Coverage of Medically Necessary Hysterectomies Requires Proper Documentation BT201229 July 31, 2012

Per 405 IAC 5-28-9, the Indiana Health Coverage Programs (IHCP) provides coverage for a medically necessary hysterectomy performed to treat an illness or injury only when the member has given informed consent and prior authorization (PA) has been obtained.

Effective for dates of service on or after September 2, 2012

The procedure codes that will be added to the list of hysterectomy codes requiring PA can be found in the IHCP Manual Chapter 8-485 on the Indiana Medicaid website. [www.indianamedicaid.com](http://www.indianamedicaid.com)

Requirement for informed consent documentation

To document informed consent, the IHCP requires that all claims for hysterectomy procedure codes be submitted with the member’s acknowledgement of receipt of hysterectomy information. While no specific format is mandated for the acknowledgement, an example that includes the information necessary to satisfy documentation requirements can be found in Chapter 8 of the IHCP Provider Manual.

All providers must attach a photocopy of the properly completed acknowledgement to their paper claim form or send it separately as an attachment to the electronic claim transaction. These requirements apply to all providers, including attending physicians and surgeons, assistant surgeons, anesthesiologists, inpatient and outpatient hospital facilities, or other providers of directly related services. Claims that do not include proper documentation will be denied. An example of the acknowledgement of receipt of hysterectomy information can be found in the IHCP Manual Chapter 8 on the Indiana Medicaid website. [www.indianamedicaid.com](http://www.indianamedicaid.com)
ICD-10 Implementation Date Set!

On August 24, 2012, Department of Health and Human Services (HHS) Secretary Kathleen Sebelius announced a final rule that confirms a one-year proposed delay – from October 1, 2013, to **October 1, 2014** – as the compliance date for use of new codes that classify diseases and health problems. These code sets, known as the International Classification of Diseases, 10th Edition diagnosis and procedure codes, or ICD-10, will include codes for new procedures and diagnoses that improve the quality of information available for quality improvement and payment purposes.

Now that the October 1, 2014 implementation date has been set, you should remain diligent in your implementation plans and preparations for the transition to ICD-10. ICD-10 will affect nearly all areas of your practice, and the time to conduct a thorough impact assessment is now!

More information on the final rule is available in a fact sheet at http://www.cms.gov/apps/media/fact_sheets.asp. The final rule may be viewed at www.ofr.gov/inspection.aspx.

Professional Medical Coding Certification

Looking for an opportunity to reach a higher level of skill and recognition in the field of medical coding? We invite you to attend our 15-week certification prep course.

The Professional Medical Coding Curriculum (PMCC) is geared toward learning the proficiency required to correctly code CPT®, HCPCS and ICD-9-CM for medical procedures performed by the physician. After passing the AAPC certification exam, students with at least 2 years previous work experience in the field will be recognized as a Certified Professional Coder (CPC).

See attached the attached FAQ and flier for more details and to register. Registration deadline is November 1!

MyAnthem for Provider Functionalities Moving Exclusively to Availity on November 2

Due to Availity’s ease of use, broad functionality and breadth of services, Anthem will transition functionality from our secure, legacy provider portal, MyAnthem, to exclusive access via Availity. Therefore, on November 2, 2012, we are shutting down MyAnthem links to Eligibility & Benefits Inquiry, Claim Status Inquiry and Secure Messaging.

(Note: Electronic transactions submitted via our Enterprise EDI Gateway are unaffected; you may continue to submit all X12 transactions through your current EDI transmission channels.)

What to do before MyAnthem for Provider functionalities move to Availity on November 2, 2012

We want to make sure you have all the information you need to give you and your users time to get acclimated to Availity as our shut down date is quickly approaching! Note that Availity offers a variety of training options, including live and on-demand webinars, online demonstrations, local workshops, comprehensive help topics, tip sheets and more. Once you have registered to become an Availity user, simply log into the Web portal and click “Free Training” from the top navigation bar.

IMPORTANT NOTE for Primary Access Administrators (PAA): Registering an Availity user for Anthem Services (User must have a MyAnthem user id):

AAPC Webinars

The AAPC offers weekly specialty webinars. IMM has purchased the series and invites you to attend at no cost to you or your practice. The events are scheduled on site at VEI, 7330 Shadeland Station. There is no remote access. Please see this month’s webinar topics below. Email tschuster@ecommunity.com to register.

**Wednesday, September 12**
1:00 – 2:00pm
Documentation: How to Learn What the Doctor Didn’t Write

**Wednesday, September 19**
1:00 – 2:00pm
Documentation: Patient Encounters, Medical Necessity, and Revenue
CODING CORNER

New Specialty Code C1 Centralized Flu
(CMS MM7784 Effective 01.01.2013)

The Centers for Medicare & Medicaid Services (CMS) established a new non-physician practitioner specialty code for Centralized Flu effective January 1, 2013. The new non-physician practitioner specialty code for Centralized Flu is C1 and is only applicable to the CMS-855B enrollment application Medicare physician/non-physician practitioner specialty codes describe the specific/unique types of medicine that physicians and non-physician practitioners (and certain other suppliers) practice. Physicians self-designate their Medicare physician specialty on the Medicare enrollment application (CMS-855B) or Internet-based Provider Enrollment, Chain, and Ownership System (PECOS) when they enroll in the Medicare program. However, non-physician practitioners are assigned a Medicare specialty code when they enroll. The specialty code becomes associated with the claims submitted by that physician or non-physician practitioner. Specialty codes are used by CMS for programmatic and claims processing purposes and the new code for Centralized Flu, C1, will be added to PECOS and recognized as the non-physician practitioner code for Centralized Flu.

