

IMM

Insight

The IMM Newsletter



Indianapolis Medical Management
7330 Shadeland Station, Ste 200
Indianapolis, IN 46256

IMM

INSIGHT

❖ CMS ELIMINATES
USE OF
CONSULTATION
CODES FOR 2010

❖ PECOS –
IMPORTANT
INSTRUCTION WITH
CRITICAL
DEADLINES

❖ NEW MODIFIERS IN
ASSOCIATION WITH
ADVANCED
BENEFICIARY
NOTICES (ABN)

❖ IMM'S NEWEST
MEMBER OF THE
BILLING AND
CODING TEAM

MERRY
CHRISTMAS
AND
HAPPY NEW
YEAR!

CMS ELIMINATES THE USE OF CONSULTATION CODES FOR 2010

CMS has announced that they will no longer pay for consultation services in 2010. This includes CPT codes 99241-99245 (outpatient consultations) and 99251-99255 (inpatient consultations).

In the outpatient setting, Established Patient Visit codes 99211-99215 and New Patient Visit codes 99201-99205 will be used in place of the consultation codes. When billing consultation services in the inpatient setting, providers will use the Initial Inpatient Visit codes 99221-99223. Currently only one provider can use the Initial Inpatient Visit code however beginning in 2010 CMS will allow multiple providers to use the Initial Inpatient Visit code. The admitting provider will use the Initial Inpatient Visit code with a modifier that will identify him/her as the admitting provider. To date CMS has not released the modifier that will be used.

CAUTION should be used when selecting the appropriate level of service to bill in place of the consultation codes. The requirements for consultations do not always crosswalk directly to the appropriate inpatient or outpatient service codes.

Further billing instructions are pending release from CMS. IMM will be sending out additional information as soon as it is available.

* * * *

IMPORTANT INSTRUCTION WITH CRITICAL DEADLINES FOR ORDERING/REFERRING PROVIDERS FOR PART B AND DURABLE MEDICAL EQUIPMENT (DME)

Source: CMS MM 6417 and MM 6421

CMS has issued instruction MM6417 and MM6421 which requires Medicare implementation of system edits to assure that Part B providers and DME suppliers bill for ordered or referred items or services **only** when those items or services are ordered or referred by physician and non-physician practitioners who are eligible to order/refer such services. Physician and non-physician practitioners who order or refer must be enrolled in the Medicare Provider Enrollment, Chain and Ownership System (PECOS) and must be of the type/specialty who are eligible to order/refer services for Medicare beneficiaries. Be sure billing staff are aware of these changes that will impact Part B provider and supplier claims for ordered or referred items or services that are received and processed on or after October 5, 2009.

Claims that are the result of an order or a referral must contain the National Provider Identifier (NPI) and the name of the ordering/referring provider as the name appears in the NPI Registry and the ordering/referring provider must be in PECOS or in the Medicare carrier's or Part B MAC's claims system.

Medicare will edit the information in box 17 or electronic equivalent against the information in the NPI Registry. CMS has confirmed that the edit will look at the first letter of the first name and the first four letters of the last name in the NPI Registry and compare that to the information placed on the claim.

**FOR ORDERING/REFERRING PROVIDERS FOR PART B, ETC (CONTINUED)...**

Example: Robert Smith MD (R SMIT) in the NPI registry will not match box 17 or electronic equivalent that reads Bob Smith MD (B SMIT). This will create a warning message in Phase 1 and a rejection in Phase 2.



During Phase 1 for Part B Providers and for DME Suppliers (October 5, 2009-April 5, 2010): If the ordering/referring provider is on the claim, Medicare will verify that the ordering/referring provider is in PECOS and is eligible to order/refer in Medicare. **If the ordering/referring provider is not in PECOS** the carrier or Part B MAC will search its claims system for the ordering/referring provider. If the ordering/referring provider is not in PECOS and is not in the claims system, the claim will continue to process and **the Part B provider or supplier will receive a warning message on the Remittance Advice.** If the ordering/referring provider is in PECOS or the claims system but is not of the specialty to order or refer, the claim will continue to process and the Part B provider or supplier will receive a warning message on the Remittance Advice.



During Phase 2 for Part B Providers (April 5, 2010 and thereafter): If the billed item or service requires an ordering/referring provider and the ordering/referring provider is not on the claim, the claim will not be paid. It will be rejected. If the ordering/referring provider is on the claim, Medicare will verify that the ordering/referring provider is in PECOS and eligible to order and refer. If the ordering/referring provider is not in PECOS, the carrier or Part B MAC will search its claims system for the ordering/referring provider. **If the ordering/referring provider is not in PECOS and is not in the claims system, the claim will not be paid.** It will be rejected. If the ordering/referring provider is in PECOS or the claims system but is not of the specialty to order or refer, the claim will not be paid. It will be rejected.



