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VEI Consulting Services

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2013 Medicare Part B Deductible, Co-Insurance and Premium Rates

Traditional Medicare Part B Standard Premium: $104.90 and up

Traditional Medicare Part B Deductible: $147.00 a year

Traditional Medicare Part B Coinsurance: 20% for traditional

Traditional Medicare Part B Psyche Reduction: Patient pays 35%

New HCPCS Codes for 2013

G0454 DME face to face visits effective 07/01/2013. Use when ordering DME such as hospital beds, glucose monitors, manual wheelchairs, etc.

- This new HCPCS code G0454 is used when practice physicians have to fill out documentation for non-physician practitioners (NPPs) work for certain durable medical equipment (DME) orders. This puts accountability on physicians to make sure that the patient is getting equipment that is medically necessary.
- The practice will also have to turn in the documentation to the supplier.
- This visit, G0454, cannot be billed incident to.

G0456, G0457 negative pressure wound therapy. For surface areas less than or greater than 50 square centimeters.

G0452 molecular pathology interpretation

G0453 remote intraoperative monitoring

G0455 fecal bacteriotherapy

CGI RAC Issues

1. **Problem**: **Incorrect Billing of Diagnosis Codes for Colonoscopy and Sigmoidoscopy**

Provider Types Affected: Physicians **Type of Audit:** Automated

Description: This is an automated review to ensure correct reporting of diagnosis codes for colonoscopy and sigmoidoscopy services.

Policy Related Links: WPS Medicare L30304

Continued on next page

CGI RAC Issues (continued)

2. **Problem**: **No Skilled Service**

Provider Types Affected: Home Health (HHA) **Type of Audit:** Complex

Description: To qualify for the home health benefit, a patient must need a skilled service. When a skilled service is needed, dependent services may also be covered. Dependent services are not covered for a patient who no longer needs a skilled service. Claims with no skilled service billed will be reviewed to determine whether the qualifying criteria of having an ongoing skilled service has been met.

Policy Related Links: Social Security Act 1814 (2)(C) CMS IOM 100-02 Chapter 7, Section 30

3. **Problem**: **Professional Trastuzumab Off-Label Uses**

Provider Types Affected: Physician **Type of Audit:** Automated

Description: The purpose for this automated edit is to identify claims for Traztuzumab (Herceptin®) being used for off-label indications.

Policy Related Links: CMS Pub 100-02 (Medicare Benefit Policy Manual)

CMS Pub 100-04 CMS WPS Chemotherapy Drugs

4. **Problem**: **Skilled Nurse Length of Stay**

Provider Types Affected: Home Health (HHA) **Type of Audit:** Complex

Description: Late episodes (third and later) receive increased payments, therefore payment incentives exist for extended home health care. Medicare covers skilled nursing services when they are reasonable and necessary. Extended nursing care for observation and assessment may not be covered. Claims for nursing services into the third episode and after will be reviewed to determine if all Medicare coverage criteria is met.

Policy Related Links: 42CFR 409.42 and 409.44 CMS IOM MedPac Report

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Correct Coding Initiative 2013

(CMS Transmittal 1136)

National Correct Coding Initiative has added Modifier 24 (Unrelated E/M service by the same physician during the post-operative period) and Modifier 57 (Decision for surgery) to the list of CCI associated modifiers 2013. Check with private payers for the modifiers that they will allow, as Chapter 1 of the CCI Manual only lists Modifier 25 (Significant separately identifiable E/M on the same day by same physician), Modifier 58 (Staged or related procedure by same physician during the post-operative period), Modifier 78 (Unplanned return to the operating room during the post-op period), and Modifier 70 (Unrelated procedure or service by the same physician during the post-op period). While the CMS Manual 100-04 Chapter 12 Section 40.4(A) directs you to use Modifiers 24 and 57 with E/M services, many private payers will only follow what is in Chapter 1 of the CCI Manual. The ability to be able to use these additional modifiers will create additional revenue opportunities. Also, if a private payer denies the use of these modifiers, you may be able to use CMS Transmittal 1136 in your appeal.

Protect Member PHI When Submitting Records for BlueCard® Claims

In order to safeguard protected health information (PHI), please submit only relevant member information to Anthem. When sending an EOB (explanation of benefits) to Anthem as part of a BlueCard inquiry, make sure that the only viewable information pertains to the member for whom you are making the inquiry. Please remove (i.e., white out or black out) any other member's information so that the document can be passed on, as needed, to another Blue Plan.

