

Pinnacle Medicare Providers' News



Serving the Medicare Part B Providers of Arkansas, Louisiana and Rhode Island

July 2008

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**New 2008 Medicare Physician Fee Schedule Payment
Rates Effective for Dates of Service July 1, 2008
through December 31, 2008**

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Rhode Island (81)

Clinical Laboratory

New Waived Tests

Reference: Trans. 1538, CR #6060, Pub. 100-04, MLN: MM6060

Provider Types Affected

Providers and suppliers submitting claims to Medicare contractors (carriers and/or Part A/B Medicare Administrative Contractors (A/B MACs)) for clinical laboratory services provided to Medicare beneficiaries

Impact to You

This article is based on Change Request (CR) 6060 which informs Medicare contractors of new waived tests approved by the Food and Drug Administration (FDA) under Clinical Laboratory Improvement Amendments of 1988 (CLIA).

What You Need to Know

These 241 newly added CLIA waived tests are marketed immediately after approval and, through CR6060, the Centers for Medicare & Medicaid Services (CMS) notifies its Medicare contractors of the new tests so that the contractors can accurately process claims.

What You Need to Do

See the Background and Additional Information Sections of this article for further details regarding these changes.

Background

The Clinical Laboratory Improvement Amendments of 1988 (CLIA) regulations require a facility to be appropriately certified for each test performed. To ensure that the CMS only pay for laboratory tests categorized as waived complexity under CLIA in facilities with a CLIA certificate of waiver, laboratory claims are currently edited at the CLIA certificate level.

The following table includes the latest new tests approved by the Food and Drug Administration as waived tests under CLIA. The Current Procedural Terminology (CPT) codes for these new tests must have the modifier QW to be recognized as a waived test.

CPT Code	Effective Date	Description
86318QW	February 1, 2005	Alfa Scientific Designs Instant View H. Pylori Whole Blood Rapid Test
82977QW, 84460QW	January 22, 2007	Abaxis Piccolo Blood Chemistry Analyzer (General Chemistry 6 Panel){Whole Blood}
82977QW, 84460QW	January 22, 2007	Abaxis Piccolo xpress Chemistry Analyzer (General Chemistry 6 Panel){Whole Blood}
82150QW, 82977QW, 84075QW, 84460QW	January 22, 2007	Abaxis Piccolo Blood Chemistry Analyzer (General Chemistry 13 Panel){Whole Blood}
82150QW, 82977QW, 84075QW, 84460QW	January 22, 2007	Abaxis Piccolo xpress Chemistry Analyzer (General Chemistry 13 Panel){Whole Blood}
82565QW, 82947QW, 82950QW, 82951QW, 82952QW, 84450QW, 84520QW	March 14, 2007	Abaxis Piccolo Blood Chemistry Analyzer (General Chemistry 6 Panel){Whole Blood}
82565QW, 82947QW, 82950QW, 82951QW, 82952QW, 84450QW, 84520QW	March 14, 2007	Abaxis Piccolo xpress Chemistry Analyzer (General Chemistry 6 Panel){Whole Blood}

82042QW, 82247QW, 82310QW, 82565QW, 82947QW, 82950QW, 82951QW, 82952QW, 84157QW, 84450QW, 84520QW, 84550QW,	March 14, 2007	Abaxis Piccolo Blood Chemistry Analyzer (General Chemistry 13 Panel){Whole Blood}
82042QW, 82247QW, 82310QW, 82565QW, 82947QW, 82950QW, 82951QW, 82952QW, 84157QW, 84450QW, 84520QW, 84550QW,	March 14, 2007	Abaxis Piccolo xpress Chemistry Analyzer (General Chemistry 13 Panel){Whole Blood}
80101QW	June 28, 2007	Alfa Scientific Designs, Inc. Instant View Multi-Drug of Abuse Urine Test
80101QW	June 28, 2007	Alfa Scientific Designs, Inc. Instant-View Multi-Drug of Abuse Urine Cup Test
82330QW, 82374QW, 82435QW, 82565QW, 82947QW, 82950QW, 82951QW, 82952QW, 84132QW, 84295QW, 84520QW	September 21, 2007	Abbott i-STAT Chem8+ Cartridge {Whole Blood}
82274QW, G0328QW	October 5, 2007	BTNX Inc. Rapid Response Fecal Occult Blood (FOB) Self Test
82274QW, G0328QW	October 5, 2007	BTNX Inc. Know Fecal Occult Blood (FOB) Self Test
80101QW	January 8, 2008	Abbott Diagnostics Signify ER Drug Screen Test
86308QW	January 8, 2008	Jant Pharmacal Accutest Value + Mononucleosis Rapid Test {Whole Blood}
86308QW	January 8, 2008	Stanbio Rely Mono Rapid Test{Whole Blood}
87880QW	January 22, 2008	Becton Dickinson BD Chek Group A Strep A Test
86318QW	January 22, 2008	Diagnostic Test Group Clarity H. pylori Rapid Test Device {Whole Blood}
80101QW	January 30, 2008	BTNX Inc. Rapid Response Multi-Drug One Step Screen Test Panel (Urine)
80101QW	January 30, 2008	BTNX Inc. Know Multi-Drug One Step Screen Test Panel (Urine)
87807QW	February 25, 2008	Quidel Quick Vue RSV Test

84443QW	February 29, 2008	Qualigen, Inc. FastChek TSH {Whole Blood}
83036QW	March 31, 2008	Bayer A1CNow+ {For professional use}

The new waived CPT/Healthcare Common Procedure Coding System (HCPCS) code(s),

- 84550QW has been assigned for the uric acid test performed using the Abaxis Piccolo Blood Chemistry Analyzer (General Chemistry 13 Panel){Whole Blood} and the Abaxis Piccolo xpress Chemistry Analyzer (General Chemistry 13 Panel){Whole Blood}; and
- 82330QW, 82374QW, 82435QW, 84132QW and 84295QW have been assigned for the ionized calcium, carbon dioxide, chloride, potassium, and sodium tests performed using the Abbott i-STAT Chem8+ Cartridge {Whole Blood}.

Previously, CR 5913 (see <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5913.pdf> on the CMS website) assigned the following CPT/HCPCS codes:

- 80048QW for the tests performed using the Abaxis Piccolo Blood Chemistry Analyzer (Basic Metabolic Reagent Disc){Whole Blood} and the Abaxis Piccolo xpress Chemistry Analyzer (Basic Metabolic Reagent Disc){Whole Blood}; and
- 80053QW for the tests performed using the Abaxis Piccolo Blood Chemistry Analyzer (Comprehensive Metabolic Reagent Disc){Whole Blood} and the Abaxis Piccolo xpress Chemistry Analyzer (Comprehensive Metabolic Reagent Disc){Whole Blood}.

The effective date for the above CPT/HCPCS codes mentioned in CR 5913 is revised from January 16, 2008 to October 30, 2007.

CR 6060 also includes an attachment listing tests granted waived status under CLIA. The tests mentioned on the first page of the attachment (i.e., CPT codes: 81002, 81025, 82270, 82272, G0394, 82962, 83026, 84830, 85013, and 85651) do not require a QW modifier to be recognized as a waived test.

Additional Information

The official instruction, CR 6060, issued to your carrier and A/B MAC regarding this change may be viewed on the CMS web site at:

<http://www.cms.hhs.gov/Transmittals/downloads/R1538CP.pdf>

If you have any questions, please contact your carrier or A/B MAC at their toll-free number, which may be found on the CMS web site at:

<http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip>

Effective Date: July 1, 2008; Implementation Date: July 7, 2008

Coding & Coverage

Reminder – Medicare Provides Coverage of Diabetes Screening Tests

Reference: MLN: SE0821

Provider Types Affected

All Medicare fee-for-service (FFS) physicians, qualified non physician practitioners (physician assistants, nurse practitioners, and clinical nurses), providers, suppliers, and other health care professionals who furnish or provide referrals for and/or file claims for Medicare-covered diabetes screening tests.

Provider Action Needed

This article conveys no new policy information. This article serves as a reminder to health care professionals and their staff that Medicare pays for diabetes screening tests. To ensure proper reimbursement for these screening tests the correct procedure and diagnosis codes and modifier (when appropriate) must be used when filing claims.

Important Claim Filing Information

When filing claims for diabetes screening tests the following Healthcare Common Procedure Coding System (HCPCS) codes/Current Procedural Terminology (CPT) codes, and diagnosis codes must be used to ensure proper reimbursement:

Table 1 HCPCS/CPT Codes and Descriptors

HCPCS/CPT Codes	Code Descriptors
82947	Glucose; quantitative, blood (except reagent strip)
82950	Glucose; post glucose dose (includes glucose)
82951	Glucose; Tolerance Test (GTT), three specimens (includes glucose)

Table 2 Diagnosis Code and Descriptor

Criteria	Modifier	Diagnosis Code	Code Descriptor
DOES NOT MEET	None	V77.1	To indicate that the purpose of the test(s) is for diabetes screening for a beneficiary who does not meet the *definition of pre-diabetes, screening diagnosis code V77.1 is required in the header diagnosis section of the claim.
MEET	-TS	V77.1	To indicate that the purpose of the test(s) is for diabetes screening for a beneficiary who meets the *definition of pre-diabetes, screening diagnosis code V77.1 is required in the header diagnosis section of the claim <i>and</i> modifier “TS” (follow-up service) is to be reported on the line item.

IMPORTANT NOTE: The Centers for Medicare & Medicaid Services (CMS) monitors the use of its preventive and screening benefits. By correctly coding for diabetes screening and other benefits, providers can help CMS to more accurately track the use of these important services and identify opportunities for improvement. *When submitting a claim for a diabetes screening test it is important to use diagnosis code V77.1 and the “TS” modifier on the claim as indicated in Table 2 above along with the correct HCPCS/CPT code (Table 1) so that the provider/supplier can be reimbursed correctly for a screening service and not for another type of diabetes testing service.*

Definitions

Diabetes: Diabetes mellitus, is defined as a condition of abnormal glucose metabolism diagnosed using the following criteria:

- A fasting blood glucose greater than or equal to 126 mg/dL on two different occasions;
- A 2-hour post-glucose challenge greater than or equal to 200 mg/dL on two different occasions; or

- A random glucose test over 200 mg/dL for a person with symptoms of uncontrolled diabetes.

Pre-diabetes: A condition of abnormal glucose metabolism diagnosed using the following criteria:

- A fasting glucose level of 100 to 125 mg/dL, or
- A 2-hour post-glucose challenge of 140 to 199 mg/dL.

The term “pre-diabetes” includes:

- Impaired fasting glucose; and
- Impaired glucose tolerance.

Covered Tests

Medicare will pay for the following diabetes screening tests:

- A fasting blood glucose test, and
- A post-glucose challenge test; not limited to
 - Ø An oral glucose tolerance test with a glucose challenge of 75 grams of glucose for non-pregnant adults), **OR**
 - Ø A 2-hour post-glucose challenge test alone.

Note: Other diabetes screening tests for which the CMS has not specifically indicated national coverage continue to be non-covered.

Eligibility

Medicare beneficiaries who have any of the following risk factors for diabetes are eligible for this screening benefit:

- Hypertension;
- Dyslipidemia;
- Obesity (a body mass index equal to or greater than 30 kg/m²); or
- Previous identification of elevated impaired fasting glucose or glucose tolerance.

OR

Medicare beneficiaries who have a risk factor consisting of *at least two* of the following characteristics are eligible for this screening benefit:

- Overweight (a body mass index greater than 25, but less than 30 kg/m²);
- A family history of diabetes;
- Age 65 years or older;
- A history of gestational diabetes mellitus, or of delivering a baby weighing greater than 9 pounds.

Note: No coverage is permitted under the screening benefit for beneficiaries previously diagnosed with diabetes since these individuals do not require screening.

Frequency

Medicare provides coverage for diabetes screening tests with the following frequency:

Beneficiaries diagnosed with pre-diabetes:

Medicare provides coverage for a maximum of two diabetes screening tests per calendar year (but not less than 6 months apart) for beneficiaries diagnosed with pre-diabetes.

Beneficiaries previously tested but not diagnosed with pre-diabetes or who have never been tested:

Medicare provides coverage for one diabetes screening test per year (i.e., at least 11 months have passed following the month in which the last Medicare-covered diabetes screening test was performed) for beneficiaries who were previously tested and who were not diagnosed with pre-diabetes, or who have never been tested.

Note: The Medicare beneficiary must be provided with a referral by a physician or qualified non-physician practitioner for the diabetes screening test(s). The diabetes screening service covered by Medicare is a stand alone billable service separate from the initial preventive physical examination (also referred to as the Welcome to Medicare Physical Examination) and does not have to be obtained within the first six months of a beneficiary’s Medicare Part B coverage.

Additional Information

If you have any questions, please contact your Medicare Carrier or your Medicare Administrative Contractor at their toll-free number, which may be found on the CMS web site at:

<http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip>

Claim Status Category Code and Claim Status Code Update

Reference: Trans. 1533, CR #6090, Pub. 100-04, MLN: MM6090

Provider Types Affected

Physicians, providers, and suppliers who bill Medicare contractors (carriers, fiscal intermediaries (FI), regional home health intermediaries (RHHI), Part A/B Medicare Administrative Contractors (A/B MAC), and Durable Medical Equipment Medicare Administrative Contractors (DME MAC) for services provided to Medicare beneficiaries.

What You Need to Know

CR 6090, from which this article is taken, reminds providers of the periodic updates to the Claim Status Codes and Claim Status Category Codes that Medicare contractors use with the Health Care Claim Status Request (ASC X12N 276), and the Health Care Claim Response (ASC X12N 277).

Background

The Claim Category and Claim Status Codes explain the status of submitted claims. The Health Insurance Portability and Accountability Act (HIPAA) requires all health care benefit payers to use only national Code Maintenance Committee-approved codes in the X12 276/277 Health Care Claim Status Request and Response format adopted as the standard for national use (004010X093A1).

The national Code Maintenance Committee meets at the beginning of each X12 trimester meeting (February, June, and October) to decide about additions, modifications, and retirement of existing codes. Included in the code lists are specific details, including the date when a code was added, changed, or deleted.

CR 6090, from which this article is taken, updates the changes in the Claim Status Codes and Claim Status Category Codes from the February 2008 committee meeting, which were posted at <http://www.wpc-edi.com/content/view/180/223/> on February 29, 2008 (previously referenced by <http://www.wpc-edi.com/codes>). CR6090 reminds Medicare contractors that they must have completed the entry of all applicable code text changes and new codes, and terminated the use of deactivated codes by its implementation date (October 6, 2008). On and after this date, these code changes are to be used in editing of all X12 276 transactions processed, and to be reflected in the X12 277 transactions issued.

Additional Information

You can find the official instruction, CR6090, issued to your carrier, FI, RHHI, A/B MAC, or DME MAC by visiting the CMS web site at:

<http://www.cms.hhs.gov/Transmittals/downloads/R1533CP.pdf>

If you have any questions, please contact your carrier, FI, RHHI, A/B MAC, or DME MAC at their toll-free number, which may be found on the CMS web site at:

<http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip>

Effective Date: October 1, 2008; Implementation Date: October 6, 2008

Screening Pelvic Examination

Reference: Trans. 1541, CR #6085, Pub. 100-04, MLN: MM6085

Provider Types Affected

Physicians and other providers who bill Medicare contractors (carriers, fiscal intermediaries (FI), and Medicare Administrative Contractors (A/B MAC)) for providing screening pelvic examinations for Medicare beneficiaries.

What You Need to Know

The Centers for Medicare & Medicaid Services (CMS) has become aware that the *Medicare Claims Processing Manual*, Chapter 18 (Preventive and Screening Services), Section 40 (Screening Pelvic Examinations) is not clear on what elements are needed during a screening pelvic examination. CR 6085, from which this article is taken, clarifies this unclear information, specifically adding the following language (displayed below in bolded, underlined italics):

- “Section 4102 of the Balanced Budget Act of 1997 (P.L. 105-33) amended §1861(nn) of the Act (42 USC 1395X(nn)) to include Medicare Part B coverage of screening pelvic examinations *(including a clinical breast examination)* for all female beneficiaries for services provided January 1, 1998 and later; and
- A screening pelvic examination *with or without specimen collection for smears and cultures*, should include at least seven of the following *eleven* elements:
 - Ø Inspection and palpation of breasts for masses or lumps, tenderness, symmetry, or nipple discharge; and
 - Ø Digital rectal examination including sphincter tone, presence of hemorrhoids, and rectal masses.
 - Ø External genitalia (for example, general appearance, hair distribution, or lesions);
 - Ø Urethral meatus (for example, size, location, lesions, or prolapse);
 - Ø Urethra (for example, masses, tenderness, or scarring);
 - Ø Bladder (for example, fullness, masses, or tenderness);
 - Ø Vagina (for example, general appearance, estrogen effect, discharge, lesions, pelvic support, cystocele, or rectocele);
 - Ø Cervix (for example, general appearance, lesions or discharge)
 - Ø Uterus (for example, size, contour, position, mobility, tenderness, consistency, descent, or support);
 - Ø Adnexa/parametria (for example, masses, tenderness, organomegaly, or nodularity); and
 - Ø Anus and perineum.

Please note that CR 6085 does not provide any change in policy. It simply clarifies unclear information in the manual as stated above.

Additional Information

You can find more information about screening pelvic examinations by going to CR 6085, located at <http://www.cms.hhs.gov/Transmittals/downloads/R1541CP.pdf> on the CMS website. You will find the updated *Medicare Claims Processing Manual*, Chapter 18 (Preventive and Screening Services), Section 40 (Screening Pelvic Examinations) as an attachment to CR 6085.

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

Effective Date: September 23, 2008; Implementation Date: September 23, 2008

Medicare Acute Care Episode (ACE) Demonstration (CR 6001 rescinds and fully replaces CR 5767)

Reference: Trans. 58, CR #6001, Pub. 100-19, MLN: MM6001

Provider Types Affected

Hospitals submitting claims to Medicare contractors (especially those providers billing the Part A/B Medicare Administrative Contractor (A/B MAC)) in Medicare MAC jurisdiction 4. Physicians and other providers treating inpatients or referring inpatients covered by the demonstration within MAC jurisdiction 4 may also find this article of interest

Impact to You

This article is based on Change Request (CR) 6001 which provides details regarding the Medicare Acute Care Episode (ACE) Demonstration and rescinds and replaces CR 5767 (Transmittal 55, dated January 25, 2008). The article is informational, especially for hospitals and providers in Texas, Oklahoma, Colorado, and New Mexico. Only hospitals in those states may apply to participate in this demonstration.

What You Need to Know

CR 6001 remains the same as CR 5767 (Transmittal 55) except for specifying that the geographic location of the Medicare Acute Care Episode (ACE) Demonstration is A/B MAC Jurisdiction 4 (Texas, Oklahoma, Colorado, and New Mexico). Only providers in these states may volunteer to participate in the ACE demonstration. CR 6001 also contains claims processing instructions and changes required for Medicare systems to process and pay for acute inpatient episodes of care under this demonstration. A summary of the demonstration design and how it relates to the required system changes is included in Attachments I through V of CR 6001.

What You Need to Do

See the Background and Additional Information Sections of this article for further details regarding this demonstration project.

Background

The Acute Care Episode (ACE) Demonstration is being implemented under the provisions of the Medicare Health Care Quality Demonstration Programs (Social Security Act; Section 1866C; see http://www.ssa.gov/OP_Home/ssact/title18/1866C.htm on the Internet), as amended by the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Public Law 108-173; Section 646). Section 1866C of the Social Security Act allows the Secretary to approve demonstration projects that examine health delivery factors that encourage the delivery of improved quality in patient care, including the provision of incentives for improving the quality and safety of care and achieving the efficient allocation of resources.

As a value-based purchaser of care, the Centers for Medicare & Medicaid Services (CMS) seeks to devise and test new methods of paying providers that will encourage improvements in both the efficiency and quality of care provided to Medicare beneficiaries. With this in mind, the goal of the ACE Demonstration is to align hospitals' and physicians' incentives to work together to provide coordinated, cost-effective care by:

- Bundling all related services into an "episode of care," and
- Paying a single, global payment that can be used as the providers of care deem most appropriate.

It is expected that the ACE Demonstration will achieve savings to the Medicare program and give hospitals and physicians the flexibility to allocate resources as they determine to be most appropriate.

Approximately 15 demonstration sites will be selected to participate in this demonstration, currently projected to start on January 1, 2009, with site selection occurring during the fall of 2008. Sites will be selected from states previously mentioned in this article that pay claims under the diagnostic related group (DRG) inpatient prospective payment system (IPPS). Individual demonstration sites will participate for three years from their first date of operation, and CMS has the option to add demonstration sites.

All proposals will be thoroughly reviewed by a technical expert panel to insure the organization's capacity to carry out the demonstration. Entities may submit proposals for a global payment under the demonstration for one or more of the categories listed in Attachment II of CR 6001. However, if a demonstration site is selected for a particular category of DRGs, all admissions for eligible beneficiaries to the facility for DRGs in that category shall

be processed under the demonstration payment rules. In addition, participating entities will be required to submit quality data relevant to the services being provided under the demonstration.

CMS staff will provide Medicare contractors with a list of all demonstration providers and their associated identification numbers (e.g. National Provider Identifier (NPI), Medicare legacy provider identification number, etc) as well as DRGs covered under the demonstration for each facility. This information is expected to be relatively static and stable during the course of the demonstration. However, there is the possibility that some information may require infrequent updates during the course of the demonstration.

Systems shall be operational to process claims under this demonstration with dates of admission on or after October 1, 2008 however claims will begin to be processed under the demonstration on January 1, 2009. The period October through December, 2008 will be used to educate providers, beneficiaries, and other stakeholders about the demonstration and test the claims processing systems. Under this demonstration, it is intended that the cost reports and settlement for disproportionate share and indirect medical education be processed based on what the A/B MAC would have paid for Part A services in the absence of the demonstration.

Patients eligible for the demonstration must be eligible for Medicare Part A and Part B under Medicare's traditional fee-for-service program and they must have at least one lifetime reserve day at the time of admission to the demonstration hospital in order for the stay to be covered under the demonstration. Beneficiaries enrolled in any type of Medicare health plan are not eligible for the demonstration, even if all or a portion of the claim is processed using Medicare fee-for service claims processing systems

Additional Information

The official instruction, CR 6001, issued to your A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R58DEMO.pdf> on the CMS website. Attached to CR6001 you will find a more detailed description of the demonstration design and the DRGs that may be part of a hospital's demonstration application.

If you have any questions, please contact your A/B MAC at their toll-free number, which may be found on the CMS web site at:

<http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip>

Effective Date: Admissions occurring on or after January 1, 2009; Implementation Date: January 1, 2009

Cardiac Computed Tomographic Angiography (CTA)

Reference: Trans. 85, CR #6098, Pub. 100-03, MLN: MM6098

Provider Types Affected

Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), and/or Part A/B Medicare Administrative Contractors (A/B MACs)) for Cardiac CTA services provided to Medicare beneficiaries.

