Medicare Pay Cut Delayed 10 Months Under Agreement

Physicians will get a 10-month reprieve from a 27 percent cut in Medicare payments scheduled for March 1, 2012. A payment freeze will be in effect through the end of the year.

The agreement is part of a deal to extend a payroll tax cut and added unemployment benefits. Under Medicare’s sustainable growth rate formula (SGR), the Medicare payment cut was scheduled to go into effect January 1, 2012, however was averted by a last-minute extension in late December of current payment rates.

President Obama signed the payroll tax cut extension into law on February 22, 2012.

E-Prescribe and PQRS News and Notes

Four months remain to e-prescribe 10 times before the June 30, 2012 deadline! Failure to do so may result in a 1.5% Medicare payment reduction in 2013. To avoid the payment adjustment in 2013 you must fulfill one of the following:

- Successfully e-prescribed at least 25 times in 2011 or
- E-prescribe at least 10 times between January 1, 2012 and June 30, 2012 or
- Submit a hardship exemption request by June 30, 2012 via the Communication Support Page (available March 1, 2012)

For purposes of the payment adjustment, code G8553 must be submitted via claims and can be reported with any billable code. In a National Provider Call on February 21, 2012, CMS clarified that CPT 99024 (Postoperative follow-up visit, normally included in the surgical package, to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) related to the original procedure) should **not** be reported with G8553. For more e-prescribing information refer to February’s Insight or go to www.cms.gov/ERxIncentive/.

In PQRS news, CMS has recently identified an error related to the submission of Measure #235, “Hypertension: Plan of Care.” Claims are rejecting due to a problem with the quality data codes for this measure. If you are reporting this measure, please go to www.cms.gov/PQRS//15_MeasuresCodes.asp for more information.
Manually Priced DME

The Indiana Health Coverage Programs (IHCP) issued a clarification regarding what is acceptable documentation of manufacturer’s suggested retail price (MSRP) and how claims are reimbursed if the MSRP is not available for a manually priced medical supply or durable medical equipment (DME) procedure code. This is a clarification only; this does not change policies outlined in previous banners. Providers are still required to submit both a cost invoice and documentation of MSRP for manually priced medical supply and DME procedure codes. Claims for these manually priced procedure codes will continue to be reimbursed at 75% of the MSRP, unless no MSRP is available for the item. If there is no MSRP for the item you are billing for, you should identify on the cost invoice that the “MSRP is not available for the product billed.” When this is noted on the cost invoice, the IHCP will contact the manufacturer directly to confirm there is no MSRP for the product being billed. Manually priced medical supply and DME procedure codes that have no MSRP will be reimbursed at the provider’s cost plus 20%, in accordance with List of Sections Affected (LSA) document #11-441(E), published in the Indiana Register August 3, 2011. If the manufacturer informs the IHCP that an MSRP is available for the product, the detail being reviewed will be denied with Explanation of Benefit (EOB) 6126 – The IHCP has verified with the manufacturer that MSRP pricing is available. Please resubmit the claim with the proper documentation.

The following are considered acceptable documentation of the MSRP:

- Manufacturer’s catalog page showing MSRP, suggested retail price, or retail price
- Manufacturer’s invoice showing MSRP, suggested retail price, or retail price
- Quote from the manufacturer showing the MSRP, suggested retail price, or retail price

Documentation of MSRP must clearly come from the manufacturer of the DME or supply item. Claims on which the provider has handwritten the MSRP or modified the manufacturer’s MSRP documentation will be denied with EOB 6169 – The MSRP documentation submitted with the claims is not acceptable for adjudication. Providers may resubmit denied claims with proper documentation of MSRP. See banner BR201206 for codes that require the MSRP.

2012 Indiana Medicaid Update Seminars

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This program has the prior approval of AAPC for 6 continuing education hours. (Granting of prior approval in no way constitutes endorsement by AAPC of the program content or the program sponsor.)

See attached flyer to register in your city!
Coding Corner

I heard Medicare now covers intensive behavioral therapy for obesity. Please explain this new benefit.

Effective for claims with dates of service November 29, 2011, and later, Medicare beneficiaries with obesity, defined as Body Mass Index (BMI) equal to or greater than 30 kg/m2, and whose counseling is furnished by a qualified primary care physician or other primary care practitioner in a primary care setting, are eligible for:

- One face-to-face visit every week for the first month;
- One face-to-face visit every other week for months 2-6; and
- One face-to-face visit every month for months 7-12, if the beneficiary meets the 3kg (6.6 lbs) weight loss requirement during the first 6 months.

At the 6-month visit, a reassessment of obesity and a determination of the amount of weight loss should be performed. To be eligible for additional face-to-face visits occurring once a month for months 7-12, beneficiaries must have achieved a reduction in weight of at least 3kg (6.6 lbs.), over the course of the first 6 months of intensive therapy. This determination must be documented in the physician office records for applicable beneficiaries. For beneficiaries who do not achieve a weight loss of at least 3kg (6.6 lbs.) during the first 6 months of intensive therapy, a reassessment of their readiness to change and BMI is appropriate after an additional 6-month period.