If you submit an EOB with viewable information on multiple member claims, Anthem will return the inquiry with this message: "*Please be advised that your office submitted a primary explanation of benefits for the noted claim; however, you did not white out the other member information. We cannot accept your submission as it was sent. If you are attempting to send the primary information for this member, please white out all other member information on the primary EOB copy and resend to our office for handling.*"

CPT Code Changes for Anthem's Sleep Management Program

In 2013, there will be CPT code changes that necessitate updates to Anthem's sleep management program precertification requirements. The services represented by the following new codes are already included in the sleep management program:

New Code **95782**	Polysomnography, younger than 6 years, sleep staging with 4 or more additional parameters of sleep, attended by a technologist.
New Code **95783**	Polysomnography; younger than 6 years, sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bi-level ventilation, attended by a technologist.

Reminder: Sleep Therapy Services for MA Members Will Require Precert

Effective **January 1, 2013,** Anthem will implement a precertification requirement for sleep therapy services for Medicare Advantage (MA) members. The requirement considers the medical necessity of sleep testing and therapy services, including the need for use of a facility vs. doing the test in the home. As a reminder, precert requirements are already in place for most Anthem members. The program is administered by AIM and includes the following:

- Home sleep test (HST)
- In-lab sleep study (PSG)
- Titration study
- Initial treatment order (APAP, CPAP, BPAP and oral devices, appliances and related supplies)
- Ongoing treatment order (APAP, CPAP, BPAP and oral devices, appliances and related supplies)

For additional details, please see July 2012 Anthem Network Update.

Anthem - New Precertification Requirements Effective January 1, 2013

The following medical policy and clinical guideline will be added to precertification review, effective January 1, 2013. This will apply to group members of Anthem's local plans: Blue Priority, Blue Preferred Primary, Blue Priority Plus, Blue Preferred Primary Plus, Blue Access, Blue Access Choice, Blue Preferred Plus and Lumenos® health plans.

MED.00032 Treatment of Hyperhidrosis. CPT code: 32664.

CG-Surg-05 MAZE Procedure. CPT codes: 33254, 33255, 33256, 33257, 33258, 33259, 33265, and 33266

Note: In most cases, the above does not apply to Blue Traditional, Medicare Advantage (MA), Federal Employee Plan (FEP) or select National Accounts.

Anthem - New Precertification Requirements Effective January 1, 2013 (continued)

Age restrictions and vaccinations

Beginning December 7, 2012, Anthem will apply age restrictions to claims for vaccinations only for the reasons listed below:

- Correct Coding – determined by the code's descriptive text. (e.g. age 6 – 35 months)
- Medical Policy
- Benefits as indicated in the member's Certificate of Coverage

Claims that have already been adjudicated with a system process date prior to December 7, 2012 will NOT be adjusted and reprocessed as a result of this change in age restrictions.

E-Prescribe 1.5% Reduction (Source Quality Net.org)

CMS will be mailing letters that will indicate if your practice will be subject to the 1.5% payment adjustment for falling short of e-prescribing requirements. The letter from CMS will give you two options:

1. Request an informal review if you believe your individual providers submitted e-prescriptions each by June 30 to satisfy the requirements
    a. Confirm that G8553 was included on your claims submitted to CMS
    b. Look for the N365 remark code on your remittance advice for confirmation CMS received the G code
    c. eRxInformalReview@cms.hhs.gov
        i. Include the provider's individual NPI (not a group NPI), email address, telephone #, and mailing address
    d. Request informal review through February 28, 2013
    e. CMS will provide a written notification of its decision

2. Submit a hardship request if you meet one of the available exemptions
    a. Use individual NPI not group NPI
    b. Submit request prior to January 31 via Quality Reporting Communication Support website
    c. Exemptions
        i. Inability to electronically prescribe because of state or federal law or local law or regulation
        ii. Eligible professional (EP) prescribes fewer than 100 prescriptions during a six month payment adjustment reporting period
        iii. EP professional practices in a rural area without sufficient high speed internet access
        iv. EP practices in an area without sufficient available pharmacies for e-prescribing
    d. New exemptions for 2013
        i. Providers must attest to meaningful use of EHR or register to participate in meaningful use by January 31
            1. EP who achieve meaningful use during certain e-Rx timeframes (Jan 1,2011 through June 30, 2012 and attest by January 31, 2013
            2. EP who register for the EHR incentive program by January 31, 2013. Must enter entire EHR certification number to receive this hardship exemption