- **VEI Consulting Insight:** New non-physician practitioner specialty code for Centralized Flu-C1
- **Applicable to the CMS 855B Enrollment application**

*Note: This article was revised on August 15, 2012, to show it does not apply to providers billing claims to Fiscal Intermediaries or DME MACs. All other information remains the same.*

Affordable Care Act (ACA) Section 1104 Administration Simplification
(PartB News Aug 2012)

On January 1, 2013 health plans are required to give you real time insurance verification within 20 seconds of your request. Your front desk and/or check out person will be able to know the patient’s financial responsibility, including co-pay and deductible, for that visit and be able to collect these amounts at the time of service. Many of the bigger health plans are already offering this feature, some in real time, others not quite so fast. This new requirement will require the health plans to get it done faster and more accurate or pay a penalty.

- **VEI CONSULTING INSIGHT:** To see a full list of what payers are currently compliant go to [http://www.caqh.org/CORE_organizations.php](http://www.caqh.org/CORE_organizations.php).
- **Be somewhat cautious as there are a few bugs.** Even when the health plan tells you the patient is eligible for a certain service one day, the plan can deny the claim because it may turn out that the patient changed jobs and the employer took a while to update enrollment rolls. Many provider advocacy groups, such as MGMA, have long been an advocate for getting this fixed as to who should bear the responsibility.
- **Ask your practice management vendor whether it will be ready with access in the insurance verifications.**
- **Prepare for a system upgrade which may mean $$$**
- **Ensure that your vendor can accommodate eligibility verification within a few days prior to the appointment so you can check with the patient prior to their visit.**
WPS 2nd Quarter CERT Error Summary

In order to improve the processing and medical decision making involved with payment of Medicare claims, the Centers for Medicare & Medicaid Services (CMS) designed the Comprehensive Error Rate Testing (CERT) program. WPS (Wisconsin Physician Services) Medicare received error findings in the following categories during the second quarter of 2012 (April – June) as identified by the CERT contractor.

**Insufficient Documentation - 61% of total errors**

Reasons for Errors:

- Missing signed physician order or progress note supporting physician intent and medical necessity for diagnostic labs and x-rays, chemotherapy, triamcinolone injection, fundus photography and sleep study
- Progress notes with missing or illegible provider signatures
- Missing documentation to support medical necessity of home visit made in lieu of an office or outpatient visit
- No documentation of face-to-face patient encounter for nursing home visit and hospital discharge services
- Billed occupational therapy missing plan of care
- Missing treating physician plan for beneficiary's dystrophic toenails to be trimmed by office nurse, incident to treating physician's services
- Missing administration record for chemotherapy
- No documentation that services were provided as billed for office visit, hospital visit and cataract removal
- Chiropractic documentation missing treatment plan
- Medication management documentation missing initial evaluation with diagnosis, functional status of beneficiary, prognosis, plan of care, etc.

**Incorrect Coding - 35% of total errors**

Reasons for Errors:

- Multiple Evaluation and Management (E/M) services down coded one level based on documentation (CPT 99222, 99233, 99239, 99285, 99310)
- Hospital visits (CPT 99223, 99233) and home visit (99350) down coded two levels based on documentation
- Hospital visits (CPT 99231, 99232) and office visit (CPT 99213) up coded one level based on documentation
- Outpatient monthly ESRD services (CPT 90960 - 4 or more visits) down coded to 90962 (1 visit) with only one face-to-face patient encounter documented
- Critical care service (CPT 99291) recoded to subsequent visit
- Physical therapy units reduced based on time documented

**Medically Unnecessary Service or Treatment - 3% of total errors**

Reasons for Errors:

- Blood draw denied due to lab tests missing valid physician order/documentation of intent or medical necessity
- Chiropractic services documented as non-payable maintenance therapy
- Billed CPT 36514 (therapeutic apheresis), CPT 76881 (extremity ultrasound, non vascular, real time with image documentation, complete), and CPT 20610 (major joint arthrocentesis, aspiration and/or injection). Documentation supports performance of a prolotherapy injection of Platelet Rich Plasma (PRP) into right patellar tendon anteriorly under ultrasound guidance. Prolotherapy is denied on the grounds that it is not reasonable and necessary per Medicare regulations
WPS 2nd Quarter CERT Error Summary (Continued)

**Service Provided but not by Billing Provider - .5% of total errors**

Reasons for Errors:
- Chiropractic service (CPT 98941-AT) billed by D.O., but performed and documented by a Chiropractor (D.C.)

**Response Received - Improper Documentation - .5% of total errors**

Reasons for Errors:
- Provider reported billed computer ophthalmic imaging optic nerve (CPT 92133) was not performed

Based on CERT error findings for this quarter, below are links to educational resources that can assist in avoiding these issues in your practice.

**CMS Resources**

- Requirements for Ordering and Following Orders for Diagnostic Tests
  CMS Internet-Only Manual (IOM), Publication 100-02, Chapter 15, Section 80.6Adobe Portable Document Format

- Provider Signature Requirements
  CMS Internet Only Manual (IOM), Publication 100-08, Chapter 3, Section 3.3.2.4Adobe Portable Document Format

- Evaluation and Management Services GuideAdobe Portable Document Format

- Fact Sheet: Outpatient Rehabilitation Therapy Services: Complying with Documentation RequirementsAdobe Portable Document Format

- Prolotherapy, Joint Sclerotherapy, and Ligamentous Injections with Sclerosing Agents
  CMS Internet-Only Manual, Publication 100-03, Chapter 1 (Part Two), section 150.7Adobe Portable Document Format

- Physicians’ Services - Outpatient Maintenance Dialysis
  CMS Internet-Only Manual, Publication 100-02, Chapter 11, section 80.2Adobe Portable Document Format