Provider Action Needed

This article is informational only and based on Change Request (CR) 6098 which announces that the Centers for Medicare & Medicaid Services (CMS), upon review of the available evidence, has determined that the coverage of cardiac computed tomographic angiography (CTA) to diagnosis coronary artery disease (CAD) will remain at local Medicare contractor discretion, and no national coverage determination (NCD) is appropriate at this time.

Background

CTA is a noninvasive method (using intravenous contrast) to visualize the coronary arteries (or other vessels) using high resolution, high speed computed tomography (CT).

After examining the medical evidence, CMS has determined that no NCD is appropriate at this time, effective March 12, 2008. Pursuant to the Social Security Act (Section 1862(a)(1)(A)), decisions should be made by local contractors through:

- The local coverage determination process,
- Or case-by-case adjudication.

Therefore, all claims for CTA used to diagnose CAD will continue to be determined by local Medicare contractor discretion and section 220.1 of Publication 100-03 of the NCD Manual remains unchanged.

Additional Information

The official instruction, CR 6098, issued to your carrier, FI, and A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R85NCD.pdf> on the CMS website.

If you have any questions, please contact your carrier, FI, or A/B MAC at their toll-free number, which may be found on the CMS web site at:

<http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip>

Effective Date: March 12, 2008; Implementation Date: July 28, 2008

Continuous Positive Airway Pressure (CPAP) Therapy for Obstructive Sleep Apnea (OSA)

Reference: *Trans. 86, CR #6048, Pub. 100-03, MLN: MM6048*

Provider Types Affected

Physicians, providers and suppliers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), and/or Part A/B Medicare Administrative Contractors (A/B MACs)) for OSA-related services provided to Medicare beneficiaries.

Impact on Providers

Providers need to be aware that effective for claims with dates of service on and after March 13, 2008, Medicare will allow for coverage of CPAP therapy based upon a positive diagnosis of OSA by home sleep testing (HST), subject to the requirements of CR6048.

Background

The Centers for Medicare & Medicaid Services (CMS) reconsidered its 2005 National Coverage Determination (NCD) for CPAP Therapy for OSA to allow for coverage of CPAP based upon a diagnosis of OSA by HST.

Medicare previously covered the use of CPAP only in beneficiaries who had been diagnosed with moderate to severe OSA when ordered and prescribed by a licensed treating physician and confirmed by polysomnography (PSG) performed in a sleep laboratory in accordance with section 240.4 of the Medicare NCD Manual (see the *Additional Information* section of this article for the official instruction and the revised section of the NCD). Following the reconsideration of its coverage policy, CMS is revising the existing NCD on CPAP therapy for OSA as well as allowing coverage of CPAP based on a positive diagnosis of OSA by HST, subject to all the requirements of the new NCD, as outlined in CR6048. Note that billing guidelines for capped rental equipment are contained in the *Medicare Claims Processing Manual*, Chapter 20, Section 30.5, which is available at <http://www.cms.hhs.gov/manuals/downloads/clm104c20.pdf> on the CMS website.

As part of the NCD, apnea is defined as a cessation of airflow for at least 10 seconds. Hypopnea is defined as an abnormal respiratory event lasting at least 10 seconds with at least a 30% reduction in thoracoabdominal movement or airflow as compared to baseline, and with at least a 4% oxygen desaturation. The apnea hypopnea index (AHI) is equal to the average number of episodes of apnea and hypopnea per hour. The respiratory disturbance index (RDI) is equal to the average number of respiratory disturbances per hour.

Key Points of CR6048

For coverage of routine items/services provided in the context of a clinical study, Medicare will process claims according to Coverage with Evidence Development (CED)/clinical trials criteria at section 310.1 of the NCD Manual and chapter 32 and sections 69.6-69.7 (Pub 100-04) of the *Medicare Claims Processing Manual*. Use the CPT coding referenced in the bullets as noted above.

The key changes in Medicare policy, as a result of the NCD in CR6048, coverage of CPAP based on positive diagnosis of OSA by HST is as follows:

1. Coverage of CPAP is initially limited to a 12 week period for beneficiaries diagnosed with OSA as described below. CPAP is subsequently covered for those beneficiaries diagnosed with OSA whose OSA improves as a result of CPAP during this 12 week period.

Note: Remember that Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) suppliers are required to provide beneficiaries with necessary information and instructions on how to use Medicare-covered items safely and effectively.

2. CPAP for adults is covered when diagnosed using a clinical evaluation and a positive:
 - Polysomnography (PSG) performed in a sleep laboratory; or
 - Unattended home sleep monitoring device of Type II; or
 - Unattended home sleep monitoring device of Type III; or
 - Unattended home sleep monitoring device of Type IV, measuring at least three channels

Note: Remember that, in general, pursuant to 42 CFR 410.32(a), diagnostic tests that are not ordered by the beneficiary's treating physician are not considered reasonable and necessary. Pursuant to 42

CFR 410.32(b) diagnostic tests payable under the Medicare physician fee schedule that are furnished without the required level of supervision by a physician are not reasonable and necessary.

3. A positive test for OSA is established if either of the following criteria using the Apnea-Hypopnea Index (AHI) or Respiratory Distress Index (RDI) is met:
 - AHI or RDI greater than or equal to 15 events per hour, or
 - AHI or RDI greater than or equal to 5 and less than or equal to 14 events per hour with documented symptoms of excessive daytime sleepiness, impaired cognition, mood disorders or insomnia, or documented hypertension, ischemic heart disease, or history of stroke.

Note: The AHI is equal to the average number of episodes of apnea and hypopnea per hour. The RDI is equal to the average number of respiratory disturbances per hour.

4. The AHI or RDI is calculated on the average number of events of per hour. If the AHI or RDI is calculated based on less than two hours of continuous recorded sleep, the total number of recorded events to calculate the AHI or RDI during sleep testing is at least the number of events that would have been required in a two hour period.
5. CMS is deleting the distinct requirements that an individual have moderate to severe OSA and that surgery is a likely alternative.
6. CPAP based on clinical diagnosis alone or using a diagnostic procedure other than PSG or Type II, Type III, or a Type IV HST measuring at least three channels is covered only when provided in the context of a clinical study and when that study meets the standards outlined in the NCD manual revision attached to CR6048.

Additional Information

To see the official instruction (CR6048) issued to your Medicare A/B MAC, FI or carrier visit the CMS web site at:

<http://www.cms.hhs.gov/Transmittals/downloads/R86NCD.pdf>

If you have questions, please contact your Medicare A/B MAC, FI or carrier at their toll-free number which may be found on the CMS web site at:

<http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip>

Effective Date: March 13, 2008; Implementation Date: August 4, 2008

October Quarterly Update to 2008 Annual Update of HCPCS Codes Used for Skilled Nursing Facility (SNF) Consolidated Billing (CB) Enforcement

Reference: Trans. 1537, CR #6111, Pub. 100-04, MLN: MM6111

Provider Types Affected

Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers and/or Part A/B Medicare Administrative Contractors (A/B MACs)) for services provided to Medicare beneficiaries

Provider Action Needed

This article is based on Change Request (CR) 6111 which provides the October quarterly update to the 2008 Healthcare Common Procedure Coding System (HCPCS) codes for Skilled Nursing Facility (SNF) consolidated billing (CB) enforcement.

Background

The Social Security Act (Section 1888; see http://www.ssa.gov/OP_Home/ssact/title18/1888.htm on the Internet) codifies Skilled Nursing Facility (SNF) Prospective Payment System (PPS) and Consolidated Billing (CB), and the Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of Healthcare Common Procedure Coding System (HCPCS) codes that are subject to the CB provision of the SNF PPS. The new coding identified in each update describes the same services that are subject to SNF PPS payment by law.

Services appearing on this list of updated HCPCS codes that are submitted on claims to Medicare Fiscal Intermediaries, Carriers, or A/B MACs will not be paid by Medicare to any providers other than a Skilled Nursing Facility (SNF) **when included** in SNF Consolidated Billing (CB).

For non-therapy services, SNF CB applies only when the services are furnished to a SNF resident during a covered Part A stay. However, SNF CB applies to physical and occupational therapies and speech-language pathology services whenever they are furnished to a SNF resident, regardless of whether Part A covers the stay.

Services excluded from SNF PPS and CB may be paid to providers, other than SNFs, for beneficiaries, even when in a SNF stay. In order to assure proper payment in all settings, Medicare systems must edit for services provided to SNF beneficiaries both included and excluded from SNF CB.

For October 1, 2008, the only change is that Medicare systems will add HCPCS code L5670 (ADDITION TO LOWER EXTREMITY, BELOW KNEE, MOLDED SUPRACONDYLAR SUSPENSION ('PTS' OR SIMILAR)) to the File 1 Coding list. Your Medicare contractor will reopen and reprocess claims with dates of service on or after January 1, 2008 that are affected by this change if you bring such claims to their attention.

Additional Information

The official instruction, CR 6111, issued to your carrier or A/B MAC regarding this change may be viewed on the CMS web site at:

<http://www.cms.hhs.gov/Transmittals/downloads/R1537CP.pdf>

If you have any questions, please contact your carrier or A/B MAC at their toll-free number, which may be found on the CMS web site at:

<http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip>

Effective Date: October 1, 2008; Implementation Date: October 6, 2008

Payment for Inpatient Hospital Visits - General (Codes 99221 – 99239)

Reference: Trans. 1545, CR #5792, Pub. 100-04, MLN: MM5792

Note: This article was revised on June 30, 2008, to reflect changes made to CR5792. The CR was revised to clarify that hospital emergency services are not paid for the same date as critical care services when provided by the same physician to the same patient. The CR transmittal number, release date, and Web address for accessing the CR were also changed. All other information remains the same.

Provider Types Affected

Physicians and non physician practitioners (NPPs), submitting claims to Medicare Administrative Contractors (A/B MACs) and/or carriers for services provided to Medicare beneficiaries during a hospital visit.

Provider Action Needed

Providers should note the payment policy for billing inpatient hospital visits provided on the same day as critical care services. See the *Key Points* section of this article for a complete list of the updates.

Background

CR5792 updates Chapter 12, Section 30.6.9 of the Medicare Claims Processing Manual. The updated section of this manual is attached to CR5792 and the address/link to that CR is listed in the *Additional Information* section of this article.

Key Points

Physicians and qualified NPPs should note the payment policy requirements according to CR5792 are as follows:

- When a hospital inpatient or office/outpatient evaluation and management (E/M) service is furnished on a calendar date at which time the patient does not require critical care and the patient subsequently requires critical care, both the critical care services (Current Procedural Terminology (CPT) codes 99291 and 99292) and the previous E/M service may be paid for the same date of service. (Note that hospital emergency department services are not paid for the same date as critical care services when provided by the same physician to the same patient.)
- During critical care management of a patient those services that do not meet the level of critical care should be reported using an inpatient hospital care service with CPT Subsequent Hospital Care using a CPT code in the 99231-99233 range.
- Physicians and qualified NPPs may report both critical care services and an inpatient hospital care service for the same patient on the same calendar date when during critical care management of a patient the services do not meet the level of critical care services.
- Physicians and qualified NPPs are reminded that both Initial Hospital Care codes (CPT codes 99221-99223) and Subsequent Hospital Care codes are “per diem” services and may be reported only once per day by the same physician or physicians of the same specialty from the same group practice.
- Physicians and qualified NPPs are advised to retain documentation for discretionary Medicare carrier or A/B MAC review in case claims are questioned. The retained documentation must support why the same physician or physicians of the same specialty in a group practice submitted claims for both critical care services and other E/M services for the patient on the same date of service.

Additional Information

You may see the official instruction (CR5792) issued to your Medicare A/B MAC or carrier by going on the CMS web site to:

<http://www.cms.hhs.gov/Transmittals/downloads/R1545CP.pdf>

If you have questions, please contact your Medicare A/B MAC or carrier at their toll-free number, which may be found on the CMS web site at:

<http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip>

Effective Date: April 1, 2008; Implementation Date: April 7, 2008

Intracranial Percutaneous Transluminal Angioplasty (PTA) with Stenting

Reference: *Trans. 87, CR #6137, Pub. 100-03, MLN: MM6137*

Provider Types Affected

Physicians and providers who may wish to submit claims to Medicare Carriers, fiscal intermediaries (FIs) and Part A/B Medicare Administrative Contractors (A/B MACs) for PTA with stenting.

What Providers Need to Know

Be aware that the Centers for Medicare & Medicaid Services (CMS) has reviewed the evidence and on May 12, 2008 posted a final decision memorandum following reconsideration of its National Coverage Determination (NCD) on PTA with intracranial stent placement at section 20.7.B.5 of the Medicare NCD Manual. With CR6137, **CMS reaffirms its existing NCD with no changes, and will continue to cover PTA and stenting of intracranial arteries for the treatment of cerebral artery stenosis \geq 50 percent in patients with intracranial atherosclerotic disease when furnished in accordance with the Food and Drug Administration (FDA) approved protocols governing Category B Investigational Device Exemption (IDE) clinical trials.** CMS will continue its national non-coverage for all other indications for PTA with or without stenting to treat obstructive lesions of the vertebral and cerebral arteries.

Background

This article is based on Change Request (CR) 6137, which responds to a request on August 24, 2007 by the manufacturer to reconsider and expand coverage to include Coverage with Evidence Development (CED) for intracranial stenting and angioplasty for patients in the IDE clinical trials.

Additional Information

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

You may see the official instruction (CR6137) issued to your Medicare Carrier, FI, or A/B MAC, by going to <http://www.cms.hhs.gov/Transmittals/downloads/R87NCD.pdf> on the CMS website. Section 20.7 of the Medicare NCD Manual is attached to CR6137.

You may also review MM5432 which preceded this article and provides the previous CMS response to PTA with stenting at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5432.pdf> on the CMS website.

Effective Date: May 12, 2008; Implementation Date: August 11, 2008

Extension of Payment Rule for Brachytherapy and Therapeutic Radiopharmaceuticals

Reference: *JSM CI 5460-08415; 07-16-08*

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), enacted on July 15, 2008, extends the use of the cost to charge payment methodology for Brachytherapy and Therapeutic Radiopharmaceuticals through January 1, 2010. This change is retroactive to July 1, 2008. Some claims have already been processed, however, using the Outpatient Prospective Payment System (OPPS) rates that were in effect until MIPAA enactment. To avoid a disruption in payment while the cost to charge payment methodology is re-implemented, impacted claims will continue to be paid based on the OPPS rates. Contractors will mass adjust all impacted OPPS claims with dates of service beginning July 1, 2008, as soon as the cost to charge payment methodology has been implemented. Reprocessing will be complete by September 30, 2008.

Critical Care Visits and Neonatal Intensive Care (Codes 99291 - 99292)

Reference: Trans. 1548, CR #5993, Pub. 100-04, MLN: MM5993

Note: This article was revised on July 10, 2008, to reflect changes made to CR5993 on July 9. CR5993 was revised to reflect longstanding policy regarding critical care services and other evaluation and management services on the same day, to correct information regarding calculation of critical care time to be consistent with the American Medical Association's Current Procedural Terminology, and to make minor clarifications in language related to time spent reviewing or discussing patient information and off the unit/floor and split/shared service discussions.

Provider Types Affected

Physicians and Qualified Non-Physician Practitioners (NPP) who bill Medicare carriers and Medicare Administrative Contractors (A/B MAC) for critical care services provided to Medicare beneficiaries.

What You Need to Know

CR 5993, from which this article is taken, revises the *Medicare Claims Processing Manual* Chapter 12 (Physicians/Non-physician Practitioners), Section 30.6.12. (Critical Care Visits and Neonatal Intensive Care (Codes 99291 - 99292)), replacing all previous critical care payment policy language in the section and adding general Medicare evaluation and management (E/M) payment policies that impact payment for critical care services.

Specifically, CR 5993:

- Explains the definition of, and how to bill for, critical care services, and includes the American Medical Association (AMA) Current Procedural Terminology (CPT) definitions of critical care and critical care services.
- **Adds a new CPT code for 2008 (36591) which replaces code 36540.** Code 36591 identifies a bundled vascular access procedure when performed with a critical care service.

Make sure that your billing staffs are aware of these revisions.

Background

CR 5993, from which this article is taken, explains the definition of critical care services and how to correctly bill for these services. It discusses medically necessary services, full physician attention, counting the hours of critical care billing, performance of other evaluation and management (E/M) services on the same day as critical care services, group practice issues, services by a qualified non-physician practitioner (NPP), bundled procedures, global surgery issues, ventilation management, teaching physician issues, physician services off the unit/floor, split/shared services, unbundled procedures, and inappropriate use of time and family counseling and discussions.

The following summarizes the information contained in CR 5993 and in *Medicare Claims Processing Manual* Chapter 12, Section 30.6.12, which is an attachment to CR5993.

Use of Critical Care Codes (CPT codes 99291-99292)

Critical care is defined as a physician's (or physicians') direct delivery of medical care for a critically ill or critically injured patient. A critical illness or injury acutely impairs one or more vital organ systems such that there is a high probability of imminent or life threatening deterioration in the patient's condition.

Critical care involves high complexity decision making to assess, manipulate, and support vital system functions to treat single, or multiple, vital organ system failure; and/or to prevent further life threatening deterioration of the patient's condition. Examples of vital organ system failure include (but are not limited to):

- Central nervous system failure;
- Circulatory failure;
- Shock;
- Renal, hepatic, metabolic, and/or respiratory failure.

Although it typically requires interpretation of multiple physiologic parameters and/or application of advanced technology(s), critical care may be provided in life threatening situations when these elements are not present.

You should remember that providing medical care to a critically ill, injured, or post-operative patient qualifies as a critical care service only if both the illness or injury and the treatment being provided meet the above

requirements. While critical care is usually given in a critical care area such as a coronary care unit, intensive care unit, respiratory care unit, or the emergency department, payment may also be made for critical care services that you provide in any location as long as this care meets the critical care definition.

When all these criteria are met, Medicare contractors (carriers and A/B MACs) will pay for critical care and critical care services that you report with CPT codes 99291 and 99292 (described below).

Critical Care Services and Medical Necessity

Critical care services must be reasonable and medically necessary. As explained above, critical care services encompass both the treatment of “vital organ failure” and “prevention of further life threatening deterioration in the patient’s condition.” Therefore, delivering critical care in a moment of crisis, or upon being called to the patient’s bedside emergently, is not the only requirement for providing critical care service. Treatment and management of a patient’s condition, in the threat of imminent deterioration; while not necessarily emergent, is required.

In this context, examples of patients whose medical conditions may warrant critical care services would include:

1. An 81 year old male patient is admitted to the intensive care unit following abdominal aortic aneurysm resection. Two days after surgery he requires fluids and vasopressors to maintain adequate perfusion and arterial pressures. He remains ventilator dependent.
2. A 67 year old female patient is three days status post mitral valve repair. She develops petechiae, hypotension, and hypoxia requiring respiratory and circulatory support.
3. A 70 year old admitted for right lower lobe pneumococcal pneumonia with a history of COPD becomes hypoxic and hypotensive two days after admission.
4. A 68 year old admitted for an acute anterior wall myocardial infarction continues to have symptomatic ventricular tachycardia that is marginally responsive to antiarrhythmic therapy.

You should not consider that the provision of care to a critically ill patient is automatically a critical care service just because the patient is critically ill or injured. To this point, each physician providing critical care services to a patient during the critical care episode of an illness or injury must be managing one or more of the critical illness(es) or injury(ies) in whole, or in part.

In this context, examples of scenarios in which a patient’s medical condition may not warrant critical care services would include:

1. A dermatologist evaluating and treating a rash on an ICU patient who is maintained on a ventilator and nitroglycerine infusion that are being managed by an intensivist.
2. Daily management of a patient on chronic ventilator therapy unless the critical care is separately identifiable from the chronic long term management of the ventilator dependence.
3. Management of dialysis or care related to dialysis for a patient receiving End Stage Renal Disease (ESRD) hemodialysis, unless the critical care is separately identifiable from the chronic long term management of the dialysis dependence (Refer to *Medicare Claims Processing Manual*, Chapter 8 (Outpatient ESRD Hospital, Independent Facility, and Physician/Supplier Claims), Section 160.4 (Requirements for Payment)).

Note: When a separately identifiable condition (e.g., management of seizures or pericardial tamponade related to renal failure) is being managed it may be billed as critical care, if critical care requirements are met. Modifier –25 (significant, separately identifiable evaluation and management services by the same physician on the day of the procedure) should be appended to the critical care code when applicable in this situation.

Similarly, examples of patients who may not satisfy Medicare medical necessity criteria for critical care payment would include:

- Patients admitted to a critical care unit because no other hospital beds were available,
- Patients admitted to a critical care unit for close nursing observation and/or frequent monitoring of vital signs (e.g., drug toxicity or overdose), or
- Patients admitted to a critical care unit because hospital rules require certain treatments (e.g., insulin infusions) to be administered in the critical care unit.

You may also want to consult the American Medical Association (AMA) CPT Manual for the applicable codes and guidance for critical care services provided to neonates, infants and children. Critical care services provided in the outpatient setting (e.g., emergency department or office) for neonates and pediatric patients up through 24 months of age, use the hourly critical care codes 99291 and 99292.

For all other inpatient neonatal and pediatric critical care, refer to AMA CPT for guidance on the correct use of codes.

Critical Care Services and Full Attention of the Physician

The duration of critical care services that physicians should report is the time you actually spend evaluating, managing, and providing the critically ill, or injured, patient's care. Be aware that during this time, you cannot provide services to any other patient, but rather must devote your full attention to this particular critically ill patient.

This time must be spent at the patient's immediate bedside or elsewhere on the floor, or unit, so long as you are immediately available to the patient. For example, time spent reviewing laboratory test results or discussing the critically ill patient's care with other medical staff in the unit or at the nursing station on the floor would be reported as critical care, even when it does not occur at the bedside; if this time represents your full attention to the management of the critically ill/injured patient.

Note: Time spent off the unit or floor where the critically ill/injured patient is located (i.e., telephone calls, whether taken at home, in the office, or elsewhere in the hospital) floor may not be reported as critical care time because the physician is not immediately available to the patient. This time is regarded as pre- and post service work bundled in evaluation and management services.

Critical Care Services and Qualified Non-Physician Practitioners (NPP)

Qualified NPPs may provide critical care services (and report for payment under their National Provider Identifier (NPI)), when these services meet the above **critical care services definition and requirements**.

Notes: 1) The critical care services that NPPs provide must be within the scope of practice and licensure requirements for the State in which they practice and provide the services; and 2) NPPs must meet the collaboration, physician supervision requirements, and billing requirements; and physician assistants (PA) must meet the general physician supervision requirements.