IHCP Implements Family Planning Eligibility Program

Effective January 1, 2013, the Indiana Health Coverage Programs (IHCP) will implement the Family Planning Eligibility Program, which provides only family planning services to IHCP members who:

- Do not qualify for any other category of Medicaid
- Are male or female of any age
- Are not pregnant
- Have not had a hysterectomy or sterilization
- Have income that is at or below 133% of the federal poverty level
- Are U.S. citizens, certain lawful permanent residents, or certain qualified documented aliens

Description of service

The Family Planning Eligibility Program provides services and supplies to men and women for the primary purpose of preventing or delaying pregnancy.

Services covered under the Family Planning Aid Category include:

- Annual family planning visits, including health education and counseling necessary to understand and make informed choices about contraceptive methods MDWise-Healthy Indiana Plan new claims address

- Laboratory tests, if medically indicated as part of the decision-making process regarding contraceptive methods

- Limited health history and physical (H&P) examinations

- Pap smears

- Initial diagnosis and treatment of sexually transmitted diseases (STDs) and sexually transmitted infections (STIs), if medically indicated, including the provision of Food and Drug Administration (FDA)-approved anti-infective agents

- Providing FDA-approved oral contraceptives, and contraceptive devices and supplies, including emergency contraceptives

- Screening, testing, counseling, and referral of members at risk for HIV

- Tubal ligations

- Hysteroscopic sterilization with an implant device

- Vasectomies

Services not covered under the Family Planning Aid Category include:

- Abortions
- Any drug or device intended to terminate fertilization
- Artificial insemination
- IVF (in vitro fertilization)
- Fertility counseling
- Fertility treatment
- Fertility drugs
- Inpatient hospital stays
- Reversal of tubal ligation and vasectomies
- Treatment for any chronic condition, including STDs or STIs that have advanced to chronic conditions

Reimbursement requirements

IHCP reimbursement is available for Family Planning Eligibility Program-covered services rendered by IHCP-enrolled providers, including but not limited to physicians, certified nurse midwives, family planning clinics, and hospitals. Family Planning Eligibility Program services may be self-referred.

Member eligibility

Members who are eligible for the Family Planning Aid Category will be identified as being in the "MA E" aid category.

Providers must check eligibility before rendering services, either via Web interChange or via one of the following Eligibility Verification Systems (EVS):

- Automated Voice Response
- OMNI
- Electronic Data Interchange (EDI) 270/271 – Eligibility Benefit Transaction

Additional guidelines pertaining to covered services and billing instructions for these services will be provided in upcoming IHCP publications.

The IHCP Announces Changes to CRNA Coding and Billing (BR201247)

The Indiana Health Coverage Programs (IHCP) has reviewed and updated the Current Procedural Terminology (CPT) codes for which certified registered nurse anesthetists (CRNAs) can bill. CRNAs are allowed to bill using the CPT anesthesia codes 00100-01999, as well as the other CPT codes identified in the following tables. The CPT codes in Table 1 of the IHCP banner page BR201247 indicates procedure codes that CRNAs are allowed to bill beginning with dates of service on or after January 1, 2013. The CPT codes in Table 2 of the IHCP banner page BR201247 indicates procedure codes currently billable by CRNAs that will continue as billable codes. Procedure codes that do not appear on one of these two tables are no longer billable by CRNAs, effective for dates of service on or after January 1, 2013. Please refer to Chapter 8 of the IHCP Provider Manual for complete CRNA billing instructions.

Drug Coverage Change for Dually Eligible Medicaid Members (BT201244)

Effective January 1, 2013, Medicare is revising coverage of Part D drugs to include: 1) barbiturates when used for the medical indications of epilepsy, cancer, or chronic mental health disorders; and 2) benzodiaze-pines. As a result, for dates of service on or after January 1, 2013, the Indiana Health Coverage Programs (IHCP) will discontinue covering benzodiazepines, as well as most barbiturates for the previously noted medical indications, for members that also have Medicare Part D prescription drug coverage.

