be aware of, when using email to send forms, is that you do not use the patient's full name in the email, just in case you would inadvertently type in the wrong email address. You don't want to put your practice name and the patient's full name out there for the wrong person to see.

Cell phone numbers should also be obtained. This is for many reasons one being that people carry their phones with them all the time so if you have to reach a patient in a timely manner and can't get them at home, the cell phone will enable you to contact them more readily than leaving a message on the home phone for the patient to call you back. Depending on your practice you may have a privacy issue with leaving any kind of message on a home answering machine. Also, most people keep their cell phone numbers even if they move to another state.

It was suggested in a *Part B News* article that you may run into a privacy issue when requesting email addresses and cell phone numbers. People may be reluctant to give out that information. They suggest that you can handle this with something as simple as a laminated sign in your waiting room that states that your practice "will safeguard contact information in the same way you protect their HIPAA-protected medical information". Just make sure that you are not emailing any sensitive information. A blank patient information form for them to print out, fill out, and bring into the office should be fine.

RADIOLOGY INTERPRETATION PLACE OF SERVICE

With all the new communication technology, radiologists can now, and often do, perform interpretations in varied places. CMS has issued some guidance with regard to which POS code to use. If the interp is done in the physicians home, CMS is suggesting either 11 (office) or 99 (other). A hotel room would be coded 16 (temporary lodging) and a wireless device would require the code relative to where the physician is located, as well as, what ever zip code is applicable for the physician's physical location.

If you have any questions on the POS code to use, contact your local carrier.

CMS REVISED MEDICARE PHYSICIAN GUIDE

CMS's Medicare Learning Network offers you the revised *Medicare Physician Guide: A Resource for Residents, Practicing Physicians, and Other Health Care Professionals* (Oct 2009). This guide has general information about the Medicare program, how to become a Medicare provider or supplier, Medicare payment policies, Medicare reimbursement, evaluation and management services, protecting the Medicare Trust Fund, inquiries, overpayments, and fee-for-service appeals. The guide is now available in CD-ROM format. To place your order, visit http://www.cms.hhs.gov/MLNGenInfo/, scroll down to *Related Links Inside CMS* and select *MLN Product Ordering Page*.

ANTHEM RADIOLOGY PRE-CERT MOVING TO AIM

Effective March 15 Anthem's radiology management program is moving its pre-certification process to American Imaging Management (AIM).

You may submit your pre-cert requests two ways:

- Online at www.anthem.com. For instructions go first to www.anthem.com>Provider (enter state).Answers@Anthem:online Submission Tools for Radiology Pre-Certification and OptiNet Site Assessment.)

- Or you may authorize by phone at (800)554-0580.

In the past if you faxed a pre-cert request which was incomplete, a representative would call you but now any incomplete faxed request will be returned to you.

Only physician offices will be allowed to process requests through AIM. If your patient tries to request a pre-certification, the call will be transferred to Anthem.

Anthem is encouraging you to get your requests in **before** the service is provided but if a request is received more than 48 hours after the service is provided, AIM will forward your request to Anthem for further action.

CONSULTS THAT ARE NO LONGER CONSULTS

If your provider is asked by another provider to see a patient while in observation at the hospital, do you know how to bill your visit? Only the ordering provider can bill the observation codes and now you can no longer bill consultation codes. **You bill the appropriate level of outpatient service codes**.

In the emergency department if the patient's personal physician asks your provider to see his patient but does not admit the patient, **you bill the appropriate level of ER service.** This also holds true if the ER physician requests you to see the patient in the ER but does not admit the patient, again, **you bill the appropriate level of ER service.** However, if the patient is admitted, you bill the appropriate level of initial hospital care and add the modifier AI if you are the admitting physician.

If Medicare is the secondary payer and the primary insurance allows consult codes, you have to convert the consult code to the appropriate E/M code before submitting to Medicare or if Medicare is in the picture at all, you may choose to bill only E/M codes to all payers. This may be the easier road to take; the choice is up to you. There will be technical issues in converting your consult codes to E/M codes.