Critical Care Services and Physician Time

Critical care is a time- based service. Payment for critical care services is not restricted to a fixed number of hours, days, or physicians (on a per-patient basis) when such services meet medical necessity; and time counted toward critical care services may be continuous clock time or intermittent in aggregated time increments (e.g. 50 minutes of continuous clock time or five ten minute blocks of time spread over a given calendar date). Only one physician may bill for critical care services during any one single period of time even if more than one physician is providing care to a critically ill patient. For each medical encounter, the physician's progress notes must document the total time that critical care services are provided.

For Medicare Part B physician services, paid under the physician fee schedule, critical care is not a service that is paid on a "shift" basis or a "per day" basis. Documentation may be requested for any claim to determine medical necessity. Examples of critical care billing that may require further review could include:

- Claims from several physicians submitting multiple units of critical care for a single patient; and
- Submitting claims for more than 12 hours of critical care time by a physician for one or more patients on the same given calendar date.

Physicians assigned to a critical care unit (e.g., hospitalist, intensivist etc.) may not report critical care for patients based on a 'per shift' basis. You should use CPT code 99291 (evaluation and management of the critically ill or critically injured patient, first 30-74 minutes) to report the first 30-74 minutes of critical care on a given calendar date of service. You can only use this code once per calendar date to bill for care provided for a particular patient by the same physician or physician group of the same specialty.

CPT code 99292 (critical care, each additional 30 minutes) is used to report each additional 30 minutes beyond the first 74 minutes of critical care. It may also be used to report the final 15 - 30 minutes of critical care on a given date. Critical care of less than 15 minutes beyond the first 74 minutes or less than 15 minutes beyond the final 30 minutes is not separately payable. Critical care of less than 30 minutes total duration on a given calendar date is not

reported separately using the critical care codes. This service should be reported using another appropriate E/M code such as subsequent hospital care.

Table 1 (below) illustrates the correct reporting of critical care services, followed by a clinical example.

Table 1
Reporting of Critical Care Services

Total Duration of Critical Care	Appropriate CPT Codes
Less than 30 minutes	99232 or 99233 or other appropriate E/M code
30 - 74 minutes	99291 x 1
75 - 104 minutes	99291 x 1 and 99292 x 1
105 - 134 minutes	99291 x1 and 99292 x 2
135 - 164 minutes	99291 x 1 and 99292 x 3
165 - 194 minutes	99291 x 1 and 99292 x 4
194 minutes or longer	99291 – 99292 as appropriate (per the above illustrations)

Clinical Example of Correct Billing of Time:

A patient arrives in the emergency department (ED) in cardiac arrest. The emergency department physician provides 40 minutes of critical care services. A cardiologist is called to the ED and assumes responsibility for the patient, providing 35 minutes of critical care services. The patient stabilizes and is transferred to the CCU. In this instance, the ED physician provided 40 minutes of critical care services and reports only the critical care code (CPT code 99291) and not also codes for emergency department services. Using CPT code 99291, the cardiologist may also report the 35 minutes of critical care services provided in the ED. Additional critical care services by the cardiologist in the CCU (on the same calendar date) using 99292 or another appropriate E/M code depending on the clock time involved.

Other Critical Care Issues

There are some specific rules about physician services and time that you should know:

1. Only one physician can bill for critical care during any one single period of time. Unlike other E/M services, critical care services reflect one physician’s (or qualified non-physician practitioner’s) care and management of a critically ill or critically injured patient for the specified reportable period of time. You cannot report a split/shared E/M service performed by a physician and a qualified NPP of the same group practice (or employed by the same employer) as a critical care service. The critical care service reported should reflect the evaluation, treatment and management of the patient by the individual physician or qualified non-physician practitioner and not representative of a combined service between a physician and a qualified NPP.

When CPT code requirements for time and critical care requirements are met for a medically necessary visit by an individual clinician the service shall be reported using the appropriate individual NPI number. Medically necessary visit(s) that do not meet these requirements shall be reported as subsequent hospital care services.

Please note that medically necessary service(s) that do not meet critical care criteria may be reported as subsequent hospital care services.

In denying a claim for a critical care service that is a split/shared service, carriers and A/B MACS will use the following messages:

Claims Adjustment Reason Code:

150 – Payment adjusted because the payer deems the information submitted does not support this level of service.

Remittance Advice Reason Code:

N180 – This item or service does not meet the criteria for the category under which it was billed.

Medicare Summary Notice:

17.11 – This item or service cannot be paid as billed.

For unassigned claims, Medicare contractors will use add-on message 16.34 – You should not be billed for this service. You are only responsible for any deductible and coinsurance amounts listed in the ‘you may be billed’ column; or

For assigned claims, Medicare contractors will use add-on message 16.35 – You do not have to pay this amount.

2. When performed on the day a physician bills for critical care, the following services are included in the critical care service, and should not be reported separately:
 - The interpretation of cardiac output measurements (CPT 93561, 93562)
 - Chest x-rays, professional component (CPT 71010, 71015, 71020)
 - Blood draw for specimen (CPT 36415)
 - Blood gases, and information data stored in computers (e.g., ECGs, blood pressures, hematologic data (CPT 99090))
 - Gastric intubation (CPT 43752, 91105)
 - Pulse oximetry (CPT 94760, 94761, 94762)
 - Temporary transcutaneous pacing (CPT 92953)
 - Ventilator management (CPT 94002 – 94004, 94660, 94662)
 - Vascular access procedures (CPT 36000, 36410, 36415, 36591, 36600)

No other procedure codes are bundled into the critical care services. Therefore, other medically necessary procedure codes may be billed separately.

3. Concurrent care by more than one physician (generally representing different physician specialties) is payable if the services all meet critical care requirements, are medically necessary, and are not duplicative (refer to *Medicare Benefit Policy Manual*, Chapter 15 (Covered Medical and Other Health Services), Section 30 (Physician Services) for concurrent care policy discussion).

Critically ill or injured patients may require the care of more than one physician medical specialty, but keep in mind that the critical care services provided by each physician must be medically necessary. Medicare will pay for non-duplicative, medically necessary critical care services provided by 1) physicians from the same group practice; or 2) from different group practices to the same patient.

Note: Physician specialty means the self-designated primary specialty by which the physician bills Medicare and is known to the carrier who adjudicates the claims. Physicians in the same group practice who have different medical specialties may bill and be paid without regard to their membership in the same group. For example, if a cardiologist and an endocrinologist are group partners and the critical care services of each are medically necessary and not duplicative the critical care services may be reported by each regardless of their group practice relationship.

Your medical record documentation must support that the critical care services each physician provided were necessary for treating and managing the patient’s critical illness(es) or critical injury(ies). Each physician must accurately report the service(s) he/she provided to the patient in accordance with any applicable global surgery rules or concurrent care rules. (Refer to *Medicare Claims Processing Manual*, Chapter 12 (Physicians/Non-physician Practitioners), and Section 40 (Surgeons and Global Surgery); and *Medicare Benefit Policy Manual*, Chapter 15 (Covered Medical and Other Health Services), and Section 30 (Physician Services)).

You will need to follow these specific coding requirements.

- The initial critical care time (billed as CPT code 99291) must be met by a single physician or qualified NPP. This may be performed in a single period of time or be cumulative by the same physician on the same calendar date. A history or physical examination performed by one group partner for another group partner in order for the second group partner to make a medical decision would not represent critical care services.
- Subsequent critical care visits performed on the same calendar date are reported using CPT code 99292. The service may represent aggregate time met by a single physician or physicians in the

same group practice with the same medical specialty in order to meet the duration of minutes required for CPT code 99292. The aggregated critical care visits must be medically necessary and each aggregated visit must meet the definition of critical care in order to combine the times.

- Physicians in the same group practice who have the same specialty may not each report CPT initial critical care code 99291 for critical care services to the same patient on the same calendar date. Medicare payment policy states that physicians in the same group practice who are in the same specialty must bill and be paid as though each were the single physician. (Refer to *Medicare Claims Processing Manual*, Chapter 12 (Physicians/Non-physician Practitioners.)
- Physicians in the same group practice, with different specialties, who provide critical care to a critically ill or critically injured patient may not always each report the initial critical care code (CPT 99291) on the same date. When these physicians are providing care that is unique to his/her individual medical specialty, and are managing at least one of the patient's critical illness(es) or critical injury(ies); then the initial critical care service may be payable to each. However, if a physician (or qualified NPP) within a group provides "staff coverage" or "follow-up" for another group physician who provided critical care services on that same calendar date but has left the case; the second group physician (or qualified NPP) should report the CPT critical care add-on code 99292, or another appropriate E/M code.

Clinical Examples of Critical Care Services

- a. Two pulmonary specialists, who share a group practice, each provide critical care services (at different times during the same day) to a patient who has multiple organ dysfunction (including cerebral hematoma, flail chest and pulmonary contusion), is comatose, and has been in the intensive care unit for 4 days following a motor vehicle accident. Both physicians may report medically necessary critical care services provided at the different time periods. One physician would report CPT code 99291 for the initial visit and the second, as part of the same group practice, would report CPT code 99292 on the same calendar date if the appropriate time requirements are met.
- b. A 79 year old male comes to the emergency room with vague joint pains and lethargy. The ED physician evaluates him and phones his primary care physician to discuss his medical evaluation. His primary care physician visits the ER and admits him to the observation unit for monitoring, and diagnostic and laboratory tests; during which time he has a cardiac arrest. His primary care physician provides 50 minutes of critical care services, and admits him to the intensive care unit. On the same calendar day his condition deteriorates and he requires intermittent critical care services. In this scenario, the ED physician should report an emergency department visit and the primary care physician should report both an initial hospital visit and critical care services.

4. When a patient requires critical care services upon presentation to a hospital emergency department, you may only report critical care codes 99291 - 99292. You may not also report an emergency department visit code.

However, when critical care services are provided on a day during which a hospital, emergency department, or office/outpatient evaluation and management service was furnished earlier on the same date at which time the patient did not require critical care, both the critical care and the previous evaluation and management service may be paid. Hospital emergency department services are not payable for the same calendar date as critical care services when provided by the same physician to the same patient. Physicians are advised to submit documentation to support a claim when critical care is additionally reported on the same calendar date as when other evaluation and management services are provided to a patient by the same physician or physicians of the same specialty in a group practice.

5. Critical care services will not be paid on the same calendar date that the physician also reports a procedure code with a global surgical period, unless the critical care is billed with CPT modifier -25 to indicate that the critical care is a significant, separately identifiable, evaluation and management service that is above and beyond the usual pre and post operative care associated with the procedure that is performed.

Services such as endotracheal intubation (CPT code 31500) and the insertion and placement of a flow directed catheter e.g., Swan-Ganz (CPT code 93503) are not bundled into the critical care codes.

Therefore, separate payment may be made for critical care in addition to these services if the critical care was a significant, separately identifiable service and it was reported with modifier -25. The time spent

performing the pre, intra, and post procedure work of these unbundled services, e.g., endotracheal intubation, should be excluded from the determination of the time spent providing critical care.

This policy applies to any procedure with a 0, 10, or 90 day global period including cardiopulmonary resuscitation (CPR -- CPT code 92950). CPR has a global period of 0 days and is not bundled into critical care codes. Therefore, critical care may be billed in addition to CPR if critical care was a significant, separately identifiable service and it was reported with modifier -25. The time spent performing CPR should be excluded from the determination of the time spent providing critical care. In this instance the physician who performs the resuscitation must bill for this service. Members of a code team cannot each bill Medicare Part B for this service.

When a physician, other than the surgeon, provides postoperative critical care services (for procedures with a global surgical period); no modifier is required unless all surgical postoperative care has been officially transferred from the surgeon to the physician performing the critical care services. In this situation, both the surgeon and intensivist, who are submitting claim, must use CPT modifiers "-54" (surgical care only) and "-55" (postoperative management only). Critical care services must meet all the conditions previously described, and the medical record documentation of the surgeon and physician who assumes a transfer (e.g., intensivist's), must both support claims for services when CPT modifiers -54 and -55 are used indicating the transfer of care from the surgeon to the intensivist.

6. In addition to a global fee, critical care services provided during the preoperative portion and postoperative portions of the global period of procedures with 90 day global period in trauma and burn cases may be paid if the patient is critically ill and requires the full attention of the physician; and the critical care is unrelated to the specific anatomic injury or general surgical procedure performed.

Such patients may meet the definition of being critically ill and criteria for conditions where there is a high probability of imminent or life threatening deterioration in the patient's condition. Preoperatively, in order for these services to be paid, two reporting requirements must be met. Codes 99291 - 99292 and modifier -25 (significant, separately identifiable evaluation and management services by the same physician on the day of the procedure) must be used, and documentation identifying that the critical care was unrelated to the specific anatomic injury or general surgical procedure performed must be submitted. An ICD-9-CM code in the range 800.0 through 959.9 (except 930.0 - 939.9), which clearly indicates that the critical care was unrelated to the surgery, is acceptable documentation.

Postoperatively, in order for these services to be paid, two reporting requirements must also be met. Codes 99291 - 99292 and modifier -24 (unrelated evaluation and management service by the same physician during a postoperative period) must be used, and documentation that the critical care was unrelated to the specific anatomic injury or general surgical procedure performed must be submitted.

An ICD-9-CM code in the range 800.0 through 959.9 (except 930.0 - 939.9), which clearly indicates that the critical care was unrelated to the surgery, is acceptable documentation.

Note: Medicare policy allows separate payment to the surgeon for postoperative critical care services during the surgical global period when the patient has suffered trauma or burns. When the surgeon provides critical care services during the global period, for reasons unrelated to the surgery, these are separately payable as well.

7. Critical care CPT codes 99291 and 99292 include pre and post service work. Routine daily updates or reports to family members and or surrogates are considered part of this service.

However, time involved with family members or other surrogate decision makers, whether to obtain a history or to discuss treatment options (as described in CPT), may be counted toward critical care time when these specific criteria are met:

- The patient is unable or incompetent to participate in giving a history and/or making treatment decisions; and
- The discussion is necessary for determining treatment decisions.

For such family discussions, the physician should document:

- The medically necessary treatment decisions for which the discussion was needed;
- That the patient is unable or incompetent to participate in giving history and/or making treatment decisions;

- The necessity to have the discussion (e.g., "no other source was available to obtain a history" or "because the patient was deteriorating so rapidly I needed to immediately discuss treatment options with the family"; and
- A summary in the medical record that supports this medical necessity.

Telephone calls to family members and or surrogate decision-makers may be counted towards critical care time, only if they meet the same criteria as described in the aforementioned paragraph. Further, no other family discussions (no matter how lengthy) may be additionally counted towards critical care.

8. A teaching physician, to bill for critical care services, must meet the requirements for critical care described above. For procedure codes determined on the basis of time, such as critical care, the teaching physician must be present for the entire period of time for which the claim is submitted. For example, payment will be made for 35 minutes of critical care services only if the teaching physician is present for the full 35 minutes. (See *Medicare Claims Processing Manual*, Chapter 12 (Physicians/Non-physician Practitioners), Section 100.1.4 (Time-Based Codes).

Time spent teaching may not be counted towards critical care time. Nor, can the teaching physician bill, as critical care or other time-based services, for time spent by the resident (in the teaching physician's absence). Only time that the teaching physician spends alone with the patient (and that he/she and the resident spend together with the patient), can be counted toward critical care time.

A combination of the teaching physician's documentation and the resident's documentation may support critical care services. Provided that all requirements for critical care services are met, the teaching physician documentation may tie into the resident's documentation. The teaching physician may refer to the resident's documentation for specific patient history, physical findings and medical assessment.

However, the teaching physician medical record documentation must provide substantive information including:

- Time the teaching physician spent providing critical care;
- That the patient was critically ill during the time the teaching physician saw the patient;
- What made the patient critically ill; and
- The nature of the treatment and management provided by the teaching physician.

The medical review criteria are the same for the teaching physician as for all physicians. (See *Medicare Claims Processing Manual* Chapter 12 (Physicians/Non-physician Practitioners), Section 100.1.1 (Evaluation and Management (E/M) Services) for teaching physician documentation guidance).

The following is an example of acceptable teaching physician documentation: *"Patient developed hypotension and hypoxia; I spent 45 minutes while the patient was in this condition, providing fluids, pressor drugs, and oxygen. I reviewed the resident's documentation and I agree with the resident's assessment and plan of care."* **Conversely, the following is an example of unacceptable documentation from a teaching physician:** *"I came and saw (the patient) and agree with (the resident)"*.

9. Medicare recognizes ventilator codes (CPT codes 94002 - 94004, 94660 and 94662) as physician services payable under the physician fee schedule. Medicare Part B under the physician fee schedule does not pay for ventilator management services in addition to an E/M service (e.g., critical care services, CPT codes 99291 - 99292) on the same day for the patient even when the E/M service is billed with CPT modifier -25.

Physicians should consult the American Medical Association (AMA) CPT Manual for the applicable codes and guidance for critical care services provided to neonates, infants and children. Critical care services provided in the outpatient setting (e.g., emergency department or office) for neonates and pediatric patients up through 24 months of age, use the hourly critical care codes 99291 and 99292. For all other inpatient neonatal and pediatric critical care, refer to AMA CPT for guidance on the correct use of codes.

Additional Information

You can find more information about critical care visits and neonatal intensive care (codes 99291 - 99292) by going to CR 5993, located at <http://www.cms.hhs.gov/Transmittals/downloads/R1548CP.pdf> on the Centers for Medicare & Medicaid Services (CMS) website. Updated Medicare Claims Processing Manual Chapter 12 (Physicians/Nonphysician Practitioners), Section 30.6.12. (Critical Care Visits and Neonatal Intensive Care (Codes 99291 - 99292) is an attachment to that CR.

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

Effective Date: July 1, 2008; Implementation Date: July 7, 2008

Comprehensive Error Rate Testing (CERT)

To view the latest CERT newsletter, please visit your state website at:

Arkansas: <http://www.arkmedicare.com/provider/cert/newsletters.asp>

Louisiana: <http://www.lamedicare.com/provider/cert/newsletters.asp>

Rhode Island: <http://www.rimedicare.com/provider/cert/newsletters.asp>

DMEPOS

Delay of the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program

Reference: CMS List-Serv Message 071608

The Medicare Improvements for Patients and Providers Act of 2008 was enacted on July 15, 2008. This new law has delayed the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program. Items that had been included in the first round of the DMEPOS Competitive Bidding Program can be furnished by any enrolled DMEPOS supplier in accordance with existing Medicare rules. Payment for these items will be made under the fee schedule. Additional guidance regarding this new law will be forthcoming.

Drug Pricing

Medicare Part B Drugs Average Sales Price Files - July 2008

Reference: CMS List-Serv Message 061808

The Centers for Medicare & Medicaid Services (CMS) has made available the Medicare Part B Drug and Biological Average Sales Price (ASP) Payment Amounts for July 1, 2008 to September 30, 2008 on the CMS website at http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/01a_2008aspfiles.asp. The files are located in the "Downloads" section of this web page.

Electronic Data Interchange (EDI)

How Can I Avoid Medicare Part B Payment Problems?

Reference: AR – DKB 071508

Did you know that Medicare produces reports for each transmission file you or your clearinghouse sends for you? The Batch Detail Control Listing (H99RAR04) report details how many claims were received by a provider, how many claims were accepted, and how many claims were rejected. This report is produced the next business day for each provider and given to each submitter. In addition to the H99RAR04 report, a Detail ICN Cross Reference (H99RAR06) report is produced for each submitter showing the Assigned ICN, Patient Number, Provider NPI, and patient HIC number of each claim that has been accepted into the Medicare processing system for further adjudication.

Managing your Medicare Part B claim payments has never been easier. Once a file is uploaded to the EDI Gateway a confirmation is produced stating your file was received by EDI Services. Next the claim is passed to the EDI Translator and the Batch Processing Report (BPR) is produced 30 minutes after transmission. This report will state how many claims were sent and accepted by the translator and the number of claims passed to the Medicare system. Any claim that is rejected is also detailed on the BPR and why.

That night, the claim is forward to Medicare for front-end editing. Each claim must go through Medicare's front-end edits. The H99 and R06 ICN report are given back to EDI the next business day. These reports are cut up by submitter number and put into the submitter's electronic mailbox on the EDI Gateway. All reports, Upload confirmations, Transaction Acknowledgement (TA1), 997 Acknowledgement, which details if the EDI Translator accepted or rejected the file, BPR, H99, and R06 are all given back to each submitter daily. If you missed one simply go to your archive directory for another copy.

It's every provider's and submitter's responsibility to review these reports and understand why a reject may have occurred. This process will help ensure that your Medicare payments are not delayed. Not getting your reports? All direct submitters receive these reports for each file they submit. If you use a clearinghouse or billing agent then they receive these reports on your behalf. Contact them and request your reports be passed to you. Not all clearinghouses or billing agents give this data back to providers. Shop around if your clearinghouse or billing agent does not. You are not getting what you are paying for. Several provide this information in paper form and others via internet connections. Regardless of how it's provided, you need it to make sure your claims are being accepted by Medicare.

In reviewing some of the top billing issues with Medicare we found providers who did not receive these reports experience many more payment problems than providers who did receive them. Why take a chance with your money? Get your reports and know for certain the status of your claims.

General

Intermittent Urinary Catheterization

Reference: AR - SPH 061808

Recently Medicare changed the Local Coverage Determination (LCD) for urological supplies. The previous policy covered “clean technique” for patients without a history of recurring urinary tract infections – allowing four intermittent catheters per month, which were cleaned and re-used. Now any patient who utilizes intermittent catheterization can receive one sterile urological catheter and one packet of lubricant for each catheterization.

Because of this change in Medicare policy, medical equipment suppliers may be contacting you for new prescriptions for your patients. There are a couple important points to keep in mind. First, the prescription should reflect the actual number of times that the patient actually catheterizes him/herself per day. For example, if the patient self-catheterizes four times per day, the prescription should be for approximately 120 catheters per month. Although the LCD says that Medicare will cover up to 200 intermittent catheters per month, this is a maximum number and most patients self-catheterize less than 6 times per day. It would be inappropriate to order 200 catheters per month for every patient. The prescription must be individualized for each patient.

The second important point is that you should clearly document in your chart the number of times per day that the patient performs self-catheterization. Just listing that value on the prescription or on a separate form provided by the supplier is not sufficient. In the case of an audit, we would look for documentation in the patient’s medical record.