Indiana Medicaid will continue to cover barbiturates that are excluded from coverage by Medicare Part D when they are used for other medically accepted indications (for example, the combination product butal-bital/aspirin/caffeine, indicated for headaches).

Additional information

For questions about a member's Medicare Part D drug coverage, contact the member's Medicare plan directly,

Phase 2 of Ordering/Referring Requirement (MM SE1221)

The Affordable Care Act requires physicians and other eligible professionals to be enrolled in the Medicare program to order/refer items or services for Medicare beneficiaries. CMS will soon begin denying Part B, DME, and Part A HHA claims that fail the Ordering/Referring provider edits. These edits ensure that physicians and others who are eligible to order and refer items or services have established their Medicare enrollment records and are of a specialty that is eligible to order and refer. CMS will provide a 60-day advanced notice prior to turning on the Ordering/Referring edits. CMS is not releasing the date at this time. Informational messages will begin to indicate that the identification of the Ordering/Referring provider is missing, incomplete, or invalid or when the Ordering/Referring Provider is not eligible to order or refer. The informational messages will include remark/reason codes N264, N265, N544 and N272.

- If the billed service requires an ordering/referring provider and the ordering/referring provider is not on the claim, the claim will not be paid.
- ***VEI Consulting Insight: If you are billing for a service that is ordered or referred by another provider-verify that the provider is enrolled with the Medicare program in order to avoid claim denials. Currently the Indiana Medicare Part B Carrier is completing 855 enrollment forms in 90-120 days.***

Education Opportunity

2013 Surviving Coding and Billing for Medicare Services

Presenter: Joy Newby, LPN, CPC, PCS
Date: Wednesday, February 13, 2013
Time: 9am-4pm
Location: 6415 Castleway West Drive
Indianapolis, IN
CEU: This program has prior approval of the American Academy of Professional Coders for 6.0 Continuing Education Units

See attached flier for registration details!

Update to CMS Publication 100-04

Claims Processing Instructions for Chapter 12, Non-Physician Practitioners (NPPs)

Key manual revisions/updates conveyed in CR8010 are as follows:

- NPP assistant-at-surgery services should be billed with “AS” modifier only
- The health professional shortage area (HPSA) payment modifiers, “QB” and “QIJ” have been eliminated because they are no longer valid
- The “AH” modifier for CPs, and the “AJ” modifier for CSWs have been eliminated because they are no longer valid.
- The correct payment amount for the professional services of PAs, NPs, and CNSs is 80 percent of the lesser of the actual charge or, 85 percent of what a physician is paid under Medicare Physician Fee Schedule (MPFS).
- Additionally, the correct payment amount for assistant-at-surgery services furnished by Pas, NPS, and CNSs is 80 percent of the lesser of the actual charge or, 85 percent of 16 percent of what a physician is paid under the MPFS for surgical services
- Procedures billed with the assistant-at-surgery physician modifiers -80, -81, -82 or the AS modifier for Pas, NPSs and CNSs, are subject to the assistant-at-surgery policy. Accordingly, Medicare will pay claims for procedures with these modifiers only if the services of an assistant-at-surgery are authorized.
- Medicare’s policies on billing patients in excess of the Medicare allowed amount apply to assistant-at-surgery services.
- When a PA, NP, or CNS furnishes services to a patient during a global surgical period, Medicare contractors shall determine the level of PA, NP, or CNS involvement in furnishing part of the surgeon’s global surgical package consistent with their current practice for processing such claims.
- Billing requirements and adjudication of claims requirements for global surgeries are under chapter 12, sections 40.2 and 40.4 of the “Medicare Claims Processing Manual.”
- PAs must have their own “nonphysician practitioner” national provider identification (NPI) number. This NPI is used for identification purposes only when billing for PA services, because only an appropriate PA employer or a provider/supplier for whom the PA furnishes services as an independent contractor can bill for PA services.
- Specialty code 97 applies for PAs enrolled in Medicare. NPs enrolling in Medicare use specialty code 50 and CNSs use specialty code 89.

