



Indianapolis Medical Management

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IMM

Insight

The IMM Newsletter

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Medicare Claims Held for 10 Days

On Friday, December 23, 2011, President Obama signed into law the **Temporary Payroll Tax Cut Continuation Act of 2011 (TPTCCA)**. This new law prevents a scheduled payment cut for physicians and other practitioners who treat Medicare patients from taking effect immediately. An update of zero percent is effective for claims with dates of service **January 1, 2012**, through **February 29, 2012**.

While the physician fee schedule update will be zero percent, other changes to the relative value units used to calculate the fee schedule rates must be budget neutral. To make those changes budget neutral, the conversion factor must be adjusted for 2012. The Centers for Medicare and Medicaid Services (CMS) is currently developing the 2012 Medicare Physician Fee Schedule (MPFS) to implement the zero percent update.

As previously advised, Medicare claims administration contractors will be holding new, January 2012 claims for up to **10 business days** in order to effectively test and implement the new 2012 MPFS. They expect these claims to be released into processing no later than **January 18, 2012**. Since clean electronic claims are not paid sooner than 14 calendar days (29 days for paper claims), the hold should have minimal impact on provider cash flow. Claims with dates of service prior to January 1, 2012, are unaffected. Finally, Medicare contractors will be posting the new rates on their websites no later than January 11, 2012.

Current law requires payment rates under the MPFS to be adjusted geographically to reflect area differences in the cost of practice. The following three components of the MPFS payment are adjusted: physician work, practice expense, and malpractice expense. Section 303 of the TPTCCA extends the existing **1.0** floor on the physician work geographic practice cost index, through **February 29, 2012**. As with the physician payment update, this change will be accomplished through a revised 2012 MPFS.

CMS Learn Resource: 201112-39

2012 Electronic Prescribing (eRx) Incentive Program Payment Adjustment Update

The Centers for Medicare & Medicaid Services (CMS) will not provide 2012 Electronic Prescribing (eRx) Incentive Program payment adjustment feedback reports to providers as originally intended due to the high volume of significant hardship exemption requests received. CMS urges providers to review their remittance advices for claims submitted for dates of service on or after January 1, 2012.

Eligible professionals and group practices participating in the eRx GPRO option that are subject to the 2012 eRx payment adjustment will see the term “LE” on their remittance advice for all Medicare Part B services rendered January 1 - December 31, 2012. The remittance advice will also contain the following Claim Adjustment Reason Code (CARC) and Remittance Advice Remark Code (RARC):

- **CARC 237** – Legislated/Regulatory Penalty. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).
- **RARC N545** – Payment reduced based on status as an unsuccessful e-prescriber per the Electronic Prescribing (eRx) Incentive Program.

If an eligible professional or group practice who participated in the eRx GPRO option receives the payment adjustment in error (e.g., the eligible professional or group practice submitted a hardship exemption request that is ultimately approved by CMS), the claim will be reprocessed to return the 1.0%, and the remittance advice for the reprocessed claim will include the following codes and messages:

- **CARC 237** – Legislated/Regulatory Penalty. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).
- **RARC N546** – Payment represents a previous reduction based on the Electronic Prescribing (eRx) Incentive Program.

For more information on how the 2012 eRx payment adjustment will be assessed and applied, please refer to [MLN Matters Article SE1141](#) for additional information or visit the eRx Incentive Program webpage at <http://www.cms.gov/erxincentive>.

Coding Corner

How do we bill for a rapid flu test performed in the office if the device gives distinctive results for both the influenza A and B strains?

According to the December 2007 *CPT Assistant*, if you perform a rapid flu test by direct optical observation that yields two separate test results (influenza type A and influenza type B), each result should be reported separately as:

87804 (Infectious agent antigen detection by immunoassay with direct optical observation; influenza) AND

87804-59

To support the above billing, **documentation must include each test result**. If only one result is obtained, code one unit of 87804. **Note:** A **QW** modifier may also have to be added depending on payer guidelines.

Clarification for Vaccine Administration Codes 90460 and 90461

In 2011, CPT introduced two new vaccine administration codes, 90460 and 90461, that allowed billing for vaccine administration when counseling was provided by a physician or other qualified healthcare professional for patients under age 18. Billing for these codes was dependent on the number of vaccine/toxoid components. In 2012, CPT has updated these codes to provide further clarification. Changes included in the parenthetical instructions indicate that a component refers to all antigens present in the vaccine for one organism. Multiple antigens against a single organism are considered to be one component. The code descriptors themselves have been updated as well to provide clarification to correspond with the changes in the parenthetical instructions.