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Administrative Simplification and Compliance Act (ASCA)

Reference: AR – DKB 071508

Arkansas, Louisiana and Rhode Island Providers

Did you receive a letter from Pinnacle Medicare Services of Oklahoma regarding Review of Your Paper Claim Submission Practice or Request an Electronic Claim Submission Waiver? If so, please read the information below:

The Oklahoma office for Pinnacle Medicare Services closed in May, 2008. At that time all ASCA business moved to Little Rock, Arkansas. The contact information is:

ATTN: ASCA REVIEW
Pinnacle Business Solutions Inc
P.O. Box 1418
Little Rock, AR 72203-1418
1-866-582-3247

Oklahoma and New Mexico providers - all ASCA files and letters were transferred to Trailblazer. Contact TrailBlazer at www.trailblazerhealth.com.

Missouri providers - all ASCA files and letters were transferred to WPS. Contact WPS at www.wpsmedicare.com.

New Medicare Rule Ensures Access to Health Care for Beneficiaries in Rural Areas

Reference: CMS List-Serv Message 062608

Medicare beneficiaries who live in rural and underserved areas of the United States would be able to continue to get their health care services from Rural Health Clinics (RHCs) whose services are tailored to meet their individual needs under new rules proposed today by the Centers for Medicare & Medicaid Services (CMS).

“These proposed changes to the rural health clinic program would ensure that Medicare beneficiaries in rural underserved areas have ready access to high quality primary health care from physicians and certain non-physician providers,” said Acting CMS Administrator Kerry Weems. “The flexibilities we are proposing will help to ensure that beneficiaries and Medicare get the best value from RHC providers.”

The proposed regulation would require RHCs to establish quality assessment and performance improvement (QAPI) programs. It would also establish location requirements necessary for a clinic to continue to participate as an RHC, which would ensure that the RHC program kept pace with demographic changes in the service areas and best met the needs of underserved beneficiaries. The regulation would also provide opportunities for existing RHCs to apply for exceptions from location requirements, and would provide RHCs with greater flexibility in staffing requirements and sharing resources with fee-for-service providers in the facility. In line with statutory requirements, the rule also would limit payments for RHCs to 80 percent of reasonable costs, minus beneficiary coinsurance and deductible amounts.

More specifically, the proposed rule would:

- Implement statutory requirements that all RHCs be located in areas that were non-urban and demonstrated that there was a shortage of health care services. Existing RHCs that do not meet the location requirements but are still providing needed services in rural and underserved areas could be granted an exception as an “essential provider” if they met criteria established by the rule;
- Improve access to health care services in rural areas by providing more flexibility in staffing requirements by allowing an RHC to contract with non-physician practitioners -- such as physician assistants (PA), nurse practitioners (NP), and certified nurse midwives -- as long as one PA or NP was directly employed by the clinic;
- Clarify when an RHC could share resources (“commingling”) with an on-site Medicare or Medicaid fee-for-service provider to allow greater flexibility in providing needed services for beneficiaries in certain circumstances; and
- Implement a statutory requirement that RHCs establish a QAPI program to help these clinics identify and implement opportunities for improvement, including preventing the transmission of infectious and communicable diseases and ensuring the accuracy of patient health records.

“With the regulation we are proposing today, these providers will have better guidance on how to qualify as a **rural health clinic**,” said Weems. “Medicare will be better able to ensure that qualified rural clinics are able to seek cost-based payment under the RHC program.”

Many changes in the proposed rule, such as revisions to the payment methodology, would also apply to federally qualified health centers (FQHCs). FQHCs are similar in many respects to RHCs but may operate in urban or rural underserved areas. A CMS fact sheet provides more information on the proposed rule, including provisions that uniquely apply to FQHCs. The fact sheet may be viewed at http://www.cms.hhs.gov/apps/media/fact_sheets.asp.

The proposed regulation may be viewed at http://federalregister.gov/OFRUpload/OFRData/2008-13280_PI.pdf. Comments must be submitted by 5:00 p.m. Eastern time on August 27, 2008.

CMS Proposes Payment, Policy Changes for Physicians' Services in 2009

Reference: CMS List-Serv Message 062608

Proposed Regulation Promotes Higher Quality, Efficient Care

The Centers for Medicare & Medicaid Services (CMS) today proposed new efforts to promote access to higher quality and more efficient health care delivered by the nation's physicians to people with Medicare under the 2009 Medicare Physician Fee Schedule (MPFS).

"We are taking a multi-pronged approach to improve how Medicare pays for health care services for our nation's seniors," said CMS acting administrator Kerry Weems. "These efforts are designed to ensure that beneficiaries continue to get the highest quality of health care at the greatest value for beneficiaries and the Medicare program."

The MPFS was created by Congress and is updated annually to set the Medicare payment rates for more than 980,000 physicians and non-physician practitioners (NPPs) who bill Medicare for the services they furnish to beneficiaries. Under a formula in the Medicare statute, CMS is required to reduce 2009 Physician Fee Schedule by 5.4 percent. Total Medicare spending under the 2009 Physician Fee Schedule is projected at \$54 billion, down 5 percent from the \$57 billion projected for 2008.

Nearly 95 percent of physicians enrolled in Medicare accept the fee schedule rate as payment in full. Medicare pays 80 percent of the fee schedule rate, while the beneficiary is responsible for the remaining 20 percent.

"CMS has been carefully monitoring beneficiary access to physicians' services," said Weems. "To date, our studies, as well as studies by the Medicare Payment Advisory Commission, reveal that beneficiaries in most areas of the country are having little or no trouble in seeing their physicians and we expect this to continue in 2009."

Through the MPFS, CMS is encouraging greater efficiency in the delivery of care, while reducing treatment errors through the use of electronic health records; and exploring new payment models to see if there are ways to promote greater coordination of care among providers, producing better outcomes for the health care dollar.

CMS is proposing additional improvements to the Physician Quality Reporting Initiative (PQRI) which allows eligible professionals to report quality measures relating to their clinical practice. Proposed changes for the 2009 PQRI Program include:

- Proposing that the final set of quality measures will be selected from 175 measures that fall into four broad categories: (1) 113 current 2008 PQRI measures; (2) 17 new measures that have been endorsed by the National Quality Forum (NQF); (3) 20 new measures that have been adopted by the AQA Alliance (AQA); and (4) 25 new measures proposed for 2009 contingent on NQF endorsement or AQA adoption by July 31, 2008;
- Increasing the number of conditions covered by measures groups to nine, adding coronary artery disease, HIV/AIDS, coronary artery bypass surgery, rheumatoid arthritis, care during surgery, and back pain, to the original measures groups for diabetes, chronic kidney disease, and preventive care. Measures groups require reporting a set of related measures and can help assure that patients are receiving a range of care appropriate for a given clinical condition or clinical focus.
- Reporting options that include two new reporting periods (January 1, 2009 to December 31, 2009, or July 1, 2009 to December 31, 2009) to provide eligible professions with additional options for reporting PQRI data; and
- Accepting PQRI data via clinical registries and electronic health records systems.

Launched in 2007, the PQRI was recently expanded as a result of the Medicare, Medicaid and SCHIP Extension Act of 2007 to include additional measures that will allow more eligible professionals to earn incentive payments in 2008 for submitting 2008 data, and to provide alternative, streamlined methods for reporting. Thus, eligible professionals who are not already participating in the PQRI this year will have the opportunity to begin reporting in July 2008 to qualify for an incentive payment. Those eligible professionals who have reported PQRI data successfully for the full year can earn an incentive payment based on their total Medicare allowed charges for services furnished in CY 2008, while those who begin reporting in July can earn an incentive payment based on their total allowed charges from July 1 through December 31, 2008.

CMS is also proposing to improve the quality of diagnostic testing performed by physicians and NPPs in their offices by requiring them to enroll as suppliers of these services and to meet certain quality and performance standards, including applicable Federal and State licensure, health and safety requirements that currently apply to independent diagnostic testing facilities (IDTFs). CMS is proposing to make the standards effective January 1, 2009 for newly enrolling suppliers, but to allow existing suppliers until September 30, 2009 to come into compliance. The proposal specifically seeks public comment about whether these standards should apply to all diagnostic services or to a subset of services such as those that require more costly testing and equipment, imaging services generally, or only advanced imaging techniques.

The fee schedule proposed rule also addresses a change to the exemption that limits the use of computer-generated faxes to e-prescribe Part D covered drugs for Part D eligible individuals to instances in which temporary/transient transmission failure or communication problems preclude the use of the adopted NCPDP SCRIPT standard. This change is scheduled to take effect on January 1, 2009.

In the MPFS 2009 Proposed Rule, CMS is proposing to retain the provisions that would allow for use of computer-generated faxes in instances of temporary/transient transmission failure or communication problems that preclude the use of the adopted NCPDP SCRIPT standard, and add an exemption for computer-generated faxes used by dispensers to request refills from providers that are not capable of receiving and processing refill requests using the adopted NCPDP SCRIPT standard.

CMS will accept comments on the proposed rule until August 29, 2008, and will respond to those comments in a final rule to be issued by November 1, 2008. The revised policies and payment rates will become effective January 1, 2009.

For more information, see www.cms.hhs.gov/center/physician.asp.

Medicare Guide to Rural Health Services Information for Providers, Suppliers, and Physicians

Reference: CMS List-Serv Message 070908

The print version of the revised Medicare Guide to Rural Health Services Information for Providers, Suppliers, and Physicians (April 2008) is now available from the Centers for Medicare & Medicaid Services Medicare Learning Network. This guide contains rural health information pertaining to rural health facility types, coverage and payment policies, and rural provisions under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 and the Deficit Reduction Act of 2005. To place your order, visit <http://www.cms.hhs.gov/mlngeninfo/>, scroll down to “Related Links Inside CMS” and select “MLN Product Ordering Page.”

Medicare Coverage of Bioengineered Skin Substitutes (Revised for Clarification and Explanation)

Reference: AR – LSB 070708

The following article is written to clarify the articles previously published on August 27, 2007 and November 5, 2007.

To be covered by Medicare, any metabolically active product used in ulcer treatment must be billed under the appropriate code and used according to the FDA labeling instructions. Documentation of criteria, frequency, and duration must be included in the medical record. The medical record must clearly document that conservative pre-treatment wound management has been tried and failed to induce healing. Compliance with the FDA approved labeling provisions is subject to monitoring by pre-payment medical review and post payment data analysis with subsequent medical review. Additional utilization guidelines beyond the FDA labeling, and information based on Medical Review results of prior claim review, are included in this article for provider use.

The Contractor will continue to cover only products that have documented clinical evidence of efficacy for wound healing. Other products that are used for wound management will be included in the Evaluation and Management service provided, and not separately payable.

This article provides information for coverage of bioengineered skin substitutes and their application. The short descriptors for the codes are in accordance with the AMA copyright agreement. Please refer to the current CPT book for full descriptions. Please remember that the HCPCS/CPT code(s) may be subject to Correct Coding Initiative (CCI) edits that limits their use with certain CPT codes and global periods. Providers are also reminded that the use must be consistent with State licensure and scope of practice limitations.

Documentation should be readily available and submitted to the Contractor upon request.

When the documentation does not meet the criteria for the service billed (rendered) or the documentation does not establish the medical necessity for the services provided, such services will be denied as not reasonable and necessary under Section 1862(a)(1) of the Social Security Act.

1. **HCPCS code J7340** - Metabolically active dermal/epidermal tissue substitutes of human origin (e.g. Apligraf®). Use CPT codes 15340 and 15341 (Apply cultured skin substitute) for the application.

A manufactured viable bilaminate graft or skin substitute is designed to be used for treatment of non-infected partial and full-thickness skin ulcers due to venous insufficiency and for treatment of full-thickness neuropathic diabetic foot ulcers which extend through the dermis, but without tendon, muscle, capsule or bone exposure and which are located on the plantar, medial or lateral area of the foot excluding the heel. Coverage of this modality/product will be considered established during the Medical Review process when all of the following conditions are satisfied and documented:

- a. Partial or full-thickness skin ulcers due to venous insufficiency or full-thickness neuropathic diabetic foot ulcers;
- b. Ulcers of greater than one (1) month duration for partial or full-thickness skin ulcers due to venous insufficiency or three (3) weeks duration for full thickness neuropathic diabetic foot ulcers;
- c. Ulcers that have failed to respond to documented conservative measures;
- d. There must be measurements of the initial ulcer size, the size of the ulcer following cessation of conservative management, and the size at the beginning of skin substitute treatment; and
- e. For neuropathic diabetic foot ulcers, appropriate steps to off-load pressure during treatment must be taken and documented in the patient's medical record.

In addition, the ulcer must be free of infection and underlying osteomyelitis; and treatment of the underlying disease (e.g., peripheral vascular disease) must be provided and documented in conjunction with skin substitute treatment.

For the purposes of this article, an applied skin substitute or graftskin, e.g., Apligraf®, is deemed to be an artificial graft.

Limitations are as follows:

- a. Use of the skin substitute is generally limited to five (5) separate applications to any given ulcer.

- b. In general, there should be no fewer than six weeks between applications.
- c. Treatment of any ulcer will typically last approximately 12-weeks.
- d. Generally, no more than two applications of the skin substitute are indicated. If, after 12-weeks of compression treatment and two applications of the skin substitute, a 50 percent or greater improvement is noted and documented, then additional applications of skin substitute will be considered for coverage. Otherwise, reapplication of the skin substitute is not recommended and other treatment modalities should be considered.

A **repeat** course of treatment with skin substitute that is started within 12-months (start of treatment to start of treatment) of a previous course of treatment is subject to review.

Covered ICD-9 codes:

250.80 - 250.83	Diabetes, with other specified manifestations
454.0	Varicose veins of lower extremities, with ulcer
454.2	Varicose veins of lower extremities, with ulcer and inflammation
459.11	Post-phlebitic syndrome with ulcer
459.31	Chronic venous hypertension with ulcer
707.10	Ulcer of the lower limb, unspecified
707.13	Ulcer of ankle
707.14	Ulcer of heel and midfoot
707.15	Ulcer of other part of foot

Documentation Requirements:

1. The medical record must clearly show the criteria listed above have been met.
 2. The ulcer must be measured at the beginning of conservative treatment, following cessation of conservative treatment and at the beginning of the skin substitute treatment.
 3. The record must document that the wound treatment by this method is accompanied by appropriate wound dressing during the healing period and by appropriate compressive dressings during follow-up.
2. **HCPCS J7341** - Metabolically active dermal tissue substitutes of non-human origin (e.g. OASIS[®])

For services on or after June 12, 2007 Oasis[®] Wound Matrix is covered and separately payable when used according to FDA labeled indications and in accordance with accepted standards of medical/surgical practice. Use 15430 (apply acellular Xenograft) and 15431 (apply acellular xgraft add) for the application. Oasis[®] Wound Matrix must be used in conjunction with a comprehensive, organized wound management program, either office- or clinic-based. Oasis[®] application is considered a physician service thus it must be applied by either a physician or a qualified and duly licensed Non-Physician Practitioner (NPP) (not nurses, physical therapists, technicians, or medical assistants). The application code will be paid no more frequently than at 90-day intervals. Though payment for the product is allowed as appropriate to the clinical considerations, it is inappropriate to bill application codes multiple times within a 90-day period using such modifiers as 58, suggesting a staged procedure.

Facilities may bill for application and product at a frequency appropriate to the clinical circumstances. Critical Access Hospitals billing Method 2 should note that the product has been valued according to a 90-day global period under the Physician Fee Schedule; therefore, the application will be paid no more frequently than the 90-day interval for physicians.

Covered ICD-9 Codes:

- 454.0
- 454.2
- 940.0-949.5
- 707.10-707.19 (Primary dx)
- 250.60-250.83 (Secondary dx)

3. **HCPCS J7342** - Metabolically active dermal tissue of human origin (e.g. Dermagraft[®]).
Use CPT codes 15360 and 15361 (Apply cultured dermal substitute, trunk/arms/legs) and 15365 and 15366 (Apply cultured dermal substitute face/neck/hands/feet/genitalia) for the application.

Dermal skin substitutes are cryopreserved human fibroblast-derived dermal substitutes, which are manufactured from human fibroblast cells derived from newborn foreskin tissue. Dermal skin substitutes are indicated for use for the treatment of full-thickness diabetic foot ulcers greater than six weeks duration which extend through the dermis, but without tendon, muscle, joint capsule or bone exposure.

A. Indications:

Coverage will generally be considered established during Medical Review if the following conditions are satisfied and documented:

1. Patient has a current diagnosis of type I or type II diabetes mellitus.
2. The diabetic foot ulcers are greater than six weeks duration, which extend through the dermis, but without tendon, muscle, joint capsule or bone exposure.
3. The ulcer is located on the plantar, medial, or lateral surface of the foot, and is greater than or equal to 1 cm² and less than or equal to 20 cm².
4. The ulcer has failed to respond to conservative measures such as non-weight bearing regimen, debridement of necrotic and callused tissue, and acceptable methods of wound care.
5. Foot ulcer (after debridement) is free of necrotic debris, exhibits no sign of clinical infection, and the patient has adequate circulation to the foot as evidenced by a palpable pulse (either dorsalis pedis or posterior tibial artery) in order to support tissue growth.
6. It should be used in conjunction with standard wound care regimens and in patients that have adequate blood supply to the involved foot.
7. Patients must receive pressure-reducing footwear and must be encouraged to stay off their treated foot during treatment.

B. Limitations are as follows:

1. Use of dermal skin substitutes for diabetic ulcers, is limited to weekly applications to the ulcer for up to eight weeks. Wound closure must be evident in twelve weeks after initiation of therapy.
2. It is contraindicated for use in ulcers that have signs of clinical infection (e.g., increased exudates, odor, redness, swelling, heat, pain, tenderness, purulent discharge) or in ulcers with tunnel or sinus tracts that cannot be completely debrided.
3. It is contraindicated in patients who have clinical evidence of cellulitis, gangrene or osteomyelitis on any part of the affected foot.
4. It is contraindicated in patients with known hypersensitivity to bovine products, as it may contain trace amounts of bovine proteins from the manufacturing medium and storage solution.
5. Arterial disease with an ankle brachial index (ABI) of less than 0.65, lack of pedal pulses, or other physician documentation of inadequate perfusion are not-covered.

Covered ICD-9 codes:

Primary diagnosis:

250.80 - 250.83 Diabetes with other specified manifestations

Secondary Diagnosis:

707.14.1 Ulcer of heel and midfoot

707.14.2 Ulcer of other part of foot (toes)

Documentation Requirements:

1. For treatment of venous insufficiency ulcers and diabetic foot ulcers, the record must identify the duration of the ulcer's presence with a description of the conservative treatment measures taken. The medical record must contain a description of the wound at baseline (prior to beginning conservative treatment) relative to size, location, stage, and presence of infection. The documentation must provide an updated description of the wound prior to the dermal skin substitute application in terms of response to treatment (i.e., ulcer measurement and progress toward healing). Following the application, continued documentation noting changes in the ulcer must be present.
2. The patient's medical record must contain documentation that fully supports the medical necessity for application of the skin substitute as it is covered by Medicare (see "Indications and Limitations of

Coverage" section). This documentation includes, but is not limited to, relevant medical history, physical examination, and results of pertinent diagnostic tests or procedures.

3. Additional applications must also be noted.

The following diagnoses do not support reasonableness for any bioengineered skin substitutes:

- Infected ulcer;
- Osteomyelitis;
- Allergy to bovine collagen;
- Uncontrolled diabetes; "controlled" diabetes for purposes of this article would be based on documentation in the medical record;
- Vasculitis;
- Uncontrolled rheumatoid arthritis and/or rheumatoid ulcers;
- Other uncontrolled collagen vascular disease;
- Patients under treatment with high dose corticosteroids or immunosuppressants;
- Patients who have undergone radiation and/or chemotherapy within the month immediately preceding proposed skin substitute treatment.

Non-Covered HCPCS codes:

J7343	Non-metabolic act d/e tissue
J7344	Non-metabolic active tissue
J7345	Non-human, non-metab tissue
J7346	Injectable human tissue

Coding Product Wastage (JW Modifier)

Medicare provides payment for the amount of the skin substitute/replacement product that is reasonable and necessary to treat the patient's wound. If the physician has made good faith efforts to minimize the unused portion of the skin substitute/replacement product in how patients are scheduled and how he ordered, accepted, stored, used the product, and made good faith efforts to minimize the unused portion of the product in how it is supplied, then the program will cover the amount of product discarded along with the amount used to treat the wound. If after taking the above measures a portion of the single use product must be discarded, HCPCS modifier JW may be used to indicate the amount discarded/not used on any patient. The amount used to treat the wound must be on a separate detail line from the amount wasted (when applicable). The modifier JW would not be used for claims billing when the product code description already includes the amount administered along with the amount wasted. Please reference "Drug Wastage" in the *Pinnacle Medicare Providers' News*, February 2007, publication for examples in determining the correct way of billing drug wastage to Medicare. The same methodology applies to billing skin substitute/replacement products.

The following information is applicable to Part A facilities:

1. **HCPCS Code J7348 and J7349** – Dermal (sub) tissue of nonhuman origin, with or without other bioengineered or processed elements, without metabolically active elements, per sq cm, and 15431 (apply acellular xgraft add) for the application.

Types of Bill: 11X, 12X, 13X, 18X, 21X, 23X, 75X, 85X

Use TOB applicable to your state.

Revenue Codes: 036X, 045X, 049X, 0636, 070X, 075X, 076X, 096X

References:

1. Pinnacle Medicare Local Coverage Determinations: AC-00-009 (retired 5/31/2007), AC-03-004 (retired 5/31/2007), ARA-00-009 (retired 6/30/2007), and ARA-03-004 (retired 6/30/2007).
2. TrailBlazer Health Enterprises, LLC Local Coverage Determination: Skin Substitutes/Replacements S-129B-R5
3. Noridian Administrative Services Local Coverage Determination, L24409.

Electronic Medical Records May Lead to Decreased Payment

Reference: AR - HDM 071708

With the advent of increasingly popular Electronic Medical Record (EMR) templates, comes an increased risk of noncompliance, as well as potential patterns of fraud and abuse. Physicians often work hard to comply with Medicare's sometimes complex documentation guidelines, especially the 1995 and 1997 Evaluation and Management Documentation Guidelines. EMR templates make documentation faster, easier, and oftentimes, more efficient. They may provide immediate accessibility of data and allow greater ease of sharing data among healthcare providers. EMRs may allow for decreased need of ancillary staff to transcribe information, clarify information/data, or manually enter data into the information system; as well as decrease the amount of staff necessary to create, file, store, and transport paper records. EMRs also speed the transmission of claims, providing for faster payment. Reduction of errors and greater legibility of documentation are two other reasons why providers are increasingly using EMR templates.

However, EMRs may reduce the confidentiality of patients' health information. If not properly used, they may also lead to "cloning" of medical records. When medical records have nearly identical documentation, the medical necessity of the services is questionable. Misleading or providing false information can occur. Physicians may copy and paste a patient's information from one day to the next without modifying the record to reflect all changes in the patient's status. If the physician copies and pastes without editing, a patient's physical exam or medical decision making may not be a true reflection of that patient for that service. In addition, a procedure may be carried over and billed for, when it wasn't actually repeated. Medical record cloning may cause documentation for many beneficiaries to be remarkably similar as well, leading to some confusion regarding patient care among specialties for consultations, as well as among other health care professionals. It could also lead to excessive billing at the higher ends of E/M codes.