The official instruction, CR8010 issued to your carrier and A/B MAC regarding this change may be viewed at CR8010

United Heathcare - Important Change to DME Providers Network

Effective February 1, 2103, there will be a change to the Durable Medical Equipment (DME) network that may affect patients who have medical benefits with United Healthcare SecureHorizons, Evercare and United Healthare Community Plans. American Homepatient will no longer participate in the UHC DME network and will be a non-participating DME provider. Members who receive services provided by a non-network DME provider may incur increased financial liability and be exposed to higher out-of-pocket expenses. Patients should be referred to in-network DME providers, as outlined in the network participation agreement. Rotech Healthcare is widely utilized in tne Northeast, Southeast and Central regions. UHC is currently working with physicians and healthcare professionals to transition members currently receiving services from American Homepatient to Rotech or other participating providers. Affected physicians and their patients should have received letters in advance of the changes. Rotech Healthcare can be contacted at 877-254-1725 or rotech.com. Additional national DME providers include Apria Healthcare and Lincare. Additional local providers may be located by visiting UnitedHealthcareOnline.com.

Simple Steps to Improve Clinical Documentation

On October 1, 2014, your practice and the clearinghouses, payers, and billing companies that you work with will need to use ICD-10 codes. One way to help your practice prepare for ICD-10 is to work on improving how you document your clinical services. This will help you and your coding staff become more accustomed to the specific, detailed clinical documentation needed to assign ICD-10 codes.

Take a look at documentation for the most often used codes in your practice, and work with your coding staff to determine if the documentation would be specific and detailed enough to select the best ICD-10 codes. For example, laterality is expanded in ICD-10-CM. Therefore, clinical documentation for diagnoses should include information on which side of the body is affected (i.e., right, left, or bilateral).

Below are additional examples of the specific information needed to accurately code the following common diagnoses:

Diabetes Mellitus:

- **Type of diabetes**
- **Body system affected**
- **Complication or manifestation**
- **If type 2 diabetes, long-term insulin use**

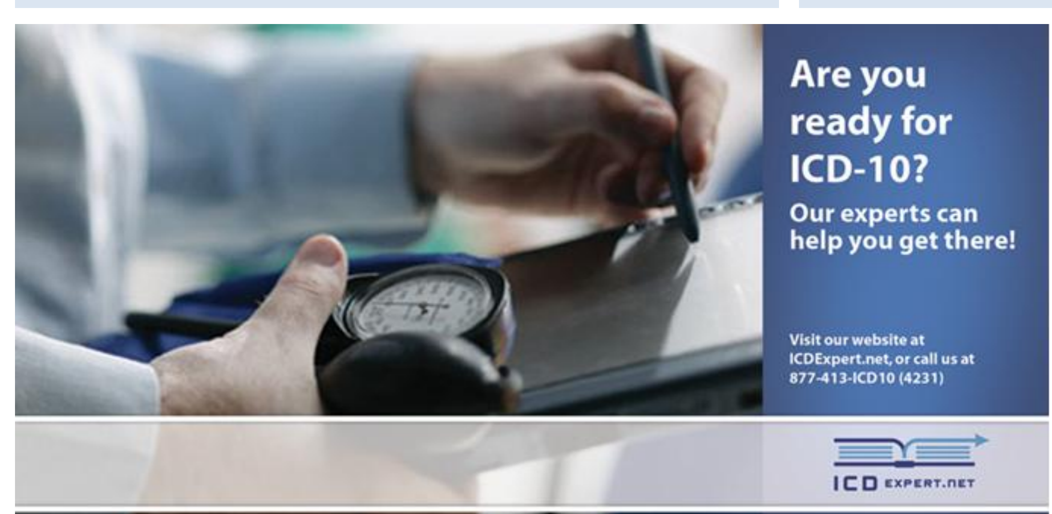
Fractures:

- **Site**
- **Type**
- **Laterality**
- **Location**

Injuries:

- **External cause –** Provide the cause of the injury; when meeting with patients, ask and document "how" the injury happened.
- **Place of occurrence –** Document where the patient was when the injury occurred; for example, include if the patient was at home, at work, in the car, etc.
- **Activity code –** Describe what the patient was doing at the time of the injury; for example, was he or she playing a sport or using a tool?
- **External cause status –** Indicate if the injury was related to military, work, or other.

Remember, ICD-10 will not affect the way you provide patient care. It will just be important to make your documentation as detailed as possible since ICD-10 gives more specific choices for coding diagnoses. This information is likely already being shared by the patient during your visit—it's just a matter of recording it for your coding staff. Good documentation will also help reduce the need to follow-up on submitted claims—saving you time and money.



Call

877-413-ICD10

to schedule a Documentation Assessment

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