If your provider sees a patient in the hospital or a nursing facility but does not meet the minimal documentation for an "initial" E/M you should bill the appropriate subsequent level code. Remember that you must bill the supported level of care according to the place of service. If the initial level is not met, take the code down to the subsequent visit code that is supported.

- Resources listed by PalmettoGBA:
  Internet-Only Manuals - Pub. 100-04 Chapter 12:
  http://www.cms.hhs.gov/manuals/downloads/clm104c12.pdf

- MLN Matters Article – MM6740 – Revisions to Consultation Services Payment Policy:
  http://search.cms.hhs.gov/search?q=AI+modifier&site=cms_collection&output=xml_no_dtd&client=cms_frontend&proxystylesheet=cms_frontend&oe=UTF-8

Final rule: www.cms.hhs.gov/PhysicianFeeSched/PFSFRN/lost.asp

- Select the CMS-1413-FC link
- Select CMS-1413-FC (Published November 25, 2009) located at the bottom of the page under "Related Links Outside CMS".

OHIO UPDATES FEES FOR COPIES OF RECORDS

The Ohio Department of Health (ODH) has released the updated amounts hospitals and companies can charge for copying medical records in 2010.

For requests made by patients or their representatives, hospitals may now charge:

$2.73 per page for the first 10 pages,
57 cents per page for pages 11-50,
23 cents per page for pages numbering more than 50.

With respect to data recorded on something other than paper (e.g. X-rays, CDs); the new maximum charge is $1.86 per page. The actual cost of postage may be charged.

For a requests made by someone other than the patient or patient's representative, hospitals may now charge:

An initial fee of $16.78 to compensate for the records search.
$1.11 per page for the first 10 pages,
57 cents per page for pages 11 through 50,
23 cents per page for pages numbering more than 50.

With respect to data recorded on something other than paper (e.g. X-rays, CDs); the new maximum charge is $1.86 per page. The actual cost of postage may be charged.

Each state is different so be sure to check with your particular state for the fee allowances. Your local Medical Society should be able to help you with that information.

CMS ONLINE LIST OF PROVIDERS

As of April 5th, of this year if a provider refers a Medicare patient to you and that provider is not enrolled in Medicare, your claims will be denied. There is an easy way to check all providers' status with Medicare now through CMS PECOS. You can download the PDF file from the CMS site www.cms.hhs.gov/MedicareProviderSupEnroll/Downloads/OrderingReferringReport.pdf . This list contains over 800,000 providers whom CMS considers fully updated in PECOS. The list contains the last name, first name and NPI of each provider. There is no further information listed.

If you have providers who regularly refer to you, it may be of benefit to make sure they are on this list and if not, let them know that you will not be able to take their referrals until they get PECOS updated. As of April 5th Medicare carriers will begin to automatically reject claims from providers not on the list.

Part B News gives this tip: "If you have Adobe Acrobat (the full version, not just the Adobe Reader) you can save the PDF as a Microsoft Excel File, which will let you sort the list by provider NPI or name.

WELCOME TO MEDICARE AND A SEPARATE E/M

You may have an instance where you are seeing an established patient for their Welcome to Medicare visit and also provide services above and beyond the minor physical requirements for the Welcome to Medicare examination. Basically the Welcome to Medicare visit (G0402) does require a lengthy review of history but the physical examination is limited to taking vitals, a vision screen and body mass index measurement. You may need to do a more involved visit with your established patient to cover his ongoing problems and handle his medications.

So how do you bill both the G0402 and the E/M at the appropriate level of care on the same day? Add modifier 25 to the E/M as long as you have met the requirements for the level billed and charted accordingly. Remember that modifier 25 is telling Medicare that the E/M was a separate, identifiable service so be sure that you don't bill the separate E/M unless it truly was additional work on your part.

ON-CALL PHYSICIAN BILLING MEDICARE

If you have been billing Medicare under your physician's numbers when the service was actually provided by the "on-call" physician you should stop that practice immediately. PalmettoGBA reports that their audits have found many instances where the modifiers Q5 (service furnished by a substitute physician under a reciprocal billing arrangement) and Q6 (service furnished by a locum tenens physician) are being used incorrectly when the service was found to be furnished by the "on-call" provider. The Q5 and Q6 are inappropriate for this situation.