Medicare Contractors are noting increasing frequency of cloned records. Each E/M service should stand alone. When no documentation differences are noted for several services for one beneficiary or for services for multiple beneficiaries, there may be a question of potential fraud. According to Change Request (CR) 5644, Transmittal 252, "The PSC [Program Safeguard Contractor] shall determine if patterns and/or trends exist in the medical record which may indicate potential fraud, waste or abuse. Examples include, but are not limited to:

- The medical records tend to have obvious or nearly identical documentation
- In reviews that cover a sequence of codes (Evaluation & Management codes, therapies, radiology, etc.) there may be evidence of a trend to use the high ends codes more frequently than would be expected..."

According to the *1997 Documentation Guidelines for Evaluation and Management Services*, "Medical record documentation is required to record pertinent facts, findings, and observations about an *individual's* health history... (Emphasis added)" Medical record cloning will not satisfy that E/M requirement.

Physicians' documentation must support the medical necessity and appropriateness of the services they provide. Electronic medical record templates can assist them in this process, if care is taken to edit records to accurately reflect the condition of a patient at every patient/physician encounter. In the absence of such editing, cloning of records will most likely lead to denial of services due to lack of medical necessity and may lead to investigation of potentially fraudulent practices.

New Report Shows CMS Pilot Program Saving Nearly \$700 Million in Improper Medicare Payments

Reference: CMS List-Serv Message 071408

On Friday, July 11, 2008, the Centers for Medicare & Medicaid Services (CMS) released a new report offering fresh evidence that the recovery audit contractors (RACs) pilot program is successfully identifying improper payments. The findings will also help the agency improve the program as it is expanded nationwide within two years, officials say.

The evaluation report shows that \$693.6 million in improper Medicare payments was returned to the Medicare Trust Funds between 2005 and March 2008. The funds returned to the Medicare Trust Funds occurred after taking into account the dollars repaid to health care providers, the money overturned on appeal and the costs of operating the RAC demonstration program.

Of the overpayments, 85 percent were collected from inpatient hospital providers, and the other principal collections were 6 percent from inpatient rehabilitation facilities, and 4 percent from outpatient hospital providers.

The program, designed to protect the Medicare Trust Funds and beneficiaries from improper payments, began in California, Florida and New York in 2005 and in July 2007 expanded to Arizona, Massachusetts and South Carolina.

CMS has begun the expansion process by initiating a competition for four permanent RACs after the pilot program ended in March 2008. CMS also has developed a strategy to ensure that the RAC program does not interfere with the transition from the existing Medicare claims processing contractors to the new claims processors, called Medicare Administrative Contractors (MACs). This will allow the new MACs to focus on claims processing activities before working with the RACs, according to a report evaluating the RAC pilot program issued today by CMS.

When a new RAC begins to issue its first overpayment notification letters, it will be limited to “black-and-white” billing issues, such as duplicate claims and wrong fee schedule amounts.

“Because of the success of the recovery audit contractor pilot, Congress has made the program permanent and required its expansion throughout the country,” Acting CMS Administrator Kerry Weems said. “The RAC pilot helped us refine and plan the implementation of the future, permanent national program.”

The results described in the evaluation report demonstrate that the RAC program is a needed and useful resource for detecting and correcting past improper payments. CMS continues to evaluate the extent to which the program protects the Medicare Trust Funds from improper payments.

“We need to ensure accurate payments for services to Medicare beneficiaries,” Weems said. “With a permanent recovery audit contractor program, people with Medicare can be assured they are being charged correctly for their share of their health care services.”

The RACs corrected over \$1 billion of Medicare improper payments from 2005 through March 27, 2008. Roughly 96 percent of the improper payments (\$992.7 million) were overpayments collected from providers, while the remaining 4 percent (\$37.8 million) were underpayments repaid to providers.

Of the \$1 billion in improper payment determinations by the RACs, providers chose to appeal only 14 percent of the RAC decisions. Of all the RAC overpayment determinations, only 4.6 percent were overturned on appeal. Throughout the demonstration, the RAC program has cost only 20 cents for each dollar collected.

The evaluation report found that the RAC program has had a limited financial impact on most providers. For example, in fiscal years 2006-2008, over 84 percent of hospitals in California, Florida and South Carolina had their Medicare revenue impacted by less than 2.5 percent, while in New York and Massachusetts over 94 percent of hospitals had their Medicare revenue impacted by less than 2.5 percent.

“A key part of the future recovery audit contractor program will be to contract with a RAC validation contractor to conduct independent third-party reviews of RAC claim determinations,” Weems said. “Other changes will include limiting the claim review look-back period to three years, requiring each RAC to hire a medical director, and conducting significant outreach to providers. These and other program improvements are a direct result of lessons learned from the pilot program.”

The RAC program was created by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) to find and correct improper Medicare payments paid to health care providers participating in fee-for-service Medicare.

Medicare processes more than 1.2 billion Medicare claims annually, submitted by more than one million health care providers, including hospitals, skilled nursing facilities, physicians and medical equipment suppliers. Errors in claims submitted by these health care providers for services provided to Medicare beneficiaries can account for billions of dollars in improper payments each year.

Most of the improper payments that the RACs identified occurred when health care providers submitted claims that did not comply with Medicare's coverage or coding rules. The types of inadvertent errors leading to improper payments, found by the RACs include billing for a procedure multiple times (for example, when a health care provider charged Medicare for conducting three colonoscopies on the same patient on the same day), incorrectly coded procedures, and submission of duplicate claims resulting in two payments to a provider.

The permanent RAC demonstration is a key tool that CMS will use to ensure that payments to health care providers are accurate and proper and that the number of errors in Medicare claims continues to decline. Medicare calculates the error rate – the amount of incorrect claims submitted by health care providers – as part of the Comprehensive Error Rate Testing (CERT) program.

Since CMS began the program, the error rate dropped from 14.2 percent in 1996 to 3.9 percent in 2007. This decline in improper payments reflects CMS' efforts to target erroneous claims processing, inaccurate billing and errors by health care providers.

Implementation of the RAC program has been guided by reports from the Department of Health and Human Services' Office of Inspector General and the Government Accountability Office. The RACs in the demonstration returned funds to the Medicare Trust Funds based on the recommendations included in these reports and experience gained from their work conducting audits of Medicaid and the private sector health care claims.

The RAC demonstration, authorized in the MMA, was required by Congress to be a permanent part of Medicare in the Tax Relief and Healthcare Act of 2006. The law states the national program must be implemented by Jan. 1, 2010.

For more information on the RAC program and to view the evaluation report, visit:
<http://www.cms.hhs.gov/RAC>

Critical Access Hospital Fact Sheet

Reference: CMS List-Serv Message 071408

The *Critical Access Hospital Fact Sheet* is now available in print format from the Centers for Medicare & Medicaid Services **Medicare Learning Network**. This fact sheet provides information about eligible Critical Access Hospital (CAH) providers; CAH designation; CAH payments; reasonable cost payment principles that do not apply to CAHs; election of Standard Method or Optional (Elective) Payment Method; Medicare Rural Pass-Through funding for certain anesthesia services; Health Professional Shortage Area Incentive payments; Physician Scarcity Area Bonus payments; Medicare Prescription Drug, Improvement, and Modernization Act of 2003; and grants to states under the Medicare Rural Hospital Flexibility Program. To place your order, visit <http://www.cms.hhs.gov/mlnngeninfo/>, scroll down to "Related Links Inside CMS" and select "MLN Product Ordering Page."

Rural Health Clinic Fact Sheet

Reference: CMS List-Serv Message 071108

The April 2008 version of the *Rural Health Clinic Fact Sheet*, which provides information about Rural Health Clinic (RHC) services, Medicare certification as a RHC, RHC visits, RHC payments, cost reports, and annual reconciliation, is now available from the Centers for Medicare & Medicaid Services **Medicare Learning Network** in downloadable format at <http://www.cms.hhs.gov/MLNProducts/downloads/RuralHlthClinfactsht08.pdf>. If this hyperlink does not take you directly to the fact sheet, please copy and paste the URL in your Internet browser.

Laboratory

Changes to the Laboratory National Coverage Determination (NCD) Edit Software for July 2008

Reference: *Trans. 1531, CR #6084, Pub. 100-04, MLN: MM6084*

Note: This article was revised on June 27, 2008, to reflect the re-issuance of CR6084 to show that Medicare contractors use the appropriate ICD-9-CM and CPT codes effective dates, which are October 1, 2007 for the ICD-9-CM codes and January 1, 2008, for the CPT codes. All other information remains the same.

Provider Types Affected

Clinical diagnostic laboratories billing Medicare contractors (carriers, Fiscal Intermediaries (FIs) and/or Part A/B Medicare Administrative Contractors (AB MACs))

Provider Action Needed

This article is based on Change Request (CR) 6084 which announces the changes that will be included in the July 2008 quarterly release of the edit module for clinical diagnostic laboratory services. The last quarterly release of the edit module was issued in April 2007. CR 6084 incorporates all changes from April 2007 to the present and has no other changes.

Background

The National Coverage Determinations (NCDs) for clinical diagnostic laboratory services were developed by the laboratory negotiated rulemaking committee and published in a final rule on November 23, 2001. Nationally uniform software was developed and incorporated in the shared systems so that laboratory claims subject to one of the 23 NCDs were processed uniformly throughout the nation effective January 1, 2003.

In accordance with the *Medicare Claims Processing Manual* (Chapter 16, Section 120.2; see <http://www.cms.hhs.gov/manuals/downloads/clm104c16.pdf> on the Centers for Medicare & Medicaid Services (CMS) website) the laboratory edit module is updated quarterly as necessary to reflect ministerial coding updates and substantive changes to the NCDs developed through the NCD process. These changes are a result of coding analysis decisions developed under the procedures for maintenance of codes in the negotiated NCDs and biannual updates of the ICD-9-CM codes.

CR 6084 announces changes to the laboratory edit module for changes in laboratory NCD code lists for July 2008 as described below. These changes become effective for services furnished on or after July 1, 2008.

Note: Medicare contractors use the appropriate effective dates for the ICD-9-CM and CPT codes, which are October 1, 2007 for the ICD-9-CM codes and January 1, 2008, for the CPT codes.

Contractors are not required to search their files to adjust affected claims between the July 1, 2007, and the July 1, 2008, quarterly clinical lab edit module updates.

CR 6084 reports the following changes effective July 1, 2008:

For HIV Testing:

- Add ICD-9-CM codes 079.83 and 288.66 to the list of ICD-9-CM codes covered by Medicare for the HIV Testing (190.14) NCD.
- Modify the descriptor for Current Procedural Terminology (CPT) code 86701 in the HIV Testing (190.14) NCD to read "Antibody; HIV-1."
- Modify the descriptor for CPT code 86702 in the HIV Testing (190.14) NCD to read "Antibody; HIV-2."
- Modify the descriptor for CPT code 86703 in the HIV Testing (190.14) NCD to read "Antibody; HIV-1 and HIV-2, single assay."

For Blood Counts:

- Add ICD-9-CM codes 388.45, 389.05, 389.06, 389.13, 389.17, 389.20, 389.21, 389.22, V25.04, V26.41, V26.49, V26.81, V26.89, V49.85 and V72.12 to the list of ICD-9-CM codes that Do Not Support Medical Necessity for the Blood Counts (190.15) NCD.

- Delete ICD-9-CM codes 389.2, V26.4 and V26.8 from the list of ICD-9-CM codes that Do Not Support Medical Necessity for the Blood Counts (190.15) NCD.
- Modify the descriptor for ICD-9-CM code 389.14 to read “Central hearing loss” in the list of ICD-9-CM codes that Do Not Support Medical Necessity for the Blood Counts (190.15) NCD;
- Modify the descriptor for ICD-9-CM code 389.18 to read “Sensorineural hearing loss, bilateral” in the list of ICD-9-CM codes that Do Not Support Medical Necessity for the Blood Counts (190.15) NCD; and
- Modify the descriptor for ICD-9-CM code 389.7 to read “Deaf, non-speaking, not elsewhere classifiable” from the list of ICD-9-CM codes that Do Not Support Medical Necessity for the Blood Counts (190.15) NCD.

For Prothrombin Time:

- Add ICD-9-CM codes 415.12, 789.51, 789.59, V12.53, and V12.54 to the list of ICD-9-CM codes covered by Medicare for the Prothrombin Time (190.17) NCD.
- Delete ICD-9-CM code 789.5 from the list of ICD-9-CM codes covered by Medicare for the Prothrombin Time (190.17) NCD.

For Serum Iron Studies:

- Add ICD-9-CM codes 233.30, 233.31, 233.32, and 233.39 to the list of ICD-9-CM codes covered by Medicare for the Serum Iron Studies (190.18) NCD.
- Delete ICD-9-CM code 233.3 from the list of ICD-9-CM codes covered by Medicare for the Serum Iron Studies (190.18) NCD.

For Glycated Hemoglobin/Glycated Protein:

- Add ICD-9-CM codes 258.01, 258.02 and 258.03 to the list of ICD-9-CM codes covered by Medicare for the Glycated Hemoglobin/Glycated Protein (190.21) NCD.
- Delete ICD-9-CM code 258.0 from the list of ICD-9-CM codes covered by Medicare for Glycated Hemoglobin/Glycated Protein (190.21) NCD.

For Thyroid Testing:

- Add ICD-9-CM codes 255.41, 255.42, 258.01, 258.02, 258.03, 787.20, 787.21, 787.22, 787.23, 787.24, 787.29, 789.51 and 789.59 to the list of ICD-9-CM codes covered by Medicare for the Thyroid Testing (190.22) NCD.
- Delete ICD-9-CM codes 255.4, 258.0, 787.2 and 789.5 from the list of ICD-9-CM codes covered by Medicare for the Thyroid Testing (190.22) NCD.

For Gamma Glutamyl Transferase:

- Add ICD-9-CM codes 359.21, 359.22, 359.23, 359.24 and 359.29 to the list of ICD-9-CM codes covered by Medicare for the Gamma Glutamyl Transferase (190.32) NCD.
- Delete ICD-9-CM code 359.2 from the list of ICD-9-CM codes covered by Medicare for the Gamma Glutamyl Transferase (190.32) NCD.

For Hepatitis Panel/Acute Hepatitis Panel:

- Delete ICD-9-CM code 999.3 from the list of ICD-9-CM codes covered by Medicare for the Hepatitis Panel/Acute Hepatitis Panel (190.33) NCD.

For Fecal Occult Blood Test:

- Add ICD-9-CM codes 569.43, 787.20, 787.21, 787.22, 787.23, 787.24, 787.29, 789.51 and 789.59 to the list of ICD-9-CM codes covered by Medicare for the Fecal Occult Blood Test (190.34) NCD.
- Delete ICD-9-CM codes 787.2 and 789.5 from the list of ICD-9-CM codes covered by Medicare for the Fecal Occult Blood Test (190.34) NCD.
- Modify the descriptor for ICD-9-CM code 005.1 in the Fecal Occult Blood Test (190.34) NCD to read “Botulism food poisoning.”

- Modify the descriptor for CPT code 82272 in the Fecal Occult Blood Test (190.34) NCD to read “Blood, occult, by peroxidase activity (e.g., guaiac), qualitative, feces, 1-3 simultaneous determinations, performed for other than colorectal neoplasm screening.”

Additional Information

The official instruction, CR 6084, issued to your carrier, FI, and A/B MAC regarding this change may be viewed on the CMS web site at:

<http://www.cms.hhs.gov/Transmittals/downloads/R1531CP.pdf>

If you have any questions, please contact your carrier, FI, or A/B MAC at their toll-free number, which may be found on the CMS web site at:

<http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip>

Effective Date: July 1, 2008; Implementation Date: July 7, 2008

Reinstatement of the Moratorium That Allows Independent Laboratories to Bill for the TC of Physician Pathology Services Furnished to Hospital Patients

Reference: JSM CI 5459-08413; 07-16-08

In the final physician fee schedule regulation published in the *Federal Register* on November 2, 1999, the Centers for Medicare & Medicaid Services (CMS) stated that it would implement a policy to pay only the hospital for the technical component (TC) of physician pathology services furnished to hospital patients. Prior to this proposal, any independent laboratory could bill the carrier under the physician fee schedule for the TC of physician pathology services for hospital patients. At the request of the industry, to allow independent laboratories and hospitals sufficient time to negotiate arrangements, the implementation of this rule was administratively delayed. Subsequent legislation formalized a moratorium on the implementation of the rule. As such, during this time, the carriers and, more recently, Medicare Administrative Contractors (MAC) have continued to pay for the TC of physician pathology services when an independent laboratory furnishes this service to an inpatient or outpatient of a covered hospital.

The most recent extension of the moratorium, established by the Medicare, Medicaid, and SCHIP Extension Act (MMSEA), Section 104, expired on June 30, 2008. A new extension of the moratorium has been established by the Medicare Improvements for Patients and Providers Act of 2008, Section 136, retroactive to July 1, 2008.

A previous communication indicated that the moratorium had ended and that independent laboratories may no longer bill Medicare for the TC of physician pathology services furnished to patients of a covered hospital, regardless of the beneficiary's hospitalization status (inpatient or outpatient) on the date that the service was performed. This prohibition is rescinded and the moratorium will continue effective for claims with dates of service on and after July 1, 2008, but prior to January 1, 2010.

Medicare Physician Fee Schedule (MPFS)

New 2008 Medicare Physician Fee Schedule Payment Rates Effective for Dates of Service July 1, 2008 through December 31, 2008

Reference: JSM CI 5455-08410; 07-16-08

The Medicare Improvements for Patients and Providers Act of 2008 was enacted on July 15, 2008. As a result, the mid-year 2008 Medicare Physician Fee Schedule (MPFS) rate of -10.6 percent has been replaced with the January-June 2008 0.5 percent update, retroactive to July 1, 2008.

Physicians, non-physician practitioners and other providers of services paid under the MPFS should begin to receive payment at the 0.5 % update rates in approximately 10 business days, or less. Medicare contractors are currently working to update their payment system with the new rates.

In the meantime, to avoid a disruption to the payment of claims for physicians, non-physician practitioners and other providers of services paid under the MPFS, Medicare contractors will continue to process the claims that have been on hold on a rolling basis (first in/first out) for payment at the -10.6% update level. After your local contractor begins to pay claims at the new 0.5% rate, to the extent possible, the contractor will begin to automatically reprocess any claims paid at the lower rates.

Under the Medicare statute, Medicare pays the lower of submitted charges or the Medicare fee schedule amount. Claims with dates of service July 1 and later billed with a submitted charge at least at the level of the January 1 – June 30, 2008, fee schedule amount will be automatically reprocessed. Any lesser amount will require providers to contact their local contractor for direction on obtaining adjustments. Non-participating physicians who submitted unassigned claims at the reduced nonparticipation amount also will need to request an adjustment.

Contractor websites are being updated with the new rates and these should be available shortly.

Be aware that any published MLN Matters articles affected by the new law will be revised or rescinded as appropriate.

Finally, be on the alert for more information about other legislative provisions which may affect you

National Provider Identifier (NPI)

Medicare FFS NPI Update & Part B Issues Identified

Reference: CMS List-Serv Message 061908

The NPI is here. The NPI is now. Are you using it?

NPI News for Medicare FFS Providers

Medicare FFS NPI Update & Part B Issues Identified

As of 5/23/08, the National Provider Identifier (NPI) became mandatory on all HIPAA claims transactions and on Medicare paper transactions as well. All transactions must be submitted with the NPI in fields requiring a provider identifier (see items 1-3 below concerning the reporting of the Taxpayer Identification Number (TIN)). The Centers for Medicare & Medicaid Services (CMS) continues to see progress with NPI compliance and most Medicare contractors are reporting over 95 percent of claims contain only NPI. However, for some of the relatively few claims which continue to reject, we have determined that some of the reasons are related to the following issues identified for Part B claims:

1. The Employer Identification Number (EIN) or Social Security Number (SSN) being submitted in the 2010AA / REF02 (Billing Provider Secondary Identifier), 2010AB / REF02 (Pay to Provider Secondary Identifier) and/or 2310B / REF02 (Rendering Provider Secondary Identifier) of the Medicare X12N 837P transaction does not match the TIN information on the Medicare crosswalk.
2. While EIN or SSN is not required to be submitted in the 2310B loop for Medicare claims, if submitted, the appropriate qualifier must be submitted in the 2310B / REF01.
 - Qualifier EI must be submitted in the 2310B / REF01 when an EIN is being submitted in the REF02.
 - Qualifier SY must be submitted in the 2310B / REF01 when an SSN is being submitted in the REF02.
3. The Medicare legacy provider identifier is being submitted in the primary and/or secondary provider loops. Legacy provider numbers are no longer allowed on ANY Medicare claim or transaction. If sent, the claim or transaction will reject.

Medicare providers should review this list and take appropriate actions to resolve problems they may be experiencing. As a result, providers may decide to stop sending non-required segments, such as the TIN in 2310B/REF02 of the X12N 837P transaction. Providers may also want to consult their clearinghouses or software vendors for additional advice to solve the issues listed in this message.

Need More Information?

Still not sure what an NPI is and how you can get it, share it and use it? As always, more information and education on the NPI can be found through the CMS NPI page www.cms.hhs.gov/NationalProvIdentStand on the CMS website. Providers can apply for an NPI online at <https://nppes.cms.hhs.gov> or call the NPI enumerator to request a paper application at 1-800-465-3203. Having trouble viewing any of the URLs in this message? If so, try to cut and paste any URL in this message into your web browser to view the intended information.

Note: All current and past CMS NPI communications are available by clicking "CMS Communications" in the left column of the www.cms.hhs.gov/NationalProvIdentStand CMS webpage.

Physician Quality Reporting Initiative (PQRI)

2008 Physician Quality Reporting Initiative (PQRI) Establishment of Alternative Reporting Periods and Reporting Criteria

Reference: Trans. 355, CR #6104, Pub. 100-20, MLN: MM6104

Note: This article was revised on July 2, 2008, to remove the phrase “on 15 consecutive patients” from the first two G code descriptions under the *HCPCS Codes* section below of this article. All other information remains the same.

Provider Types Affected

Physicians and other practitioners who qualify as eligible professionals to participate in the Centers for Medicare & Medicaid Services (CMS) Physician Quality Reporting Initiative (PQRI)

What You Need to Know

CMS is taking steps to encourage physicians and other eligible professionals to participate in the Physician Quality Reporting Initiative (PQRI), a program designed to improve the quality of care provided to Medicare beneficiaries. CR 6104, from which this article is taken, announces the establishment of alternative reporting periods and alternative criteria for satisfactorily reporting quality measures for the 2008 PQRI.