2011 CPT descriptors:

90460 – “Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; **first vaccine/toxoid component**”

90461 – “Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; **each additional vaccine/toxoid component** (List separately in addition to code for primary procedure)”

2012 CPT descriptors:

90460 – “Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; **first or only component of each vaccine or toxoid administered**”

90461 – “Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; **each additional vaccine or toxoid component administered** (List separately in addition to code for primary procedure)”

On 12/21/2011, the American Medical Association (AMA) released a corrections document to their *CPT Changes 2012: An Insider's View*, which indicated code 90460 could only be reported once per day of service. The correction document states codes 90460 and 90461 were revised to clarify that code 90460 can be reported more than once per day of service, as appropriate.*

***Please note this is an update to information provided by IMM in our 2012 Coding Updates seminars.**

Are You Ready for ICD-10? Our Experts Can Help Get You There!

Are you ready for ICD-10? The time to begin preparation for clinical documentation improvement is now. Do not waste the opportunity to improve on current diagnosis documentation in ICD-9-CM. Learning how to improve your documentation now will make the transition to ICD-10-CM much easier.

Our certified ICD-10 instructors with ICDExpert.net are here to help with your transition to ICD-10! For additional information on ICD-10 implementation or an evaluation of your ICD-10 readiness as well as training for you and your staff, please visit our website at www.icdexpert.net or call us at 877-413-ICD-10.



National Government Services Implementation Plan for 5010/D.0 Enforcement Discretionary Period

Though CMS announced an enforcement discretionary period of 90 days for Version 5010 compliance, the deadline is still **January 1, 2012**. Though enforcement will not be exercised until **April 1, 2012**, it is important that organizations continue to complete the transition to Version 5010 as soon as possible.

National Government Services' plan is:

Part B Providers and Trading Partner Impact

1. Effective January 1, 2012, Trading Partners that have been approved for 5010 production will have 30 days to migrate over.
2. Trading Partners that have not begun 5010 testing by January 1, 2012, will have to submit a testing plan and timeline within 30 days starting January 1, 2012. March 31, 2012 is the last date that electronic transactions will be processed in the 4010 format.

Part A Providers and Trading Partner Impact

1. Effective February 1, 2012, Trading Partners that have been approved for 5010 production will have 30 days to migrate over.
2. Trading Partners that have not begun 5010 testing by February 1, 2012, will have to submit a testing plan and timeline within 30 days starting February 1, 2012. March 31, 2012, is the last date that electronic transactions will be processed in the 4010 format.

When a transition plan is submitted by the deadline, they will have until April 1, 2012 to complete their transition to the 5010 format. If no transition plan is submitted, Medicare may direct the Medicare Administrative Contractors (MACs) to reject 4010 claims. However, at this time the MACs have not been directed to reject 4010 claims. MACs will be able to accept a mix of 5010 and 4010 claims during the 90 day grace period. Please visit the [Version 5010](#) and [Latest News](#) pages on the CMS ICD-10 website for resources to assist with the Version 5010 transition.

Non-Specific Procedure Code Description Requirement for HIPAA Version 5010 Claims

When submitting "unclassified" or "not otherwise classified" procedure codes, the description should no longer be placed in the line item note NTE segment. It should instead be placed in the 2400.SV101-7 segment. This change affects all Healthcare Common Procedure Coding System (HCPCS) codes that contain verbiage below and require a description be submitted:

- NOC – not otherwise classified
- NEC – not elsewhere classified
- NOS – not otherwise specified
- NES – not elsewhere specified
- NOR – not otherwise reported

Detailed information regarding this new requirement can be found in the 837I and 837P implementation guides (837I – 005010X223A2 and 837P – 005010X222A1). If the corresponding non-specific procedure code description is not submitted, the transaction does not comply with the implementation guide and is not HIPAA compliant. Note that the non-specific procedure code's descriptor terms as listed above do not constitute a description of the procedure, drug, or service. For example, simply using "Not Otherwise Classified" as the description does not pass editing, and the claim will be rejected.

A complete listing of the Not Otherwise Classified Code Set is available at:

http://www.cms.gov/ElectronicBillingEDITrans/40_FFSEditing.asp

VEI / IMM Acquires Maureen Hoffmeyer's Indiana Medicaid Support Business



This six-hour course will present Indiana Medicaid specific policies and procedures for correct coding and billing techniques, description of the various eligibility categories and an explanation of how they affect payment, Medicaid managed care program guidelines, new initiatives for 2012 and beyond.

