



PRC MEDICAL

**Monthly Newsletter
April 2010**

Please route to appropriate staff

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If any of the links in this newsletter do not work, please copy and paste them into your browser.*

QUICK REFERENCE GUIDE FOR PQRI AND ELECTRONIC RX

I have a PDF copy of a Quick Reference Guide for PQRI and eRX that contains simple, quick information along with links to more information on CMS. If you would like me to email this to you, please email me at mrcscott@comcast.net and put "Quick Reference PQRI" in the subject line. I'll be happy to send you a copy.

PALMETTOGBA CODING AND REIMBURSEMENT UPDATE

Each year your Medicare carrier comes out with a coding and reimbursement update. If Palmetto GBA is your carrier, I have downloaded that update and I'll forward it to you upon request. Email me with "2010 Coding Update" in the subject line and I'll email a copy to you.

The update gives you the 2010 modifier additions, new HCPCS code additions and deletions and changes. It also gives you bilateral modifiers and bilateral codes, 2010 Endoscopy CPT Codes and much more. It's good reference material.

CHANGE OF RESPONSIBILITY ON PROVIDER NOT ELIGIBLE DENIALS

As of April 1, 2010 the responsibility for Medicare denied claims due to the fact that the provider is not eligible to bill Medicare will change from PR – "Patient responsibility" to CO – B7 – "This provider was not certified/eligible to be paid for this procedure/service on the date of service."

Remember that you have the same appeal rights for this denial if you feel it is incorrect. You are advised to use the Redetermination Form when appealing this denial. Be sure to include supporting documentation.

MULTIPLE OR REPEAT PROCEDURES ON THE SAME DAY

When your provider does repeats or duplicates of the same procedure on the same day the best way to avoid "duplicate denials" is to use your modifiers. Whether the service is a repeat done by the same provider or repeats done by different providers, you have at your disposal modifiers to use in either case.

The first service/procedure should be billed without a modifier as 1 unit and the additional units should be billed with the appropriate unit/units and the applicable modifiers. Modifier 76 – Repeat procedure by same physician. Modifier 77 – Repeat procedure by another physician. Modifier – 91 – Repeat clinical diagnostic laboratory test.

Example of Modifier 76 would be your provider does 3 chest x-rays done on the same day for the same patient. For this you bill 71020 once without the modifier, and 2 – 71020-76 with the modifier.

Example of Modifier 77 would be that your provider does an EKG on a patient but knows from the chart that the patient had another EKG earlier in that day. He should bill his EKG with modifier 77. This one is tricky as often you will do an EKG in your office and the patient fails to tell the doctor that he had an EKG earlier in the day at another office. Remember you can always appeal your denials with a Redetermination request but you need to accompany that request with a detailed explanation along with your EKG showing time and date. It would be helpful if you could get a copy of the other provider's EKG showing that time and date also.

Example of Modifier 91 would be a patient having 2 blood sugars or hematocrits in the same day. Again if you provided both tests, bill the first without modifier and the second with modifier 91.

In a perfect world we would always know what has gone on with our patient's during the day that we see and treat them, but we all know that often we have no idea that the patient had testing outside our services until the claim is denied. Then we have to become detectives and find out if the patient was seen by another physician on that date. Call the patient and ask the question, hopefully the patient will recall and tell you if it was done or not. You may find that a blood sugar was billed by another office and the patient denies that it was done. Put that information in your Redetermination request. If you can contact the other provider and get a letter from them stating the mistake it will be helpful. However, the carrier will also investigate the situation once you bring it to their attention.

LIPID TESTING FREQUENCY RESTRICTIONS

Lipid testing is one of the most often ordered tests but CMS National Coverage Determinations Manual has assigned frequency limitations to these tests.

The CPT 80061 Lipid Panel consists of: Serum, Total Cholesterol (82465); Lipoprotein, Direct measurement, High Density, HDL Cholesterol (83718) and Triglycerides (84478). This panel can be done annually to monitor a patient on long term dietary treatment or drug therapy. Also for these treatments any one component of the Lipid Panel can be done up to 6 times the first year if reasonable and necessary for the patient's control. However, more frequent testing of HDL and LDL and Triglyceride testing may be covered if the patient has marked elevations or for changing therapy due to initial patient response to therapy (diet or pharmacological). Note: More frequent tests as listed above may be initially denied so be prepared to send in a redetermination along with test results to show that the patient's condition was difficult to maintain.

After the patient has been stabilized the LDL or total cholesterol may be tested up to 3 times a year.

Non-specific chronic liver abnormalities (elevations of transaminase, alkaline phosphatase abnormal imaging studies, etc.) support a lipid panel no more than twice a year.

Additional information: <http://www.cms.hhs.gov/manuals/IOM>. Click on Internet-Only Manual (IOM) 100-03 manual, then click on Chapter 1 – Coverage Determination, Part 3 and select Section 190.23 – Lipid Testing.