Make sure that your billing staffs are aware of the PQRI reporting changes.

Background

The 2006 Tax Relief and Health Care Act (TRHCA) (P.L. 109-432) required the CMS to establish the PQRI, that included an incentive payment for eligible professionals who satisfactorily reported data on quality measures for covered services furnished to Medicare beneficiaries during the second half of 2007 (the 2007 reporting period).

Under this program, CMS paid eligible professionals, who satisfactorily reported such data, an incentive payment equivalent to 1.5% of their total allowed charges for Medicare Physician Fee Schedule (MPFS)-covered professional services (referred to as total allowed charges) furnished during the 2007 reporting period (July 1, 2007 – December 31, 2007). The statute defines satisfactory reporting to be reporting of up to 3 applicable measures in at least 80% of the cases in which such measures are reportable. A total of 74 clinical quality measures were available for reporting for 2007, which occurred only via claims.

TRHCA also required that CMS establish a PQRI measure set for 2008. The 2008 set:

- Includes 119 measures that eligible professionals can select from (117 clinical quality measures, and 2 structural measures (use of electronic health records and electronic prescribing)); and
- Addresses the submission of PQRI measures data through registries. In the 2008 MPFS Final Rule, CMS described plans to test two methods for submission of quality measures data through registries during 2008, and the testing process for these registries is currently underway; with test data submission slated to begin in July, 2008, and to end by September 1, 2008.

The Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA – Public Law 110-173), enacted on December 29, 2007, authorizes CMS to make PQRI incentive payments for satisfactory reporting quality measures data for services furnished in 2008. For 2008, eligible professionals who meet the criteria for satisfactory submission of quality measures data on services furnished during the reporting period (January 1, 2008 – December 31, 2008) will earn an incentive payment of 1.5% of their total allowed charges for PFS covered professional services furnished during that same period (the 2008 calendar year).

MMSEA also requires that, for 2008 and 2009, the Secretary of Health and Human Services (HHS) establish alternative reporting periods and criteria for the satisfactory reporting of measure groups; and for satisfactorily reporting quality measures data through registries. Thus, in 2008, eligible professionals may earn the incentive payment based on data submitted through these alternative mechanisms. Also, please note that while TRHCA established a cap on incentive payments for 2007 (based on an average per measure payment amount) there is no cap on incentive payments under MMSEA for 2008 and 2009.

CR 6104, from which this article is taken announces the establishment of the MMSEA-mandated alternative reporting periods and alternative criteria for satisfactorily reporting 2008 PQRI quality measures.

Measures Groups

There are four measures “groups” for the 2008 PQRI: 1) Diabetes Mellitus; 2) End Stage Renal Disease; 3) Chronic Kidney Disease (CKD); and 4) Preventive Care. Each of the measure groups contains at least four PQRI measures.

The individual Diabetes Mellitus Measures are:

- Measure 1 – Hemoglobin A1c Poor Control in Type 1 or 2 Diabetes Mellitus;
- Measure 2 – Low Density Lipoprotein Control in type 1 or 2 Diabetes Mellitus;
- Measure 3 – High Blood Pressure Control in Type 1 or 2 Diabetes Mellitus;
- Measure 117 – Dilated Eye Exam in Diabetic Patients; and
- Measure 119 – Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients.

The individual ESRD measures are:

- Measure 78 – Vascular Access for Patients Undergoing Hemodialysis;
- Measure 79 – Influenza Vaccination in Patients with ESRD;
- Measure 80 – Plan of Care for ESRD Patients with Anemia; and
- Measure 81 – Plan of Care for Inadequate Hemodialysis in ESRD Patients.

The individual measures for CKD are:

- Measure Number 120 – ACE Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy in Patients with CKD;
- Measure Number 121 – CKD: Laboratory Testing (Calcium, Phosphorus, Intact Parathyroid Hormone (iPTH) and Lipid Profile);
- Measure Number 122 – CKD: Blood Pressure Management ; and
- Measure Number 123 – CKD: Plan of Care: Elevated Hemoglobin for Patients Receiving Erythropoiesis-Stimulating Agents (ESA)

The individual measures in the Preventive Care group are:

- Measure Number 39 – Screening or Therapy for Osteoporosis for Women Aged 65 Years and Older;
- Measure Number 48 – Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older;
- Measure Number 110 – Influenza Vaccination for Patients > 50 Years Old;
- Measure Number 111 – Pneumonia Vaccination for Patients 65 Years and Older;
- Measure Number 112 – Screening Mammography ;
- Measure Number 113 – Colorectal Cancer Screening;
- Measure Number 114 – Inquiry Regarding Tobacco Use;
- Measure Number 115 – Advising Smokers to Quit; and
- Measure Number 128 – Universal Weight Screening and Follow-Up.

Note: If you elect to report a group of measures, you must report all of the measures in the group that are applicable to the patient.

General Reporting Guidance for Professionals

CR 6104 also contains some general guidance about reporting PQRI measures that you may find to be helpful before the alternative reporting periods and criteria are described:

- “Patients” or “Medicare patients” means Part B Medicare Fee-For-Service (FFS) patients. Non-FFS Medicare (e.g. Medicare Part C patients including those enrolled in Private FFS plans) and/or Non-Medicare patients may only be included in registry based reporting under the consecutive patient criteria. “Non-Medicare patients” means persons not enrolled in Part B or Part C of Medicare.

- “Consecutive” means next in order by date of service. Patients are considered consecutive without regard to gender even though some measures in a group (e.g., preventive care measures) may apply only to males or only to females.
- “Patients for whom the measures of one measures group apply” means patients to whom services are furnished during the reporting period and for whom the measures of a particular group apply as defined by the denominator of the measures.
- Measures groups reporting requires that eligible professionals must report on each of the measures in the measures group that is applicable to the patient.
- The alternative reporting criteria for the data required for measures groups reported for the January 1, 2008 – December 31, 2008, reporting period through registry-based submission only are 30 consecutive patients for whom the measures of one measures group apply; or 80% of Medicare patients for whom the measures of the measures group apply, without regard to whether the patients are consecutive.
- The alternative reporting criteria for the data required for measures groups reported for the July 1, 2008 – December 31, 2008 reporting period are: 15 consecutive patients for whom the measures of one measure group apply for measures groups reported through registry-based reporting; 15 consecutive Medicare patients for whom the measures of one measures group apply for measures groups reported through the claims mechanism; or 80% of Medicare patients for whom the measures of the measures group apply, without regard to the submission mechanism used or whether the patients are consecutive.
- Eligible professionals who submit measures both through registries and through claims-based submission will be eligible to receive an incentive payment provided they meet the requirements for satisfactory reporting under either reporting mechanism. Qualification under both submission mechanisms will result in only one incentive bonus payment based on the longest reporting period for which the eligible professional satisfactorily reports.

Guidance for Registries

- In order to qualify to submit data under the registry-based reporting alternatives for 2008, a registry must have been in existence on January 1, 2008, and the registry also must meet certain technical and other requirements that CMS specifies. Those registry requirements will be available at <http://www.cms.hhs.gov/pqri> on the CMS website.
- The requirements for qualified registries include, but are not limited to, 1) submission of a self-nomination by a certain date. Registries that participated and/or self-nominated for the 2008 registry testing process will need to submit a new self-nomination specific to this new process in order to be considered for potential qualification; and 2) the registry having entered (or entering) into appropriate legal arrangements that provide for the registry's receipt of patient-specific data from eligible professionals, as well as the registry's disclosure of quality measure results and numerator and denominator data on behalf of eligible professionals who wish to participate in the PQRI program.
- Each registry seeking to submit data for the PQRI program will be required to meet all technical and other requirements CMS identifies for registries to submit such information.
- CMS will post on the CMS website by August 31, 2008, the names of those registries that qualify to the CMS PQRI website at <http://www.cms.hhs.gov/pqri>.
- Registry-based submissions under the 2008 registry-based reporting alternatives will begin after the completion of the 2008 registry testing process.
- Eligible professionals must comply with all applicable laws in establishing a relationship with a registry whereby the registry will report quality measures data to CMS on their behalf based on the data the eligible professional submits to the registry. The eligible professional will need to document and be able to demonstrate that this relationship has been established, and must attest to the validity of the data submitted by the eligible professional to the registry.
- The registry-based submission must meet the criteria for satisfactory reporting for PQRI measure results and/or measures group results.
- Registries must submit to CMS all required data that will include reporting and performance rates on PQRI measures or PQRI measures groups and numerator and denominators for the performance rates.

- Registries must attest that the eligible professional has satisfactorily reported data for clinical quality measures or measures groups under the PQRI program. Registries must specify the reporting criteria and reporting periods for which the eligible professional satisfactorily reported.
- Registries must also attest that all applicable statutory, regulatory, and contractual requirements for reporting of information to CMS have been met.
- Registry reporting for each eligible professional must be on 2008 PQRI measures for patient services furnished during the applicable reporting period.

Alternative Reporting Periods and Reporting Options

A description of the MMSEA-mandated alternative reporting periods and alternative criteria for satisfactorily reporting 2008 PQRI quality measures follows. There are two alternative reporting periods and nine options for the 2008 PQRI.

- **Alternative Reporting Periods**

The two alternative reporting periods are January 1, 2008 – December 31, 2008; and July 1, 2008 – December 31, 2008.

- **Reporting Options**

Three of the nine reporting options from which you may select, are claims-based and six are registry-based.

Notes:

1. *The claims-based reporting mechanism for measures groups will be first available July 1, 2008, therefore the July 1, 2008 – December 31, 2008 reporting period applies only when using the claims-based option to report measure groups.*
2. *Both reporting periods apply when using the registry-based option to report both measure groups and individual measures.*

A description of each option follows:

Option 1 – Reporting individual measures using the claims-based option (reporting period January 1, 2008 – December 31, 2008)

If you elect the claims-based option to report individual measures, you must report 3 measures (or 1 -2 measures if less than 3 measures apply to you) on 80% of applicable patient claims for 1 – 3 measures).

Option 2 – Reporting measure groups using the claims-based option (reporting period July 1, 2008 – December 31, 2008)

If you elect the claims-based option to report measure groups, you must report all of the measures in one measure group that apply to each of 15 consecutive patients. To start the count of the 15 consecutive patients, you should report the measure group specific “G code” on the claim for the first of these patients.

Option 3 – Reporting measure groups using the claims-based option (reporting period July 1, 2008 – December 31, 2008)

If you elect the claims-based option to report measures groups, you must report all measures in one measures group on 80% of patients for the applicable measures group during the reporting period. You should report the measures group specific “G code” or the claim to indicate the intent to report the measures group.

Option 4 – Reporting individual measures using the registry-based option (reporting period January 1, 2008 – December 31, 2008)

If you elect the registry-based option to report individual measures, you must report at least 3 measures on 80% of applicable Medicare FFS patients.

Option 5 – Reporting individual measures using the registry-based reporting option (reporting period July 1, 2008 – December 31, 2008)

If you elect the registry-based option to report individual measures, you must report at least 3 PQRI measures on 80% of applicable Medicare FFS patients

Option 6 – Reporting measure groups using the registry-based reporting option (reporting period July 1, 2008 – December 31, 2008)

If you elect to use the registry-based option to report measure groups, you must report all of the measures in one measure group that apply to each of 15 consecutive patients. The consecutive patients may include (but not be exclusively) non-Medicare patients. The reporting of a measures group specific “G-code” is not required for registry-based reporting.

Option 7 – Reporting measure groups using the registry-based reporting option (reporting period January 1, 2008 – December 31, 2008)

If you elect to use the registry-based option to report measure groups, you must report all of the measures in one measure group that apply to each of 30 consecutive patients. The consecutive patients may include (but not be exclusively) non-Medicare patients. The reporting of a measures group specific “G-code” is not required for registry-based reporting.

Option 8 – Reporting measure groups using the registry-based reporting option (reporting period July 1, 2008 – December 31, 2008)

If you elect to use the registry-based option to report measure groups, you must report all of the measures in one measure group on 80% of Medicare FFS patients for the applicable measures group on services provided during the reporting period. The reporting of a measures group specific “G-code” is not required for registry-based reporting.

Option 9 – Reporting measure groups using the registry-based option (reporting period January 1, 2008 – December 31, 2008)

If you elect to use the registry-based option to report measure groups, you must report all of the measures in one measure group on 80% of Medicare FFS patients for the applicable measures group for services provided during the reporting period. The reporting of a measures group specific “G-code” is not required for registry-based reporting.

HCPCS Codes

Effective for dates of service on or after July 1, 2008, Medicare carriers and A/B MACs will recognize the following Healthcare Common Procedure Coding System (HCPCS) codes, which will be included in the July Update to the 2008 MPFS Database. These codes are required for claims-submission of measures groups:

- G8485 (Clinician intends to report the Diabetes measure) for intent to report the Diabetes measure group;
- G8486 (Clinician intends to report the Preventive Care measure group) for intent to report the Preventive Care measure group;
- G8487 (Clinician intends to report the Chronic Kidney Disease (CKD) measure group) for intent to report the Chronic Kidney Disease measure group; and
- G8488 (Clinician intends to report the End Stage Renal Disease (ESRD) measure group) for intent to report the End Stage Renal Disease measure group.

Note: *The alternative reporting criteria for measure groups apply regardless of whether the measures are reported through claims-based submission or through registry-based reporting; however, these G-codes that are required for claims-submission of measures groups will not be implemented until July 1, 2008. Therefore, the July 1, 2008 – December 31, 2008 reporting period is the only available reporting period for measure groups data that you submit on claims.*

Additional Information

You can find more information about the establishment of alternative reporting periods and criteria for the 2008 PQRI by going to CR 6104, located on the CMS web site at:

<http://www.cms.hhs.gov/Transmittals/downloads/R355OTN.pdf>

If you have any questions, please contact your carrier or A/B MAC at their toll-free number, which may be found on the CMS web site at:

<http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip>

Effective Date: July 1, 2008; Implementation Date: July 7, 2008

2008 Physician Quality Reporting Initiative (PQRI) National Provider Call PowerPoint Presentation-July 9th, 2008 is Now Available

Reference: CMS List-Serv Message 070908

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce that PowerPoint presentation that was used during the July 9th, 2008 PQRI National Provider call is now available on the CMS website.

The call provided information on accessing your 2007 PQRI Feedback Report (for those of you who participated in 2007); an overview of the 2008 PQRI participation options, and a question and answer session.

The Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) (P.L. 110-173), which was enacted on December 29, 2007, requires that for 2008 and 2009 the Secretary establish alternative reporting periods and alternative criteria for satisfactorily reporting groups of measures. It also requires that for 2008 and 2009 the Secretary establish alternative reporting periods and alternative criteria for satisfactorily reporting quality measures data through registries.

To access the presentation, go to, <http://www.cms.hhs.gov/PQRI>, and select the CMS Sponsored Calls tab on the left side of the page. Next, scroll down to the Downloads section under the heading PowerPoint Presentations and select "National Provider Call 07/08/2008"

2008 Physician Quality Reporting Initiative (PQRI): New Educational Product is Now Available

Reference: CMS List-Serv Message 071008

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce that a new educational resource has been posted to the PQRI webpage on the CMS website and is available for ordering through the Medicare Learning Network product ordering system.

The following item is available for download on the PQRI Educational Resources web page:

2008 PQRI Reporting Options Quick Reference Chart - This two-sided laminated reference chart gives Eligible Professionals and practice staff a quick reference to the new reporting options available for 2008 PQRI with their corresponding alternative reporting periods.

To access this new, and all available, educational resource, visit <http://www.cms.hhs.gov/PQRI> on the CMS website and click on the Educational Resources tab. Once on the *Educational Resources* page, scroll down to the "Downloads" section and click on the "2008 PQRI Quick Reference Chart link.

To order this product, visit http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5 on the CMS website and click on the 2008 Physician Quality Reporting Initiative (PQRI) Reporting Quick Option Reference Chart (ICN# 900843)(May 2008) link.

Rollout: Medicare Quality Reporting Initiative Pays Over \$36 Million to Participating Physicians From the 2007 PQRI Reporting Period - "GO"- Begin Outreach

Reference: CMS List-Serv Message 071508

The Centers for Medicare & Medicaid (CMS) today announced payment of more than \$36 million in bonus payments to many of the more than 56,700 health professionals who satisfactorily reported quality information to Medicare under the 2007 Physician Quality Reporting Initiative (PQRI).

“Creating a value-based purchasing system is a critical way to improve our health care systems. By collecting quality data, health care providers can use the information to improve the quality care of beneficiaries,” said Health and Human Services Secretary Michael Leavitt.

Physicians, physician group practices, and other PQRI eligible professionals should receive their payments by August 2008. The average incentive amount for individual professionals is over \$600 and average incentive payment for a physician group practice is over \$4,700, with the largest payment to a physician group practice totaling over \$205,700.

The PQRI is part of the President’s Value-driven Health Care Agenda that seeks to address current problems in the health care sector regarding preventable errors, uneven quality of care and rising health care costs.

More information about the PQRI program, including how eligible professionals can participate and the criteria to qualify for an incentive payment is available at www.cms.hhs.gov/PQRI.

To read the entire CMS Press release issued today click here:
http://www.cms.hhs.gov/apps/media/press_releases.asp

Provider Enrollment

Private Contracting/Opting Out of Medicare

Reference: Trans. 92, CR #6081, Pub. 100-02, MLN: MM6081

Provider Types Affected

Physicians and practitioners who opted out of Medicare and continue to bill Medicare Carriers or Part A/B Medicare Administrative Contractors (A/B MACs) for services to Medicare beneficiaries

Impact on Providers

This article is based on CR6081 and notifies providers of the update by the Centers for Medicare & Medicaid Services (CMS) to Medicare Benefit Policy Manual, Chapter 15, sections 40.5, 40.6, 40.9, 40.11, 40.13, 40.20, 40.26, and 40.35.

- The added sections clarify that the consequences for the failure on the part of a physician or practitioner to maintain opt-out apply **regardless of whether or when a carrier/MAC notifies a physician or practitioner** of the failure to maintain opt-out.
- A new paragraph was also added to clarify that in situations where a violation is not discovered by the carrier/MAC during the 2 year opt-out period when the violation actually occurred, then the requirements are applicable from the date that the first violation for failure to maintain opt-out occurred until the end of the opt-out period during which the violation occurred (unless the physician or practitioner takes good faith efforts to restore opt-out conditions, for example, by refunding the amounts in excess of the charge limits to beneficiaries with whom he or she did not sign a private contract).

Key Points of CR6081

Failure on the part of a physician or practitioner to maintain opt-out will result in the following (unless the physician or practitioner takes good faith efforts, within 45 days of any notice from the carrier/MAC that the physician or practitioner failed to maintain opt-out, **or** within 45 days of the physician's or practitioner's discovery of the failure to maintain opt-out, **whichever is earlier, to correct his or her violations**)

A. Failure to Maintain Opt-Out Occurs if during the opt-out period:

- The physician/practitioner has filed an affidavit in accordance with §40.9 and has signed private contracts in accordance with §40.8 but, the physician/practitioner knowingly and willfully submits a claim for Medicare payment (except as provided in §40.28) or the physician/practitioner receives Medicare payment directly or indirectly for Medicare-covered services furnished to a Medicare beneficiary (except as provided in §40.28); (For specific information about Chapter 15, sections 8 and 28, refer to <http://www.cms.hhs.gov/Manuals/downloads/bp102c15.pdf> on the CMS website. The sections of Chapter 15 that are revised by CR6081 are attached to CR6081.)
- The physician/practitioner fails to enter into private contracts with Medicare beneficiaries for the purpose of furnishing items and services that would otherwise be covered by Medicare, or enters into private contracts that fail to meet the specifications of §40.8; or
- The physician/practitioner fails to comply with the provisions of §40.28 regarding billing for emergency care services or urgent care services; or
- The physician/practitioner fails to retain a copy of each private contract that the physician/practitioner has entered into for the duration of the opt-out period for which the contracts are applicable or fails to permit CMS to inspect them upon request.

B. Violation discovered by the Carrier during the 2-year opt out period:

- If a physician/practitioner fails to maintain opt-out in accordance with the provisions outlined in section A. of this article, and fails to demonstrate within 45 days of a notice from the carrier that the physician/practitioner has taken good faith efforts to maintain opt-out (including by refunding amounts in excess of the charge limits to the beneficiaries with whom the physician/practitioner did not sign a private contract), the following will result effective 46 days after the date of the notice, but only for the remainder of the opt-out period:
 1. All of the private contracts between the physician/practitioner and Medicare beneficiaries are deemed null and void.
 2. The physician's or practitioner's opt-out of Medicare is nullified.

3. The physician or practitioner must submit claims to Medicare for all Medicare covered items and services furnished to Medicare beneficiaries.
4. The physician or practitioner or beneficiary will not receive Medicare payment on Medicare claims for the remainder of the opt-out period, except as stated above.
5. The physician or practitioner is subject to the limiting charge provisions as stated in §40.10.
6. The practitioner may not reassign any claim except as provided in the Medicare Claims Processing Manual, Chapter 1, "General Billing Requirements," §30.2.13. (For more information about the General Billing Requirements refer to <http://www.cms.hhs.gov/manuals/downloads/clm104c01.pdf> on the CMS website).
7. The practitioner may neither bill nor collect any amount from the beneficiary except for applicable deductible and coinsurance amounts.
8. The physician or practitioner may not attempt to once more meet the criteria for properly opting out until the 2-year opt-out period expires.

C. Violation not discovered by the Carrier during the 2-year opt out period.

- In situations where a violation of section A is not discovered by the carrier during the 2-year opt-out period when the violation actually occurred, the requirements of section B (1) through B (8) of this article are applicable from the date that the first violation of section A occurred until the end of the opt-out period during which the violation occurred.

TAKE NOTE: For a physician/practitioner who has never enrolled in the Medicare program and wishes to opt out of Medicare, the physician/practitioner must provide the carrier or A/B MAC with a National Provider Identifier (NPI). For information on the NPI, see the NPI Resource sheet visit http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/NPI_Resource_Sheet.pdf on the CMS website.

Additional Information

To see the official instruction (CR6081) issued to your carrier or A/B MAC visit the CMS web site at:

<http://www.cms.hhs.gov/Transmittals/downloads/R92BP.pdf>

If you have questions, please contact your carrier or A/B MAC at their toll-free number which may be found on the CMS web site at:

<http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip>

Effective Date: September 29, 2008; Implementation Date: September 29, 2008

Medicare Enrollment Applications

Reference: JSM CI 5428-08378; 07-01-08

Consistent with Joint Signature Memorandum/Technical Direction Letter (JSM/TDL)-08250, dated April 4, 2008, Medicare contractors may continue to accept the 2006 Version of the CMS 855 for all providers and suppliers, except specialty hospitals, through September 2008. With the exception of specialty hospitals who are required to use the revised application immediately, providers and suppliers are encouraged to submit the revised version of the Medicare enrollment applications.