During Phase 2 for DME Suppliers (April 5, 2010 and thereafter): If the billed item or service requires an ordering/referring provider and the ordering/referring provider is not in the claim, the claim will not be paid. It will be rejected. If the ordering/referring provider is on the claim, Medicare will verify that the ordering/referring provider is in PECOS and eligible to order and refer. **If the ordering/referring provider is not in PECOS the claim will not be paid. It will be rejected**

FIVE STEPS TO GET PROVIDER ENROLLMENT INFORMATION IN PECOS:

1. Go to <https://pecos.cms.hhs.gov/> and log in using the same sign in information as you would for the NPPES.
2. Follow the step by step on-screen instructions. Save periodically; you will be logged off automatically when you are idle for more than 15 minutes.
3. You must physically sign and mail the two page certification form within seven days of your online submission.
4. You must mail any relevant supporting documentation such as IRS CP-575 form that assigned your EIN or the CMS 588 form authorizing electronic funds transfer.
5. Call CMS External Users Services (EUS) Help Desk when you run into technical difficulties like trouble signing in, or error messages on your browser when entering or saving information. The number is 1 866 484 8049 Monday through Friday from 7 am to 7 pm.

Disclaimer: The content of this newsletter is for informational purposes only and is not intended to constitute legal advice. You should not rely upon any information contained in this newsletter for any purpose without seeking legal advice from a duly licensed attorney competent to practice law in your jurisdiction.

VEI makes no warranties or representations of any kind concerning any information in this newsletter. The content of this newsletter is provided only as general information and may not reflect the most current legal or industry developments. VEI expressly disclaims all liability with respect to actions taken or not taken based upon such information or with respect to any errors or omissions in such information.



Indianapolis Medical Management
7330 Shadeland Station, Ste 200
Indianapolis, IN 46256

IMM

Insight

The IMM Newsletter

I
M
M

I
N
S
I
G
H
T

FOR ORDERING/REFERRING PROVIDERS FOR PART B, ETC (CONTINUED)...

IMM Insight: Make certain your provider is in PECOS! Compare your practice management system ordering/referring information to the NPI registry. Make certain the ordering/referring name is in your practice management system as it is listed in the NPI registry. Watch your Medicare Remittance Notices for ***WARNING***** messages and/or Reason code N264 that will alert you when an ordering/referring name is not in PECOS or does not match the NPI registry. Even though these claims are paying now, Phase 2 will put your payments at risk!**

* * * *

NEW MODIFIERS IN ASSOCIATION WITH ADVANCE BENEFICIARY NOTICES (ABN)

CR 6563, from which this article is taken, announces recent instructions for the use of modifiers in association with Advance Beneficiary Notices (ABN). Specifically, effective April 1, 2010, two HCPCS level 2 modifiers have been updated to distinguish between voluntary, and required, uses of liability notices. Those modifiers are:

- Modifier – GA has been redefined to mean “Waiver of Liability Statement Issued as Required by Payer Policy,” and should be used to report when a required ABN was issued for a service.
- A new modifier (-GX) has been created with the definition “Notice of Liability Issued, Voluntary Under Payer Policy” and is to be used to report when a voluntary ABN was issued for a service.

Make sure that your billing staffs are aware of these ABN modifier changes.

-GA Modifier:

- Medicare systems will automatically deny lines submitted with the -GA modifier and covered charges on institutional claims;
- Medicare systems will assign beneficiary liability to claims automatically denied when the –GA modifier is present; and
- Medicare will use claim adjustment reason code 50 (These are non-covered services because this is not deemed a ‘medical necessity’ by the payer.) when denying lines due to the presence of the –GA modifier.