All attendees will receive the updated *2012 Indiana Health Coverage Programs Quick Reference Survival Guide*, previously provided by Maureen Hoffmeyer of Association Management Plus. This 300+ page manual provides easy to understand translations to Medicaid Program guidelines.

This program is designed for medical practices and other professional provider billing types. It is applicable to clinical and business office staff with one or more years of experience with Medicaid billing and coding.

See attached flyer to register for the 2012 Indiana Medicaid Update seminar in your area!

AMA Practice Tip: Prior Authorization Toolkit

Prior authorization transactions can be slow and tedious. Your practice's time is better spent providing attentive medical care and responsive customer service. Handling your prior authorizations electronically can:

- Speed up health insurer response
- Minimize time and resources devoted to manual processes, such as waiting on hold and compiling faxes to payers
- Free up time for revenue-enhancing functions such as ensuring correct payment
- Reduce transaction costs by over 80%

The AMA's Prior Authorization Toolkit helps make adopting this process simpler. The toolkit includes a summary of questions to ask before enrolling in an electronic health care transaction program, a survey to evaluate your vendor's functionality, and the educational webinars, "The 'Underutilized' Transaction that can Streamline your Referral and Prior Authorization Processes," and "Beyond the Claim: HIPAA 5010 Administrative Simplification Opportunities to Positively Impact your Revenue Cycle Management." Visit www.ama-assn.org/go/htc to access these free resources.

Upcoming Educational Opportunities

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

2012 PQRS & E-Prescribe Updates Webinar

Tuesday, January 10, 2012

12:00pm – 1:00pm (ET)

Billing and Collections 101

Tuesdays, March 6 – May 15

8:30am – 11:30am (ET)

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 January below. Register by email to tschuster@ecommunity.com.

Wednesday, January 11 **1:00 – 2:00pm**
"Basics of Auditing"

Wednesday, January 25 **1:00 – 2:00pm**
"What Doctors Want: How to Interact with Doctors Without Reading Their Mind"

Medicare Changes to the Outpatient Psychiatric Reduction in 2012

The outpatient psychiatric payment reduction for Medicare will be altered as follows:

In 2012, Medicare payments for psychiatric services will be paid based on the following formula:

1. Fee schedule amount – \$100.00
2. Psychiatric reduction – 0.75
3. Reduced fee schedule allowed amount – \$75.00
4. Medicare pays 80 percent of reduced allowed amount – \$60.00
5. Patient's 20 percent coinsurance for reduced allowed amount – \$15.00
6. Difference between fee schedule and reduced allowed amount – \$25.00
7. Patient responsibility (Item 5+6) – \$40.00

The beneficiary responsibility in 2012 will generally be **40 percent of the MPFS allowed amount**. The psychiatric reduction calculator located under the Self Service Tools section of the National Government Services Web site will be updated with this information.

This change is a result of CR 6686, whereas the following changes were set into action:

Effective January 1, 2010, the previous 62.5 percent limitation increased as follows:

1. 2010-2011 = 68.75 percent
2. 2012 = 75 percent
3. 2013 = 81.25 percent, and
4. 2014 and onward = 100 percent

Effective January 1, 2014, Medicare will pay outpatient mental health services at the same level as other Part B services. That is, at 80 percent of the MPFS.

Related CMS Site Resource Link: [MLN Matters Article MM6686](#)

Multiple Procedure Payment Reduction on the Professional Component of Multiple Diagnostic Imaging Services

On January 1, 2011, CMS implemented a 50 percent payment reduction on the technical component when multiple diagnostic imaging procedures were performed on the same patient/same day/same session by the same provider. Starting **January 3, 2012**, this multiple procedure payment reduction (MPPR) will be expanded to the **professional component** in addition to the existing reduction on the technical component.

When multiple diagnostic imaging services are performed on the same day during the same session by the same provider on the same beneficiary, the professional component with the highest valued fee schedule amount will be paid at 100 percent. All subsequent and lower valued professional components on the MPFS will be paid at 75 percent of the MPFS amount (i.e., a 25 percent reduction).

This new reduction will apply on services submitted as global procedures or broken down into each component and billed separately (professional and technical).

Claims impacted by this payment reduction will have claim adjustment reason code **CO-59** appended to any line items whose payment amounts were reduced. All items that were reduced will also have the modifier 51 appended.

More information will be shared as soon as it is available.

Related CMS Site Resource Link: [CR 7442](#)