The Centers for Medicare & Medicaid Services (CMS) has placed the revised enrollment applications on the CMS' Provider Enrollment Web site at www.cms.hhs.gov/MedicareProviderSupEnroll.

Therapy

Extension of Therapy Cap Exceptions

Reference: JSM CI 5456-08411; 07-16-08

The Medicare Improvements for Patients and Providers Act of 2008 was enacted on July 15, 2008. One provision of this legislation extends the effective date of the exceptions process to the therapy caps to December 31, 2009. Outpatient therapy service providers may now resume submitting claims with the KX modifier for therapy services that exceed the cap furnished on or after July 1, 2008.

For physical therapy and speech language pathology services combined, the limit on incurred expenses is \$1810 for calendar year 2008. For occupational therapy services, the limit is \$1810. Deductible and coinsurance amounts applied to therapy services count toward the amount accrued before a cap is reached. Services that meet the exceptions criteria and report the KX modifier will be paid beyond this limit.

Before this legislation was enacted, outpatient therapy service providers were previously instructed to not submit the KX modifier on claims for services furnished on or after July 1, 2008. The extension of the therapy cap exceptions is retroactive to July 1, 2008. As a result, providers may have already submitted some claims without the KX modifier that would qualify for an exception.

Providers submitting these claims using the 837 institutional electronic claim format or the UB-04 paper claim format would have had these claims rejected for exceeding the cap. These providers should resubmit these claims appending the KX modifier so they may now be processed and paid. Providers submitting these claims using the 837 professional electronic claim format or the CMS-1500 paper claim format would have had these claims denied for exceeding the cap. These providers should request to have their claims adjusted in order to have the contractor pay the claim.

In all cases, if the beneficiary was notified of their liability and the beneficiary made payment for services that now qualify for exceptions, any such payments should be refunded to the beneficiary



Medicare Web-Based Training

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A: Medicare Web-Based Training!

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2. **Cost-effective** The training is free.
3. **Time Saver** Complete courses in the comfort of your home or office.
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Current Topics

- Introduction to Medicare
- Modifiers
- Interpreting the Remittance Advice
- Understanding the '97 Evaluation & Management Guidelines

Continuing Education Units (CEUs) and Continuing Medical Education (CME) credit will not be issued for these courses any longer.

For more information visit your Medicare Carrier's website:

Arkansas	www.arkmedicare.com/provider/wbt
Louisiana	www.lamedicare.com/provider/wbt
Rhode Island	www.rimedicare.com/provider/wbt



Pinnacle Medicare Services Seminar Registration

Medicare workshops will be FREE this year! Pre-registration is required and seating is limited so do not delay. Early birds are welcome. Registering for Medicare seminars has become easier. You can register online, by fax or by mail for Medicare seminars presented by each office within the Pinnacle consortium. If you are not able to register online, please complete all of the requested information and fax or mail this form to the address indicated below:

Arkansas <i>www.arkmedicare.com</i>	Louisiana <i>www.lamedicare.com</i>	Rhode Island <i>www.rimedicare.com</i>
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FAX TO: (225) 231-2276

Pinnacle Medicare Services
Attn: Provider Education Specialist
P.O. Box 83760
Baton Rouge, LA 70884-3760

Seminar Number: _____ Date: _____ Location: _____ <p style="text-align: center;"><u>Medicare Workshops are FREE to all attendees this year!</u></p> Attendee Name(s): _____ _____ _____ How many full time employees are employed at your facility? _____
--

Office/Physician's Name: _____

Contact Name(s): _____ Provider Number: _____

Mailing Address: _____

City: _____

State: _____ Zip: _____

Phone Number: _____ Fax Number: _____ Email Address: _____
--

Please keep a copy of this form for your records

If you are not able to register on-line, you may register by faxing this form to (225) 231-2276.

Have a Question?

Your questions are important to us! In our continuing effort to expand the communication between Medicare and the Part B providers, we have established an "And The Answer Is....." column for our providers. If you have a question about Medicare Part B policies and regulations, you may use the form shown below. We will print the most commonly asked questions with their answers. Questions not printed in the newsletter will be addressed through written or telephone response, so be sure to include your name, address and telephone number.

"Did You Know?" Question Submission Form

Provider/Group Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Provider Number: _____ Contact Name: _____

Telephone Number:(_____) _____

Question: _____

Question submission forms should be sent to:

Pinnacle Medicare Communications
Attn: Theresa Milligan
515 West Pershing Blvd.
North Little Rock, AR 72114

Your Feedback is Greatly Appreciated!

We would like to take this opportunity to ask you for your input about our service to you and how you think we can improve. Please take a few moments to answer the questions below. Your response will help us serve you better in the future. All comments, concerns and suggestions are welcome.

We suggest you make a copy of this form so that you may use it after any contact with our office (good or bad) on which you would like to comment. After completing the form, mail it to the Pinnacle Medicare Service office you had contact with. Here are the addresses to mail this form:

Arkansas

Pinnacle Medicare Services
Attn: Greg Hart
P.O. Box 1418
Little Rock, AR 72203

Louisiana

Pinnacle Medicare Services
Attn: Greg Hart
P.O. Box 1418
Little Rock, AR 72203

Rhode Island

Pinnacle Medicare Services
Attn: Greg Hart
P.O. Box 1418
Little Rock, AR 72203

Medicare Program:

Every day our staff makes numerous contacts with the provider community. Please comment on any contact you have had with our office that you would like us to know about. We appreciate being notified of any contact with an employee that meets your standard of excellence or any employee that falls below that standard.

Date of contact: _____ Contact was made: In person _____ By telephone _____

Name of Pinnacle employee that assisted you: _____

(Employees should answer with their name.)

Provide us with a general description of the topic discussed or question(s) you asked.

Was our response clear and easy to understand? _____

Was our staff member friendly and helpful? (If not, what happened?) _____

General comments: _____

Interactive Voice Response Unit:

Do you use the IVR regularly? (If not, why not?) _____

Do you find the IVR to be an effective tool for you and your staff? (Why or why not?)

What features do you feel you and your staff would use which are not available?
(Please remember, we cannot verify entitlement or deductible status through the IVR.)

(continued on next page)



Arkansas Information

This information only applies to Medicare Part B providers in Arkansas. If you have any questions regarding the information in this section, please call Pinnacle Medicare Services at (866) 345-0274.

THERE ARE NO STATE SPECIFIC ARTICLES AT THIS TIME



Louisiana Information

This information only applies to Medicare Part B providers in Louisiana. If you have any questions regarding the information in this section, please call Pinnacle Medicare Services at (866) 567-8419.

Widespread Probe Review Results of Emergency Department E/M Services in Louisiana (CPT 99282-99285) by Specialty 11 (Internal Medicine)

Reference: AR – SEM060308

A widespread pre-pay probe review was performed for Emergency Department Evaluation and Management services in Louisiana (LA) for CPT® codes 99282-99285, for specialty 11 (Internal Medicine) in place of service 23 (Emergency room – hospital). These codes are defined as follows:

99282: Emergency department visit for the evaluation and management of a patient, which requires these three key components:

- * An expanded problem focused history;
- * An expanded problem focused examination; and
- * Medical decision making of low complexity.

Usually, the presenting problem(s) are of low to moderate severity.

99283: Emergency department visit for the evaluation and management of a patient, which requires these three key components:

- * An expanded problem focused history;
- * An expanded problem focused examination; and
- * Medical decision making of moderate complexity.

Usually, the presenting problem(s) are of moderate severity.

99284: Emergency department visit for the evaluation and management of a patient, which requires these three key components:

- * A detailed history;
- * A detailed examination; and
- * Medical decision making of moderate complexity.

Usually, the presenting problem(s) are of high severity and require urgent evaluation by the physician but do not pose an immediate significant threat to life or physiologic function.

99285: Emergency department visit for the evaluation and management of a patient, which requires these three key components:

- * A comprehensive history;
- * A comprehensive examination; and
- * Medical decision making of high complexity.

Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.

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Rationale for Review:

Emergency Department Evaluation and Management Services is a continued problem area from the 2006 and 2007 fiscal years. A widespread probe review including all specialties was performed in mid-2007. The widespread review results for all specialties for CPT codes 99282-99285 revealed 52% of the services were denied due to the following reasons:

- 24% were denied as no response to ADR. The requested medical records were not received to support that the services billed were reasonable and necessary.
- 14% of these services were recoded to a lower level of emergency room service, as reflected by the documentation.
- 7% were recoded to a higher level of service, as reflected in the documentation.
- 6% were denied as not furnished to the patient; the wrong provider billed for the services.



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- 1% was denied for insufficient information; no examination, decision making, or physician signature was on the submitted data.

An education article regarding these findings and recommendations from Medical Review was posted to the state website and published in the July 2007 edition of *Pinnacle Medicare Providers' News*.

Comprehensive Error Rate Testing (CERT) data for Louisiana for sample dates October 2005 to November 2007 was analyzed and showed no errors for CPT codes 99282 - 99285 for specialty 11. National data indicates that Specialty (SP) 11 in Louisiana does exceed the nation for CPT codes 99282 - 99285 for July through December 2006. Carrier data reveals that SP 11 is the 3rd ranked specialty for utilization of CPT codes 99282-99285 for the time period June through November 2007. Carrier data further reveals that allowed dollars for SP 11 for CPT codes 99282 - 99285 have increased 7% when comparing paid dates June through November 2006 and June through November 2007, and allowed services for these codes have decreased 7% over the same time period. When evaluating the provider distribution within SP 11 for CPT codes 99282 - 99285, no provider stands out as having significantly more allowed dollars than any other provider, indicating that the problem is widespread within the specialty.

Due to the high denial rate among all specialties identified on the previous widespread probe of Emergency Department E/M services, and to aberrancies in national data, a widespread review was recommended for specialty 11 (Internal Medicine). The overall goal is to decrease the claims error rate in each state through provider education following targeted medical review, focusing on top specialties and codes.

Services were allowed as billed if all the following were present:

- The level of medical decision making was appropriate for the level of service billed;
- The levels of history and examination met or exceeded the other two required components for the code billed;
- The severity of the presenting problem was appropriate for the level of service billed;
- The service was performed by the billing provider; and
- A legible identifier of the billing provider was present.

Criteria for Review:

Randomly selected claims were reviewed, utilizing the following criteria:

- CPT code(s) 99282 - 99285
- Place of Service: 23 (Emergency room – hospital)
- Provider Specialty: 11
- Dates of Services Billed: 05/20/07 – 02/19/08
- Number of Claims: 100
- Number of Services: 100
- Number of Providers: 31
- Number of Beneficiaries: 100
- Diagnosis Code(s): Varied

Review Results:

One hundred services (from 100 claims) for procedure codes 99282-99285 were randomly selected for prepay review with no more than five claims from any one provider. Of these 100 services, 31 services (31%) were allowed as billed. The remaining 69 services (69%) were denied as follows:

- 41 services (41%) were denied as no response because no records were received in response to Medical Review's request for information to support that the service billed was reasonable and necessary
- 25 services (25%) were recoded to a lower level of service, as reflected by the documentation
- 2 services (2%) were denied for incomplete/insufficient information
- 1 service (1%) was recoded to a higher level of service, as reflected by the documentation



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The breakdown of denied services includes the denied percentage of the total number of services in this Probe sample.

The major issues identified that led to denial of services are as follows:

Issue #1: No response to ADR (Additional Documentation Request)

Forty-one services were denied because no records were received in response to Medical Review's request for additional documentation to support that the service billed was reasonable, necessary, and correctly coded. This comprised almost 60% of the total claims denied and is of significant concern. No response to such requests may result in targeted medical review of providers who do not comply.

Title XVIII of the Social Security Act, section 1862 (a)(1)(A) allows coverage and payment for only those services that are considered to be medically reasonable and necessary; therefore, no response to our request for medical records will result in denial of claims.

Improper submission of medical records to Medical Review is the primary cause of records being lost and therefore, denied. Reasons for this are:

- Submitting a **copy** of the Additional Documentation Request (ADR) letter, rather than the original, bar-coded ADR with the record.
- Submitting multiple ADRs with documentation stacked behind them.
- Submitting individual pages of the ADR, separated by documentation.
- Submitting records for other departments using the fax number for Medical Review's documentation.
- Submitting records by mail rather than faxing them. While this is acceptable, it slows down the process and records are sometimes lost.

For fast, accurate processing of your claims:

- Fax the original ADR with your documentation. This will enable the bar-code function to route the documentation directly to Medical Review.
- Fax each beneficiary's documentation behind that individual beneficiary's ADR letter of request. Always return the ADR with the requested documentation. Do not stack documentation behind multiple ADRs.
- Do not separate multiple pages of one ADR letter.
- Use the fax number for Medical Review to fax **only** the ADR and requested documentation – 501-378-5622. Do **not** use this number to fax your claims or anything else except the ADR and requested documentation.
- Fax the ADR and the requested documentation rather than mailing them. The process is working very well for the providers who are faxing their records. A neon yellow insert with your ADR is to encourage you to fax your records (with the appropriate ADR) to Medical Review.

Issue #2: Inappropriate level of service billed

Twenty-five services were recoded to a lower level of service.

4 services were billed for 99282. Of these:

- 2 services were allowed as billed
- 2 services were denied for no response to ADR

29 services were billed for 99283. Of these:

- 14 services were allowed as billed
- 7 services were denied for no response to ADR
- 8 services were recoded to 99282

31 services were billed for 99284. Of these:

- 6 services were allowed as billed
- 14 services were denied for no response to ADR



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- 2 services were denied for incomplete/insufficient information (see Issue #3)
- 5 services were recoded to 99283
- 3 services were recoded to 99282
- 1 service was recoded to 99285

36 services were billed for 99285. Of these:

- 9 services were allowed as billed
- 8 services were recoded to 99284
- 18 services were denied for no response to ADR
- 1 service was recoded to 99283

When considering all codes together, reasons for down-coding are as follows:

- **In seventeen services, the level of decision making required and documented did not meet that required for the level of service billed.** For example:

Three services billed as 99285 but recoded to 99284: The level of decision making documented and required by the condition of the patient was moderate which did not meet that required for the level of service billed. The level of history met and exam exceeded the other key components for 99284.

Additionally, the presenting problem was of high severity and required urgent evaluation by the physician but did not pose a significant immediate threat to life/physiologic function. This was further supported by the fact that in one service, documentation stated the patient arrived in ER at 1910 but was not seen by the physician until 2025, and in two other services by the fact that documentation stated the patient arrived in ER at 1009 but was not seen by the physician until 1115, then discharged; and the patient arrived in the ER at 2025, but was not evaluated by the physician until 2116.

- **In seven services, although the key components were met for the level of service billed, the nature of the presenting problem was of lower severity and supported a lower level of service.** For example:

Billed as 99285 but recoded to 99284: The level of decision making documented and required by the condition of the patient was high which was appropriate for the level of service billed. The levels of history and exam met the other key components for 99285. However, the presenting problem was of high severity and required urgent evaluation by the physician but did not pose an immediate significant to life/physiologic function. (39 year old female presented with agitation x 3 days. History of schizophrenia. Auditory and visual hallucinations. Patient was admitted. Note states patient in stable condition.)

Billed as 99284 but recoded to 99283: The level of decision making documented and required by the condition of the patient was moderate which was appropriate for the level of service billed. The levels of history and exam exceeded the other key components for 99283. The presenting problem was of moderate severity only and did not require urgent evaluation by the physician. This was further supported by the fact that documentation indicated the patient was in no acute distress, severity of symptoms was mild, and respirations even and unlabored with pulse ox 97% on RA. (Presented with complaints of productive cough/shortness of breath, intermittent. No fever. At worst symptoms were mild.)

Billed as 99284 but recoded to 99283: The level of decision making documented and required by the condition of the patient was moderate which was appropriate for the level of service billed. The level of history met and exam exceeded the other key components for 99284 as billed and both exceeded the other key components for 99283. However, the presenting problem was of moderate severity only and did not require urgent evaluation by the physician. (63 year old male with complaints of left flank pain x 2 days associated with urinary frequency. No dysuria, urgency, hematuria, fever, chills, nausea or vomiting. KUB showed questionable stone at L4, renal colic CT showed no stones or abnormalities. Was given IV Toradol and Lortab for pain while in ER and was discharged with dx musculoskeletal back pain. Patient arrived at 10:27 pm and was evaluated by physician at 1:47 am.)



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Billed as 99283 but recoded to 99282: The level of decision making documented and required by the condition of the patient was low which does not meet that required for the level of service billed. The levels of history and exam exceeded the other key components for 99282. The presenting problem was of low to moderate severity only. This is further supported by the fact that the presentation time was 1458, and the patient was seen by the physician at 1745. The patient's chief complaint was back pain ("I was taking a shower and bent over and coughed, then tried to stand up and couldn't") with a history of chronic back pain.

- **In one service (billed as 99284), both the level of history and the nature of the presenting problem failed to meet that required for the level of service billed.** The level of decision making documented and required by the condition of the patient was moderate which was appropriate for the level of service billed. However, the level of history was expanded problem focused (due to no PFSH) so all three key components were met for 99282 only, although the presenting problem was of moderate severity.

CPT codes 99282 and 99283 require an expanded problem focused history and exam. An expanded problem focused history requires a *brief* HPI (history of present illness), a *pertinent* ROS (review of systems), and *no* PFSH (past medical, family, social history).

- A brief HPI consists of one to three elements of the HPI (location, quality, severity, duration, timing, context, modifying factors, and associated signs/symptoms) or the status of one to two chronic or inactive conditions.
- A pertinent ROS inquires about the system directly related to the problem(s) identified in the HPI.

CPT code 99284 requires a detailed history and exam. A detailed history requires an *extended* HPI, an *extended* ROS, and *pertinent* PFSH.

- An extended HPI consists of at least four elements of the HPI (location, quality, severity, duration, timing, context, modifying factors, and associated signs/symptoms) or the status of at least three chronic or inactive conditions.
- An extended ROS inquires about the system directly related to the problem(s) identified in the HPI and a limited number of additional systems. The patient's positive responses and pertinent negatives for two to nine systems should be documented.
- A pertinent PFSH consists of a review of one area of past history (the patient's past experiences with illnesses, operations, injuries, and treatments), family history (a review of medical events in the patient's family, including diseases which may be hereditary or place the patient at risk), or social history (an age appropriate review of past and current activities).

CPT code 99285 requires a comprehensive history and exam. A comprehensive history requires an *extended* HPI, a *complete* ROS, and *complete* PFSH.

- An extended HPI consists of at least four elements of the HPI (location, quality, severity, duration, timing, context, modifying factors, and associated signs/symptoms) or the status of at least three chronic or inactive conditions.
- A complete ROS inquires about the system(s) directly related to the problem(s) identified in the HPI plus all additional body systems. At least ten organ systems must be reviewed. Those systems with positive or pertinent negative responses must be individually documented. For the remaining systems, a notation indicating all other systems are negative is permissible. In the absence of such a notation, at least ten systems must be individually documented.
- A complete PFSH consists of a review of at least two of these three areas: past history (the patient's past experiences with illnesses, operations, injuries, and treatments), family history (a review of medical events in the patient's family, including diseases which may be hereditary or place the patient at risk), and social history (an age appropriate review of past and current activities).

Documentation of the physical exam may be in the format of a general multi-system examination or a single organ system examination. The 1997 E/M Guidelines are more specific than the 1995 Guidelines. For purposes of medical review, documentation will be considered using the 1997 E/M Guidelines first. If the examination criteria are not met from these guidelines, documentation will be reviewed using the 1995 E/M Guidelines.



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- From the *1997 Documentation Guidelines for Evaluation and Management Services*: For the general multi-system examination,
 - ∅ An expanded problem focused exam is a limited examination of the affected body area or organ system and any other symptomatic or related body area(s) or organ systems. It should include performance and documentation of at least six elements identified by a bullet (•) in one or more organ system(s) or body area(s).
 - ∅ A detailed examination should include at least six organ systems or body areas. For each system/area selected, performance and documentation of at least two elements identified by a bullet (•) is expected. Alternatively, a detailed examination may include performance and documentation of at least twelve elements identified by a bullet (•) in two or more organ systems or body areas.
 - ∅ A comprehensive examination should include documentation of at least nine organ systems or body areas. For each system/area selected, performance and documentation of at least two elements identified by a bullet (•) is expected.
- From the *1995 Documentation Guidelines for Evaluation and Management Services*:
 - ∅ An expanded problem focused examination should include performance and documentation of at least six elements identified by a bullet (•), whether in a box with a shaded or unshaded border.
 - ∅ The extent of examination performed and documented is dependent upon clinical judgment and the nature of the presenting problem(s). Exams range from limited examinations of single body areas to general multi-system or complete single organ system examinations.
 - ∅ The content and extent of documentation will be the determining factor between an expanded problem focused examination and a detailed examination.
 - ∅ For the general multi-system examination, a detailed exam is an extended examination of the affected body area(s) and other symptomatic or related organ system(s).
 - ∅ For the general multi-system examination, a comprehensive exam includes documentation of findings about eight or more of the twelve organ systems.
- For the single organ system examination,
 - ∅ An expanded problem focused examination should include performance and documentation of at least six elements identified by a bullet (•), whether in a box with a shaded or unshaded border.
 - ∅ For the single organ system examination, the detailed examination should include performance and documentation of at least twelve elements identified by a bullet (•), whether in box with a shaded or unshaded border, except for eye and psychiatric exams, which require at least nine elements identified by a bullet.
 - ∅ The comprehensive examination should include documentation of every element in each box with a shaded border and at least one element in each box with an unshaded border.

According to the *Medicare Claims Processing Manual*, Chapter 12, section 30.6, “Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service reported.”

A newsletter article published in the May 2006 *Pinnacle Medicare Providers’ News* entitled, “Subsequent Hospital Care Codes,” states, “The nature of the presenting problem usually determines the levels of history and physical exam required.” This information applies to all evaluation and management (E/M) codes. This is reiterated in the 1997 Evaluation and Management Guidelines. Documentation of history, physical examination, and medical decision making should not be performed or billed at levels greater than needed for the patient’s condition.

According to the 1995 and 1997 Evaluation and Management Guidelines, the levels of E/M services recognize four types of medical decision making (straightforward, low complexity, moderate complexity, and high complexity). Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option as measured by:



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- The number of possible diagnoses and/or the number of management options that must be considered.
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed and analyzed.
- The risk of significant complications, morbidity and/or mortality, as well as comorbidities, associated with the patient's presenting problem(s), the diagnostic procedure(s) and/or the possible management options. (According to the AMA's Current Procedural Terminology, "Comorbidities/underlying diseases, in and of themselves, are not considered in selecting a level of E&M/Consultation service unless their presence significantly increases the complexity of the medical decision making.")