Intensive Behavioral Therapy for obesity consists of the following:

1. Screening for obesity in adults using measurement of BMI calculated by dividing weight in kilograms by the square of height in meters (expressed kg/m2);
2. Dietary (nutritional) assessment; and,
3. Intensive behavioral counseling and behavioral therapy to promote sustained weight loss through high intensity interventions on diet and exercise.

Intensive behavioral intervention for obesity should be consistent with the 5-A framework of Assess, Advise, Agree, Assist, and Arrange.

Billing Instructions

- Effective for claims with dates of service on or after November 29, 2011, Medicare will recognize HCPCS code G0447, Face-to-Face Behavioral Counseling for Obesity, 15 minutes. G0447 must be billed along with one of the ICD-9 codes for BMI 30.0 and over (V85.30-V85.39, V85.41-V85.45).

- Medicare coinsurance and Part B deductible are waived for this service.

- Services must be submitted by one of the following provider specialty types: 01 - General Practice, 08 - Family Practice, 11 - Internal Medicine, 16 - Obstetrics/Gynecology, 37 - Pediatric Medicine, 38 - Geriatric Medicine, 50 - Nurse Practitioner, 89 - Certified Clinical Nurse Specialist, and 97 - Physician Assistant. Place of service must be either: 11 - Physician’s Office, 22 – Outpatient Hospital, 49 – Independent Clinic, or 71 – State or local public health clinic. In addition, Medicare may cover behavioral counseling for obesity services when billed by one of the provider specialty types listed above and furnished by auxiliary personnel under the conditions specified at 42 CFR Section 410.26(b) (conditions for services and supplies incident to a physician’s professional service) or 42 CFR Section 410.27 (conditions for outpatient hospital services and supplies incident to a physician service).

- Effective July 2, 2012, for claims processed with dates of service on or after November 29, 2011, Medicare will pay for G0447 with an ICD-9 code of V85.30-V85.39, V85.41-V85.45, no more than 22 times in a 12-month period.

Revised Place of Service (POS) Policy Effective April 1, 2012

The Centers for Medicare and Medicaid Services (CMS) has issued new instructions regarding how the place of service (POS) code should be assigned when physicians interpret diagnostic results of tests performed outside of the office.

CR7631 establishes that for all services – with two (2) exceptions -- paid under the Medicare Physician Fee Schedule (MPFS), that effective April 1, 2012, the POS code to be used by the physician and other supplier will be assigned as the same setting in which the beneficiary received the face-to-face service. Because a face-to-face encounter with a physician/practitioner is required for nearly all services paid under the MPFS and anesthesia services, this rule will apply to the overwhelming majority of MPFS services. In cases where the face-to-face requirement is obviated such as those when a physician/practitioner provides the professional component (PC)/interpretation of a diagnostic test, from a distant site, the POS code assigned by the physician/practitioner will be the setting in which the beneficiary received the technical component (TC) of the service. For example: A beneficiary receives an MRI at an outpatient hospital near his/her home. The hospital submits a claim that would correspond to the TC portion of the MRI. The physician furnishes the PC portion of the beneficiary’s MRI from his/her office location – POS code 22 will be used on the physician’s claim for the PC to indicate that the beneficiary received the face-to-face portion of the MRI, the TC, at the outpatient hospital.

There are two exceptions to this face-to-face provision/rule in which the physician always uses the POS code where the beneficiary is receiving care as a hospital inpatient or an outpatient of a hospital, regardless of where the beneficiary encounters the face-to-face service. The correct POS code assignment will be for that setting in which the beneficiary is receiving inpatient or outpatient care from a hospital, including the inpatient hospital (POS code 21) or the outpatient hospital (POS code 22). "The Medicare Claims Processing Manual" already requires this for physician services (and for certain independent laboratory services) provided to beneficiaries in the inpatient hospital and CR7631 clarifies this exception and extends it to beneficiaries of the outpatient hospital, as well.

A few other notes that relate to MM7631:

- The same rule applies to interpretations performed under arrangement with a hospital, when the service has a separate professional component.
- When a physician sees a patient in the hospital you will need to know the patient’s status in order to select the POS code.
  - For a patient who is an inpatient of a hospital, inpatient POS 21 shall be used, irrespective of where the patient actually receives the face to face service.
  - For a patient who is in observation, outpatient POS 22 shall be used.
  - CMS also instructs you to use POS 22 for services in a provider based department. That is, any on-campus or remote facility that is owned and controlled by the hospital.
  - You will only use POS 11 office for services in a facility such as a hospital outpatient department, hospice, or ASC when the visit or service occurs in an office space that is separately maintained and owned by the practice.
    - Ex: If an ASC provides the physician with a space that includes a desk, computer, supplies and an exam room, POS 24 ASC shall be used since the physician does not own the space.