-GX Modifier

- Medicare systems will recognize and allow the –GX modifier on claims, but will return your claim if the –GX modifier is used on any line reporting covered charges;
- Medicare systems will allow the –GX modifier to be reported on the same line as the following modifiers that indicator beneficiary liability: -GY (Item or service statutorily excluded or does not meet the definition of any Medicare benefit), -TS (Follow-up service);
- Medicare systems will return your claim if the –GX modifier is reported on the same line as any of the following liability-related modifiers: -EY (no doctor's order on file), -GA, -GL (medically unnecessary upgrade provided instead of non-upgraded item, no charge, no ABN), -GZ (item or service expected to be denied as not reasonable and necessary), -KB (Beneficiary requested upgrade for ABN, more than four modifiers

Disclaimer: The content of this newsletter is for informational purposes only and is not intended to constitute legal advice. You should not rely upon any information contained in this newsletter for any purpose without seeking legal advice from a duly licensed attorney competent to practice law in your jurisdiction. VEI makes no warranties or representations of any kind concerning any information in this newsletter. The content of this newsletter is provided only as general information and may not reflect the most current legal or industry developments. VEI expressly disclaims all liability with respect to actions taken or not taken based upon such information or with respect to any errors or omissions in such information.



Indianapolis Medical Management
7330 Shadeland Station, Ste 200
Indianapolis, IN 46256

IMM

Insight

The IMM Newsletter

IMM SERVICES CONTACTS

Leisa Hills
Executive Director, IMM
621-7318

Dave Mooney
Sr. Director of Finance, IMM
621-7494

Business Consultants

Debbie Bopp 621-7196
Tim Gee 621-9580
Lindsay Gross 621-7738
Anita Huse 621-4090
Linda Hutchens 621-9772
Jason Keller 621-9750
Kathleen McAllen 621-7460
Amy Miller 621-7790
Ellen Stancil 621-9374
Betsy Walter 621-9361
Richard Zenor 621-5139

Billing and Coding Consultants

Carol Hoppe 621-7555
Amy Dempsey 621-1536
Stracy Faulkner 621-1537
Jan Hooker 621-1644
Lita Jones 621-1889
Judy Odom 621-1645
Ann Silvia 621-9783
Michelle Trandel 621-9743

TPPECC

(Third Party Payer Enrollment
Credentialing Committee)

Dave Mooney 621-7494
Darlene Gebhart 621-9312
Michelle Hayes 621-1647
Pat Schmitter 621-7187
Kara Welch 621-1886

Regulatory Compliance

Brenda Chapelle 621-9782
Beth Wilhelm 621-9751

NEW MODIFIERS IN ASSOCIATION WITH ADVANCE BENEFICIARY NOTICES (ABN) (CONTINUED)

identified on claim), -QL (Patient pronounced dead after ambulance is called), -TQ (basic life support transport by a volunteer ambulance provider);

- Medicare systems will automatically deny lines (using claim adjustment reason code 50) submitted with the -GX modifier and non-covered charges, and will assign beneficiary liability to claims automatically denied when the -GX modifier is present.

Final Note: Other than the policy and processing changes described in CR 6563, all other policies and processes regarding non-covered charges and liability continue as stated in the Medicare Claims Processing Manual, Chapter 1 (General Billing Requirements), Section 60 (Provider Billing of Non-covered Charges) and in the requirements defined in previous change requests.

See MM6563 – **Billing for Services Related to Voluntary Uses of Advance Beneficiary Notices of Noncoverage (ABNs)**
<http://www.cms.hhs.gov/MLN MattersArticles/downloads/MM6563.pdf> for more information

* * * *

IMM’S NEWEST MEMBER OF THE BILLING AND CODING TEAM

Please join us in welcoming **Michelle Trandel** to the IMM Billing and Coding team! Michelle is a certified coder, with previous experience as a Compliance Training Specialist at IU Department of Family Medicine. She has a strong computer background, excellent educational and presentation skills as well as compliance and research experience.

SUBMIT YOUR QUESTIONS FOR THE NEXT NEWSLETTER

Do you have questions we can help with? Please submit questions to be answered in a future IMM Insight Newsletter – contact us at <http://imm.ecommunity.com/>.

* * * *

HAPPY HOLIDAYS FROM IMM!

SOME HEALTHCARE RECOGNITION DATES FOR DECEMBER

Drunk and Drugged Driving (3D) Prevention Month, National

Hand Washing Awareness Week, National (2nd week)

Tie One On for Safety Campaign, Red Ribbon (Thru Dec 31st)

Disclaimer: The content of this newsletter is for informational purposes only and is not intended to constitute legal advice. You should not rely upon any information contained in this newsletter for any purpose without seeking legal advice from a duly licensed attorney competent to practice law in your jurisdiction. VEI makes no warranties or representations of any kind concerning any information in this newsletter. The content of this newsletter is provided only as general information and may not reflect the most current legal or industry developments. VEI expressly disclaims all liability with respect to actions taken or not taken based upon such information or with respect to any errors or omissions in such information.