The chart below is from the 1995 and 1997 Evaluation and Management Guidelines, and shows the progression of the elements required for each level of medical decision making. To qualify for a given type of decision making, **two of the three elements in the table must be either met or exceeded.** You may reference the details for the elements listed below for the type of decision making in the 1995 and 1997 Documentation Guidelines for Evaluation and Management (E/M) Services.

Number of diagnoses or management options	Amount and/or complexity of data to be reviewed	Risk of complications and/or morbidity or mortality	Type of decision making
Minimal	Minimal or None	Minimal	Straightforward
Limited	Limited	Low	Low Complexity
Multiple	Moderate	Moderate	Moderate Complexity
Extensive	Extensive	High	High Complexity

Other recoded services:

One service billed as 99284 was re-coded to 99285 to reflect the level of E/M service documented. The level of decision making documented and required by the condition of the patient was high which exceeded that required for the level of service billed. The levels of history and exam did not meet the other key components for 99285 but were appropriate based on the constraints imposed by the urgency of the patient's clinical condition. The presenting problem was of high severity (patient arrived in cardiopulmonary arrest) and posed an immediate significant threat to life or physiologic function.

Issue #3: Incomplete/insufficient information

Two services were denied for incomplete/insufficient information for the following reasons:

- ED Physician Assessment Record received for review contained no physical exam, so all three key components were not met for any CPT code in this range.
- No Emergency Room E/M physician note was received for review. Documentation received consisted of ED Nurses Notes only.

Title XVIII of the Social Security Act, section 1833(e) prohibits Medicare payment for any claim which lacks the necessary information to process the claim. The provider has a responsibility to ensure the medical necessity for these procedures and must maintain proper documentation available for submission if needed to adjudicate the claim.

Issue #4: Legibility of documentation

Review was somewhat limited in some cases due to poorly legible or illegible documentation and/or poor copy quality. Poor legibility may have contributed to the down-coding of services. If documentation is grossly illegible, it is impossible to support medical necessity for services and clearly define what service was performed.

Legible documentation is a requirement. Documentation that is poorly legible has a direct affect on the reviewer's ability to make a fair determination and on the overall review process.



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Recommendations for Providers:

- If you disagree with the determination to deny or re-code services, you may seek redetermination, as outlined in the *Medicare Claims Processing Manual*, Chapter 29, sections 60.2; 310.1.B.2; and 310.2. This manual may be accessed on the following Medicare website: <http://www.cms.hhs.gov/Manuals/IOM/list.asp>. The redeterminations form, CMS 20027, may be found at: <http://www.cms.hhs.gov/cmsforms/downloads/cms20027.pdf>. There is also a brochure for your review, which outlines the five levels of the appeals process at <http://www.cms.hhs.gov/MLNProducts/downloads/MedicareAppealsProcess.pdf>. You may call Customer Service, (866) 567-8419, for the address to which redeterminations must be sent.
- In the future, please be sure that all requested documentation is present, legible, signed, and submitted within the 30 day time-frame. Be sure the beneficiary's name is included on all pages of documentation. Failure to submit the requested documentation will result in complete or partial denial of your claims.
- Review the 1995 and 1997 Evaluation and Management Guidelines, which may be found on the following website http://www.cms.hhs.gov/MLNEdWebGuide/25_EMDOC.asp.
- Review the CPT key components for Emergency Department E/M services.
- Remember that for Emergency Department services, the nature of the presenting problem must also be considered when selecting the CPT code to appropriately reflect the level of service.
- Perform and document history, physical examination, and medical decision making at levels appropriate for the patient's condition.
- Choose the CPT code for the correct level of service. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted, or a lower level when a higher level of service is warranted.
- Remember that the volume of documentation should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service reported.

References:

- 1995 and 1997 Documentation Guidelines for Evaluation and Management Services, http://www.cms.hhs.gov/MLNEdWebGuide/25_EMDOC.asp.
- *Current Procedural Terminology*, CPT 2007, Professional Edition © 2006 American Medical Association. All Rights Reserved.
- *Pinnacle Medicare Provider News*, May 2006, "Coding of Subsequent Hospital Care"
- *Medicare Claims Processing Manual*, Chapter 12, sections 30.6.1.

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Widespread Probe Review Results of Care Plan Oversight in Louisiana (HCPCS G0181) For Specialty 08 (Family Practice)

Reference: AR – DLH 060508

A widespread pre-pay probe review was performed for HCPCS code G0181, for Specialty 08 (Family Practice) in Louisiana, in place of service 11 (Office). This code is defined as follows:

G0181: Physician supervision of a patient receiving Medicare-covered services, provided by a participating home health agency (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of laboratory and other studies, communication (including telephone calls) with other health care professionals involved in the patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month, 30 minutes or more.

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Rationale for Review:

“Other Medicare Fee Schedule” is a focus area for the FY2008 Part B Strategy and ranks 16th in the 2008 prioritization. Other Medicare Fee Schedule was identified through national and local data as an outlier for this issue in Louisiana. This file is opened due to recent increases in the allowed amount and the growing national aberrancy present for this code.

Louisiana Comprehensive Error Rate Testing (CERT) data was analyzed for sample dates October 1, 2006 through December 31, 2007 and showed one error for HCPCS code G0179 for 1.30% of the total errors. There were no CERT errors for G0181.

National data indicates that G0179, G0180, and G0181 were nationally aberrant in Louisiana from January through June 2007.

Specialty (SP) 08 is the second ranked specialty billing HCPCS codes G0179-G0181 during paid dates June through November 2007. Carrier data reveals that allowed dollars for SP 08 HCPCS codes G0179-G0181 have increased 7.10% when comparing paid dates June 2006 through November 2006 to June 2007 through November 2007. Allowed services for SP 08 for this code have increased 17.63% over the same time period. In addition, analysis of these HCPCS codes shows that HCPCS code G0181 has increased 60.02% by allowed dollars and 73.38% by allowed services when comparing June 2006 through November 2006 to June 2007 through November 2007.

Criteria for Review:

Randomly selected claims were reviewed, utilizing the following criteria:

- HCPCS code: G0181
- Place of Service: 11 (Office)
- Provider Specialty: 08 (Family Practice)
- Dates of Services Billed: March 1, 2007 – April 9, 2008
- Number of Claims: 100
- Number of Services: 103
- Number of Providers: 33
- Number of Beneficiaries: 92
- Diagnosis Code(s): Multiple

Review Results:

Care plan oversight (CPO) is the physician supervision of a patient receiving complex and/or multidisciplinary care as part of Medicare-covered services provided by a participating home health agency or Medicare approved hospice. CPO services require complex or multidisciplinary care modalities involving:

- Regular physician development and/or revision of care plans;
- Review of subsequent reports of patient status;
- Review of related laboratory and other studies;



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- Communication with other health professionals not employed in the same practice who are involved in the patient's care;
- Integration of new information into the medical treatment plan; and/or
- Adjustment of medical therapy.

There were a total of 100 claims, with 103 services, suspended for code G0181. Forty services (39%) were allowed as billed and sixty-three services (61%) were denied for the following reasons:

- 35 services (34%) were denied due to no response to Medical Review's request to submit documentation to support that the service(s) billed was reasonable and necessary.
- 28 services (27%) were denied because insufficient documentation was received to adjudicate the services.

The major issues identified that led to denial of services are as follows:

Issue # 1 – No Response

It is of major concern that providers are not responding to the request for medical records. Thirty-five services were denied because the medical records were not received.

- Title XVIII of the Social Security Act, section 1862 (a)(1)(A) allows coverage and payment for only those services that are considered to be medically reasonable and necessary; therefore, no response to our request for medical records will result in denial of your claims.

Also, the Additional Documentation Request (ADR) letter for one service was returned without any documentation to support the service billed.

Issue # 2 - Insufficient Documentation Submitted

Twenty-eight services were denied for insufficient documentation.

- Thirteen services were denied because documentation submitted did not support 30 or more minutes of Care Plan Oversight.
- Ten services were denied because the Plan of Care and/or Home Health Certification and/or Re-Certification form was submitted as the supporting documentation for services billed as G0181. Certification and re-certification should be billed using HCPCS codes G0179 and G0180.
- One service was denied because Medical Review requested documentation for 2/2008 and documentation submitted was for 3/2008.
- Four services had time documented and/or a time sheet that was not signed by the provider.

Title XVIII of the Social Security Act, section 1833 (a)(1) prohibits Medicare payment for any claim which lacks the necessary information to process the claim. Failure to submit the requested documentation will result in complete or partial denial of services.

Additional Issues

- According to the *Medicare Claims Processing Manual*, Chapter 12, section 180.1, "Providers billing for CPO must submit the claim with no other services billed on that claim and may bill only after the end of the month in which the CPO services were rendered. CPO services may not be billed across calendar months and should be submitted (and paid) only for one unit of service."
 - Ø Many providers sent in documentation outside of the parameters of CPO billing. For the purposes of this review, if a unit of CPO service was billed on April 1, 2008, documentation was reviewed for March and April, if submitted, and no denials resulted for this reason. However, for future reviews of G0181, only documentation submitted for the month prior to the billed date will be reviewed. If billing occurs in April, documentation will be reviewed for March.
 - Ø Some of the claims for G0181 were submitted with other services billed on the same claim. G0181 must be billed with no other services on the same claim.
- Some of the documentation submitted was not signed by the billing provider. The provider was given the benefit of the doubt that he/she signed the orders within the 30 day time frame. For future review, documentation submitted must contain the signature of the billing/performing provider. Services provided "incident-to" a physician's service do not qualify as CPO and do not count toward the thirty minute requirement.



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- Care Plan Oversight requires recurrent physician supervision of a patient involving 30 or more minutes of the physician's time per month. **Services not countable toward the 30 minutes threshold that must be provided in order to bill for CPO include, but are not limited to:**
 - Ø Time associated with discussions with the patient, his or her family or friends to adjust medication or treatment;
 - Ø Time spent by staff getting or filing charts
 - Ø Travel time; and/or
 - Ø Physician's time spent telephoning prescriptions into the pharmacist unless the telephone conversation involves discussions of pharmaceutical therapies.
- Documentation prepared by home health agencies or hospice may not be used in lieu of a physician's documentation. Home health agencies cannot estimate the time spent by a physician in performing these duties and cannot use surrogate measures to estimate the work performed. In some of the documentation reviewed, it appeared that the home health agency or hospice prepared the documentation and very little of the documentation (if any) was actually done by the billing provider. The physician must document which services were furnished and the date and length of time associated with those services.

Recommendations for Providers:

- Review the *Medicare Claims Processing Manual* Chapter 12, section 180-180.1
- In the future, please be sure that all requested documentation is present, legible, signed, and submitted within the 30 day time-frame. Be sure the beneficiary's name is included on all pages of documentation. Failure to submit the requested documentation will result in complete or partial denial of services.

References:

- HCPCS Level II 2007 Professional © 2006 by Ingenix. All Rights Reserved.
- *Medicare Claims Processing Manual*, Chapter 12, sec.180-180.1 "Care Plan Oversight Services"
- *CPT 2007 Current Procedural Terminology*, Professional Edition © 2006 American Medical Association. All Rights Reserved.
- *Pinnacle Medicare Provider's News*, July 2006, "Care Plan Oversight," page 43

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Louisiana Information

This information only applies to Medicare Part B providers in Louisiana. If you have any questions regarding the information in this section, please call Pinnacle Medicare Services at (866) 567-8419.

Probe Review Results of Care Plan Oversight (CPO) Services in Louisiana (HCPCS G0181), Specialty 11

Reference: AR – KMC 6/18/08

Widespread pre-pay probe reviews were performed for CPO services in Louisiana for HCPCS G0181, for specialty 11 (Internal medicine) in place of service office, and inpatient hospital. This code is defined as follows:

G0181, Physician supervision of a patient receiving Medicare-covered services provided by a participating home health agency (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of laboratory and other studies, communication (including telephone calls) with other health care professionals involved in the patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month, 30 minutes or more.

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Rationale for Review:

Other Medicare Fee Schedule is a problem area for the FY2008 Part B Strategy and ranked 16th in the 2008 prioritization. During the preparation of the 2008 Strategy, Other Medicare Fee Services was identified through national and local data as an outlier for this issue in Louisiana.

Louisiana Comprehensive Error Rate Testing (CERT) data for sample dates October 1, 2006, through December 31, 2007, was analyzed and showed no errors for the HCPCS G0181. Carrier data for January through June of 2007 revealed that the code was nationally aberrant in Louisiana.

Contractor data indicates specialty (SP) 11 is the top ranked specialty billing CPT Codes G179-G0181 during paid dates June 2007 through November 2007. Allowed dollars for SP 11 for CPT codes G0179 through G0181 has increased 13.56% when comparing paid dates June through November 2006 to June through November of 2007. The specialty's allowed services for this code have increased 19.68% over the same time period. The distribution of utilization is widespread among SP 11 providers. In addition, analysis of these CPT codes shows that CPT G0181 has increased 207.88% by allowed dollars and 236.14% by allowed services from paid dates June through November of 2006 to June through November of 2007.

G0181 was recommended by Medicare Data Analysis for a Widespread Probe Review for specialty 11. The overall purpose is to establish a baseline error rate and to identify any provider education needs.

Services were allowed as billed if:

- The place of service was not either POS 31 or 32
- The Care Plan was present (optional)
- Only one CPO service was billed per month according to MCS history
- The initial or subsequent care plan was signed by the same physician who was billing for the CPO service, unless the initial certification was done in the hospital, in which case a hand off to the PCP was indicated
- Submitted documentation showed evidence of home health and provider communication, including issues and provider management.
- The time and dates of the CPO service were documented, and the total time was at least 30 minutes within the calendar month.
- The billing provider's signature was present.
- The documentation submitted was for the month prior to the billed CPO service.

Review Sample:

- Dates of Services Billed: 4/30/07 through 3/31/08
- Number of Claims: 100
- Number of Services: 106
- Number of Providers: 29
- Number of Benes: 91



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- Diagnosis Code(s): Varied

Review Results:

A total of 106 services, from 100 claims for HCSPS code G0181 was randomly selected for prepay review. Of these 106 services, 24 (22.6%) were allowed as billed. The remaining 82 services (77.4%) were denied as follows:

- 38 services (35.9%) were denied for No Response to the ADR (Additional Documentation Request) because the documentation was not received to support that the service billed was reasonable and necessary.
- 31 services (29.2%) were denied for insufficient information.
- 13 services (12.3%) were denied as not furnished directly to the patient and/or not documented.

The breakdown of denied services includes the denied percentage of the total number of services in this Probe sample.

Issues Identified from the Probe:

No Response

It is of major concern that thirty-eight services were denied because the requested medical records were not received. If an Additional Documentation Request (ADR) is received, the provider must submit the appropriate medical record documentation to support the service being billed. Title XVIII of the Social Security Act, section 1862 (a) (1) (A) allows coverage and payment for only those services that are considered to be medically reasonable and necessary; therefore, no response to our request for medical records will result in denial of your claims.

Improper submission of medical records to Medical Review is one cause of records being lost and therefore, denied. Reasons for this are:

- Submitting a **copy** of the Additional Documentation Request (ADR) letter, rather than the original, bar-coded ADR with the record.
- Submitting multiple ADRs with documentation stacked behind them.
- Submitting individual pages of the ADR, separated by documentation.
- Submitting records for other departments using the fax number for Medical Review's documentation.
- Submitting records by mail rather than faxing them. While this is acceptable, it slows down the process and records are sometimes lost.

For fast, accurate processing of your claims:

- Fax the original ADR with your documentation. This will enable the bar-code function to route the documentation directly to Medical Review.
- Fax each beneficiary's documentation behind that individual beneficiary's ADR letter of request. Always return the ADR with the requested documentation. Do not stack documentation behind multiple ADRs.
- Do not separate multiple pages of one ADR letter.
- Use the fax number for Medical Review to fax **only** the ADR and requested documentation – 501-378-5622. Do **not** use this number to fax your claims or anything else except the ADR and requested documentation.

Each provider is strongly encouraged to fax the ADR and the requested documentation rather than mailing them. The process is working very well for the providers who are faxing their records. Future ADRs will contain a neon yellow insert reminding the providers to fax their records (with the appropriate ADR) to Medical Review.

Insufficient Documentation

Thirty-one services were denied as insufficient information. The majority of these claims were submitted with insufficient amounts of time documented or inadequate supporting documentation for the G0181 service. From the CMS *Medicare Claims Processing Manual*, Chapter 12, section 180:

“Care plan oversight (CPO) is the *physician supervision* of a patient receiving complex and/or multidisciplinary care as a part of Medicare-covered services provided by a participating home health agency or Medicare approved hospice.



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CPO services require complex or multidisciplinary care modalities involving:

- Regular physician development and/or revision of care plans;
- Review of subsequent reports of patient status;
- Review of related laboratory and other studies;
- Communication with other health professionals not employed in the same practice who are involved in the patient's care;
- Integration of new information into the medical treatment plan; and/or
- Adjustment of medical therapy.....”

“Implicit in the concept of CPO is the expectation that the physician has coordinated an aspect of the patient's care with the home health agency or hospice during the month for which CPO services were billed. The physician who bills for CPO must be the same physician who signs the plan of care.”

The time was not allowable if the documentation appeared to be solely generated by the home health agency or hospice; for example, a standardized activity summary performed by the nurse. Documentation prepared by home health agencies may not be used in lieu of a physician's documentation. Home health nurses should not “guess” the amount of time a physician spent in looking at lab work, and then provide a log for the provider to simply sign. Several claims were submitted with time logs signed by the physician, but had no documentation to further sustain the G0181 billing. On this probe, the ADR specifically requested documents supporting the CPO service; if a physician stated he/she reviewed laboratory reports, etc., a copy of such report must be submitted to Medicare to validate such service. Many physicians failed to initial the labs and/or time them. One of these lab services had no physician signature but a signature of a nurse. Some physicians, in order to further validate their personal involvement in the CPO, included a short progress note from the patient's office chart which corroborated the service date and time in the physician's CPO service log. For instance: “Home health nurse ___ called, reported protime of 28, Coumadin changed to 5 mg Monday and Thursday, verbal order called to Home Health nurse_____”. Often the order change was scribbled on the faxed home health lab work, initialed (by the physician), and timed; it was then faxed back to the home health agency.

Providers should recall that the medical records must be maintained and available for review if requested. Based on Title XVIII of the Social Security Act, section 1833(e), failure to submit the requested documentation will result in complete or partial denial of services.

Incorrect billing

Thirteen services were denied as not furnished directly to the patient and/or not documented. By definition, the procedure G0181 is time spent for a revision of a set care plan for home health, it is not meant to establish the care plan for certification or recertification purposes as G0180 and G0179, respectively. Several providers in the billing history had billed G0181 services exclusively, and had never billed for either G0179 or G0180. These services were submitted with only the certification or recertification plan of care, and no additional documentation to support CPO services.

A signed plan of care is not sufficient to support CPO services.

One service was denied because it was a hospice patient. CPO services for hospice patients should be billed under G0182.

One service of G0181 was billed in place of service 21 (Inpatient Hospital), which would be unusual, and may be due to provider clerical error.

Incorrect Submission of Services on Claims

According to the *Medicare Claims Processing Manual*, Chapter 12, section 180.1 “Providers billing for CPO must submit the claim with *no other services* billed on that claim and may bill only after the end of the month in which the CPO services were rendered. CPO services may not be billed across calendar months and should be submitted and paid for only one unit of service.” Many claims were received that had more than just the CPO service on the claim.



Louisiana Information

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Incorrect Documentation to Support Services

Documentation submitted was often for the current month rather than the previous month as anticipated. For example, if the provider billed CPO services on February 1, 2008, the ADR would request documentation to support the service billed on February 1, 2008. The review would be for the documentation in *January*. For purposes of this probe, MR reviewed submitted documentation for the month before and/or the month billed, but this will not be allowed for future reviews. Please note that documentation should be submitted for CPO services for the month *prior* to the billing date. (For this review, if the provider had billed the CPO service in February, but had sent February's time log and supporting documentation, the services were allowed if they met all other criteria.) It was noted that providers had interpreted the manual incorrectly to mean that it was all right to backdate the CPO service; however, this is not an acceptable practice.

Recommendations for Providers

- Review the *Medicare Claims Processing Manual*, Ch. 12, sections 180 and 180.1 Care Plan Oversight Services, which may be found on the following Medicare website:
<http://www.cms.hhs.gov/Manuals/IOM/list.asp>.
- In the future, please be sure that all requested documentation is present, legible, signed, and submitted within the 30 day time frame. Each provider is strongly encouraged to fax the ADR and the requested documentation rather than mailing them.
- Remember that the establishment of a Care Plan or Home Health Certification is a separately billable code. The time to write, read, or sign the Care Plan certification or recertification is reimbursed under HCPCS GO180 or G0179. Physicians should bill for these codes separately. These codes are reimbursed and reviewed under a different Medicare Carrier.
- Recall that Care Plan Oversight is *physician supervision* of an already established Care Plan, involving 30 or more minutes of the physician's time per month.
- When requested, the physician should be able to send in the documentation from his own maintained records.
- The supporting documentation for CPO service should reveal how and why the physician coordinated an aspect of the patient's care with the home health agency during the month for which CPO services were billed. The length of time to review pertinent information, such as MRIs, x-rays, or findings by other physicians and the incorporation of this new data into a modified care plan is justifiable as CPO service. This may include lab work, home health updates in the patient's condition and need for revision of care plans, changes in medication, or changes in frequency of visits by the Home Health staff. It does not cover the physician's time spent telephoning prescriptions into the pharmacist unless the telephone conversation involves discussions of pharmaceutical therapies.
- One of the easiest ways for a physician to justify the CPO service is to sign/initial each piece of lab or data, write the length of time it took to review, make a decision based on the information, and convey this to the home health which modifies the care plan.
- A CPO log is perfectly acceptable when it has the date and time listed of the CPO service, but it must be accompanied by the supporting documentation as above and signed by the physician.
- The physician who bills for CPO must be the same physician who signs the plan of care.
- A signed plan of care is not sufficient to support CPO services.
- Please note that documentation should be submitted for CPO services for the month *prior* to the billing date. CPO services are billed after the month the services were actually rendered; therefore the documentation submitted to respond to the ADR must come from the previous month.
- It is not permissible for the CPO service to be backdated.
- Only one CPO service should be billed per month, if documentation and total length of time (at least 30 minutes) support the service.
- CPO service should be billed with no other codes on the claim.

References:

- *Medicare Claims Processing Manual*, Chapter 12, sections 180 and 180.1 Care Plan Oversight Services
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Rhode Island Information

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THERE ARE NO STATE SPECIFIC ARTICLES AT THIS TIME

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- Arkansas (866) 345-0274 www.arkmedicare.com
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