(Continued on page 5)
Ex: If a practice is owned by a physician, the physician leases the space from the hospital and maintains their own records; you would use POS 11 office since the practice owns the space.

Clarification is still being sought from CMS for certain scenarios such as an inpatient receiving a test in the hospital’s outpatient department as to whether POS 21 or 22 should be used. Note that all Recovery Audit Contractors have been conducting automated reviews of POS errors.

The official instruction, CR7631 issued to your carrier and/or A/B MAC regarding this change may be viewed at http://www.cms.gov/transmittals/downloads/R2407CP.pdf on the CMS website.

Source: Transmittal 2407 CMS Claim Processing Manual, MM7631 02/03/2012, CFR 413.65, OIG Report Place of Service Errors, Part B News

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Transitioning from ICD-9-CM to ICD-10-CM – When is the Deadline???

The Health and Human Services (HHS) Secretary Kathleen G. Sebelius announced on February 16, 2012 that HHS intends to initiate a process to postpone the date by which certain health care entities have to comply with International Classification of Diseases, 10th Edition diagnosis and procedure codes (ICD-10-CM/PCS).

While the final rule adopting ICD-10 as a standard was published in January 2009 that set the compliance date of October 1, 2013, the Department of Health and Human Services will now “re-examine” the pace of the compliance deadline. Watch for the invitation for comment in the rule-making process in the coming weeks.

The Department of Health and Human Services recognizes that ICD-10 codes are important to many positive improvements in our health care system, and the department concedes that they have heard from many in the provider community who have concerns about the administrative burdens they face in the years ahead.

There is no question that the provider community has a “full plate” when considering the impact and expense of change. We are currently living the reality of the conversion to 5010 - the gateway to ICD-10, changes brought about by the Affordable Care Act and healthcare reform, Congressional action or non-action on the sustainable growth rate (SGR) that mandates the formula for the Medicare fee schedule, and here in Indiana we will transition to a new Medicare Carrier later this year. The Centers for Medicare and Medicaid Services (CMS) has awarded Jurisdiction 8 (this includes Indiana) to Wisconsin Physician Services. The Indiana provider community will soon be receiving transition instructions for this move.

All of us in the healthcare industry are watching this “re-examination” movement very closely. The American Health Information Management Association (AHIMA) is preparing a statement which will remind Congress of the implication of a delay to meaningful use initiatives, electronic health record and health information exchange initiatives, quality measurements and research improvements. The current 35 year old ICD-9 disease classification system is not able to keep up with medical knowledge and new disease factors. This limits the health data that can be used to improve patient care. The healthcare community is strongly encouraged to continue to prepare for the ICD-10 transition and not delay or suspend efforts to meet the documentation standards that are needed.

We will continue our educational efforts to improve the documentation standards of our current diagnostic statements to support ICD-9 coding as this will only make the transition to the ultimate goal of ICD-10 smoother.

So, when is the deadline for compliance to ICD-10? Today it is October 1, 2013. Stay tuned and watch for future announcements on this topic. Source: HHS Press Release 02/16/2012 AHIMA Press Release 02/14/2012
AMA Practice Tip:
Definitions and Use of Modifier 25

Proper coding is critical to managing a practice’s claims revenue cycle. However, the complexity can also be daunting. Knowing when and how to use modifiers such as CPT® modifier 25 ensures that your practice accurately records the services it delivers—and is paid fairly for those services.

An archived instructional webinar from the AMA walks physicians and their staff through proper and improper uses of modifier 25. AMA experts in CPT coding also discuss answers to common questions about using this modifier and provide a checklist for evaluating whether its use is appropriate.

View the webinar, “Definitions and use of modifier 25” to learn more, and bookmark www.ama-assn.org/go/psa-webinars for access to additional webinars about practice management issues.

New Virtual Practice Consultant

Wondering where to turn for help about how to automate your claims processing, work with health insurers or manage your practice’s business operations? Look no further than the newly redesigned AMA Practice Management Center website at www.ama-assn.org/go/pmc with an intuitive site map that is designed to be a virtual practice consultant to help you address typical practice management issues.

Upcoming Educational Opportunities

See attached flyers for more information and to register or visit http://www.veicorp.com/imm/

Billing and Collections 101
Tuesdays, March 6 – May 15
8:30am – 11:30am (ET)

Professional Medical Coding Certification
May – October
Now offered days, evenings and weekends!
Payment plans are available. See flyer for more details.

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 the webinar topics for March below. Register by email to tschuster@ecommunity.com.

Wednesday, March 7 1:00 – 2:00pm
Health Maintenance Exams: What’s Covered and What is Significant to E/M Code?

Wednesday, March 14 1:00 – 2:00pm
Inpatient Professional Charges and Best Practice for Coding Multiple Scenarios

Wednesday, March 21 1:00 – 2:00pm
Responding to Post Payment Audits: Taking Control of the Audit Process and Result

Wednesday, March 28 1:00 – 2:00pm
Incident To Billing as it Relates to NPP’s