Lipid testing screening tests are covered every 5 years for cardiovascular disease in limited circumstances since January 1, 2005. Several of the CPT codes in the Lipid Testing NCD may be covered for screening subject to certain frequency restrictions. See more information on this at: <http://www.cms.hhs.gov/manuals/IOM>. Click

on Internet-Only Manual (IOM) 100-04 Medicare Claims Processing Manual. Then click on Chapter 18 – Preventive and Screening Services and select Section 100 – Cardiovascular Disease Screening.

ACCEPTED AUTHENTICATION SIGNATURES

An authentication signature is required of the provider who orders or provides the service. There are three ways to accomplish this; hand-written, electronic or stamp.

CMS has deemed the following methods *acceptable*:

Handwritten signature -- a mark or a sign placed on a medical document to signify knowledge, approval, acceptance, or obligation by the individual who provided or ordered the services specified in the medical entry. Requirements for this form of authentication are dependent upon whether the signature is considered legible or illegible.

• **Legible signature** -- acceptable forms of presentation:

- Legible full signature
- Legible first initial and last name
- Initials placed above a typed or printed name
- Initials accompanied by a signature log -- lists the typed or printed name of the author associated with initials or an illegible signature. Signature logs may be included on the page where the initials or illegible signature is used, or it may be submitted as a separate document.
- Initials accompanied by an attestation statement -- must be signed and dated by the author of the medical record entry, must be associated with a specific medical entry, and must contain sufficient information to identify the beneficiary.

Note: An unsigned handwritten note may be accepted as authentication when other entries on the same page are in the same handwriting and have been signed.

• **Illegible signature** -- acceptable forms of presentation:

- Illegible signature placed above a typed or printed name
- Illegible signature where the letterhead, addressograph, or other information on the page indicates the identity of the individual who signed the entry. For example, the provider's name could be circled to indicate the identity of the individual who signed the entry.
- Illegible signature accompanied by a signature log -- lists the typed or printed name of the author associated with initials or an illegible signature. Signature logs may be included on the page where the initials or illegible signature is used, or it may be submitted as a separate document.
- Illegible signature accompanied by an attestation statement -- must be signed and dated by the author of the medical record entry, must be associated with a specific medical entry, and must contain sufficient information to identify the beneficiary.

• **Electronic signatures** -- an electronic sound, symbol, or process attached to or logically associated with an electronic medical record to signify knowledge, approval, acceptance, or obligation by the individual who provided or ordered the services specified in the medical entry.

- Electronic signatures must be authenticated, safeguarded against misuse and modification, and should be easily identifiable as electronic, rather than typewritten, signatures.
- As the individual represented by the electronic signature bears responsibility for the authenticity of the information, physicians are strongly encouraged to check with their attorneys and malpractice insurers regarding the use of alternative signature methods.

Summary of signature guidelines -- *unacceptable* forms of authentication

The following methods of authentication have been deemed unacceptable by CMS and may result in a CERT error:

- Unsigned, typed note with provider's typed name.
- Unsigned, typed note without provider's typed name
- Unsigned, handwritten note (only entry on the page)
- Illegible signature that is not placed above a typed or printed name
- Illegible signature that is not identified in a letterhead or addressograph
- Illegible signature that is not accompanied by a signature log or attestation statement
- Stamp signature
- "Signature on file"

Signature requirements -- *exceptions*

- Certification of terminal illness for hospice -- a facsimile of an original written or electronic signature is an acceptable form of authentication for certification of terminal illness for hospice.
- Orders for clinical diagnostic tests -- an unsigned order for a clinical diagnostic test that is accompanied by signed medical documentation that demonstrates the treating physician's intent for the test to be performed is an acceptable form of authentication for the test.

Note: Other regulations and CMS instructions regarding signature requirements, such as timeliness standards for particular benefits, take precedence over the guidelines listed above. In cases where the relevant regulation, coverage determination, or CMS manual outlines specific signature requirements (e.g., signatures on plans of care must be signed before those services are rendered), those signature requirements will take precedence.

e-Prescribing (eRx) signature requirements

Electronic prescribing is the transmission of prescription or prescription-related information through electronic media. Health care professionals can electronically transmit new prescriptions as well as responses to renewal requests directly to a pharmacy through a qualified eRx system, which eliminates the necessity for writing or faxing prescriptions for non-controlled substances.

Note: CMS defines a "qualified eRx system" as one that meets the Medicare Part D requirements described in Standards for Electronic Prescribing (42 CFR 423.160).

- **e-Prescribing for Part B drugs:** Non-controlled substances -- if a provider submits an order for a non-controlled substance through a qualified eRx system, the provider is not required to produce a signed hardcopy as evidence to substantiate the drug order.
- **e-Prescribing for Part B drugs:** Controlled substances -- the Drug Enforcement Agency (DEA) does not permit the prescribing of controlled substances through e-Prescribing systems; therefore, only a signed (pen and ink) hardcopy of the prescription will be accepted as evidence to substantiate a drug order for controlled substances.

Note: CMS outlines signature requirements for medical documentation as well as exceptions to the guidelines in the Medicare Program Integrity Manual, Chapter 3, Section 3.4.1.1.