PalmettoGBA states: "….the provider community should submit claims for the services that the individual provider performs and the covering physician is to submit claims for the services that he/she performs.

Refer to the Medicare Claims Processing Manual, Chapter 1, Sections 30.2.10 (Payment Under Reciprocal Billing Arrangements – Claims Submitted to Carriers) and 30.2.11 (Physician Payment Under Locum Tenens Arrangements – Claims Submitted to Carriers) for information concerning the proper use of HCPCS modifiers Q5 and Q6.

MEDICARE LIMITATIONS ON LIPID TESTING

According to CMS's NCD Manual, Section 190.23, Lipid Testing, it may be reasonable to perform a lipid panel annually on patients on long term anti-lipid diet or drug therapy and when following patients with borderline high total or LDL cholesterol levels.

CPT 80061 lipid panel includes:

- Serum, Total Cholesterol (CPT 82465)
- Lipoprotein, Direct measurement, High Density, HDL Cholesterol (CPT 83718)
- Triglycerides (CPT 84478)

To monitor dietary or drug therapy any one component of the panel or a measured LDL may be covered up to six times a year. More frequent total cholesterol, HDL cholesterol, LDL cholesterol and triglyceride tests may be covered for marked elevations or changes to anti-lipid therapy to inadequate patient response to initial therapies. However, once the treatment goals are met LDL cholesterol or total cholesterol will be covered up to three times a year.

If your patient has non-specific chronic liver abnormalities, such as elevated transaminase, alkaline phosphatase, abnormal imaging studies, etc., a lipid panel would generally be covered no more than twice a year.

Additional information: www.cms.hhs.gov/manuals/IOM , click on the Internet-Only Manual (IOM) 100-30 manual then click on Chapter 1 – Coverage Determination, Part 3 and select Section 190.23 – Lipid Testing.

Under preventive and screening services Medicare may cover routine screening and prophylactic testing for lipid disorders. Since 2005 CMS has allowed coverage of cardiovascular screening blood tests every five years.

Several codes that are part of the Lipid Testing National Coverage may be covered for screenings but with frequency restrictions.

Additional information: www.cms.hhs.gov/manuals/IOM, click on Internet-Only Manual (IOM) 100.04 Medicare Claims Processing Manual. Click on Chapter 18 – Preventive and Screening Services and select Section 100- Cardiovascular Disease Screening.

WORKER'S COMPENSATION ANSWERS

If Worker's Compensation drives you bonkers, you're not alone. I was recently reviewing an article in *Medical Office Billing and Collections* and saw some questions that would be good to go over once again. One area to be aware of is where to file your claims. Remember that Worker's Compensation is a state-run program each state has its own fee schedule and set of rules. Keep in mind that the patient you are seeing may have Worker's Compensation Benefits from another state and you must abide by that state's rules and regulations.

Typically the state is determined by in which state the claim was filed. So basically, if the patient's claim was filed in Colorado while he was working there and now he lives in Florida, you must file in Colorado under their rules and regulations.

There is an exception to this rule in the case of a federal employee. The Federal WC programs jurisdiction covers all federal employees regardless of where they were injured or where they receive care since you are filing through the nationwide federal program.

Worker's Compensation for railroad employees is a mixture of both worlds. Most states abide by "nationwide" rules, but some states have their own.

Each state has a Web site for their Worker's Compensation program so check your patient's state site for further information. Check www.workerscompensation.com for links to the individual state worker's compensation sites.

BILLING RE-PACKING

Part B News tells us that if you are seeing a patient for continuation of re-packing after an incision and drainage procedure you should be using CPT code 12021 – treatment of superficial wound dehiscence; with packing. The RVU will come to about $146 in the office setting and carries a 10 day global period. Make sure you document the depth of the wound and the packing that was applied. Also document going over with the patient and family what they will need to do at home between packing visits, watching for infections or changes, etc.

Obviously this code should only be used after the global period has expired for your initial I & D but if you are still re-packing after the initial surgery global period, don't cheat yourself out of the fee by billing E & M codes.

Mable Scott
mrscott@comcast.net