Source: CMS Change Request 6698

ICD-10 EDUCATION

Your Medicare carriers will be offering telephone conferences to help your transition into the use of the new ICD-10 diagnosis codes. The implementation date for using the new coding system in October 1, 2013, and there will be no grace period, so the carriers have already started educational services. There are some similarities between ICD-9 and ICD-10 but there are also many new features and benefits. Be sure to watch your carrier newsletters for offered conferences.

CORRECT BILLING OF MULTIPLE BUNDLED CODES

In March of this year Palmetto GBA covered in detail the correct way to bill multiple bundled codes on a single claim. The article was quite detailed and I don't have room here to cover it all but if you find yourself having to bill multiple bundled services bookmark this site: <http://www.palmettogba.com/palmetto/providers.nsf/vMasterDID/839N3U7221?opendocument> or print it out for future reference.

RE-OPENING A MEDICARE AS PRIMARY AFTER THEY PAY AS SECONDARY

If you have received payment from the primary carrier and then filed and were paid by Medicare as the secondary payer only to later find out from the primary carrier that Medicare was in fact the primary payer for the claim, you can request a re-opening of the Medicare claim. However, know that you are still required to file the re-opening with the set time limits. Your first request must be received by Medicare, using **Redetermination/Reopening form along with your supporting documentation, no later than one year from the date of the initial determination** (the date on your Medicare explanation of benefits that came with your Medicare payment as secondary payer).

Make sure that Medicare Secondary Payer information is up to date by using the MSP Look-up Tool located under Self Service Tools and Top Links on the Ohio, South Carolina and West Virginia home pages of Palmetto GBA.

The re-opening forms for Palmetto GBA can be found at:

- Ohio: www.PalmettoGBA.com/boh/forms
- South Carolina: www.PalmettoGBA.com/bsc/forms
- West Virginia: www.PalmettoGBA.com/bwv/forms

GENERAL ELECTRIC ANNOUNCES NEW HEALTH PLAN FOR EMPLOYEES

GE has announced a new health plan, adjudicated by Anthem Blue Cross/Blue Shield, called GE Health Choice. This is a consumer driven health plan and you are directed NOT to collect the co-insurance at the time of service.

The patient will receive a debit card to complete the payment once the EOB is received to show what the patient is responsible to pay. GE's hope is that by involving the patient in the process they will be better informed as to their health care.

If you have any questions about this plan please contact Anthem Customer Service at (866)804-9321.

AVAILITY WEB SITE

Availity is a multiple payer site that gives you the ability to check eligibility, claims and many other services. You can view a demo or register at www.availity.com or call Availity Client Services at (800)282-4548 for more information.

CONSULTATION QUESTIONS

CMS offers another MedLearn Matters article, in a question and answer form, to address some confusion over how to bill without Consultation codes. <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE1010.pdf>

NEW ADVANCE BENEFICIARY NOTICE (ABN) MODIFIER

CMS has a new modifier for you to start using as of April 1, 2010 when you bill any service for which you have **voluntarily** given an Advance Beneficiary Notice (ABN) to the patient.

In the past, the only modifier required was the GA modifier which was used when you provided a service which **required** the ABN. The **GA** modifier is defined as “Waiver of Liability Statement Issued as **Required** by Payer Policy.”

The new modifier GX is defined as “Notice of Liability Issued **voluntarily** Under Payer Policy”.

Prior to the new GX modifier, you used the Notice of Exclusion from Medicare Benefits form (NEMB) which has now been retired.

Please go to the link listed below to read more details on how Medicare will adjudicate your claims using Modifiers GA or GX. It also tells you what other modifiers can be used in conjunction with these modifiers.

You can read the complete MedLearn Matters article here:

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6563.pdf>

MULTIPLE WAYS TO STAY ON TOP OF MEDICARE ANNOUNCEMENTS

Did you notice that Palmetto GBA has Smartphone applications? They are also offering your Listservs via Twitter! See more instructions and links here:

<http://www.palmettogba.com/palmetto/providers.nsf/vMasterDID/83GMG23673?opendocument>

A LITTLE HUMOR

I've shared the following poem with some of you before, but I decided to end this newsletter with a little humor for all of us who work with Medicare.

SHE WAS OLD AND FEMALE,
HER HEAD WAS SNOW WHITE,
SHE COULD HARDLY MAKE IT,
SHE WAS A SORRY SIGHT.
SAINT PETER TOLD AN ANGEL
GO OUT AND HELP HER IN,
SHE'S OLD AND SO DECREPIT
AND NO DOUBT FULL OF SIN.
BUT PUT HER IN THE GOLD ROOM,
WITH OTHERS OF HER CLAN.
SET UP THE BANQUET TABLE,
BRING IN THE ANGEL BAND.
STAND BY AND FEED HER SLOWLY
BUT FEED HER VERY WELL.
ON EARTH SHE WORKED WITH MEDICARE,
SHE'S HAD HER TIME IN HELL.

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