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Indianapolis Medical Management

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Insight

The IMM Newsletter

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Information Regarding the Holding of June 2010 Claims for Services Paid Under the 2010 Medicare Physician Fee Schedule

The Continuing Extension Act of 2010, enacted on April 15, 2010, extended the zero percent (0%) update to the 2010 Medicare physician fee schedule (MPFS) through May 31, 2010. The Centers for Medicare & Medicaid Services (CMS) believes Congress is working to avert the negative update scheduled to take effect June 1, 2010. To avoid disruption in the delivery of health care services to beneficiaries and payment of claims for physicians, non-physician practitioners, and other providers of services paid under the MPFS, CMS has instructed its contractors to hold claims containing services paid under the MPFS (including anesthesia services) for the first 10 business days of June. This hold will only affect MPFS claims with dates of service June 1, 2010, and later.

This hold should have minimum impact on provider cash flow because, under the current law, clean electronic claims are not paid any sooner than 14 calendar days (29 for paper claims) after the date of receipt.

Be on the alert for more information about the 2010 MPFS update.

Enhancements to Anthem's Recoupment Notification

Anthem's Recoupment Notification page on the Remittance Advice has been revised. As of April 19, 2010, you should now see the following information designed to assist you when a negative balance is carried forward on a subsequent remit:

The Original Negative Claim Number will appear in the Prior and Current Recoupment boxes.

- The Charge Amount will be listed for the claim recouped.
- The ACR Letter ID will show the refund request identification number if the letter was generated on or after April 19, 2010.

To see a sample of the new remittance advice view the Anthem Rapid Update dated April 16, 2010 at: http://www.anthem.com/provider/no_application/f1/s0/t0/pw_b144223.pdf?refer=ahpprovider&state=oh

Screening for the Human Immunodeficiency Virus (HIV) Infection

Effective for dates of service December 8, 2009, and later, CMS will cover both standard and Food and Drug Administration (FDA)-approved HIV rapid screening tests for:

- One annual voluntary HIV screening of Medicare beneficiaries at increased risk for HIV infection per USPSTF guidelines and in accordance with CR 6786. **NOTE:** 11 full months must elapse following the month in which the previous test was performed in order for the subsequent test to be covered.
- Three voluntary HIV screenings of pregnant Medicare beneficiaries at the following times: (1) when the diagnosis of pregnancy is known, (2) during the third trimester, and (3) at labor, if ordered by the woman's clinician.

NOTE: Three tests will be covered for each term of pregnancy beginning with the date of the first test.

The following three new codes are to be implemented April 5, 2010, effective for dates of service on and after December 8, 2009, with the April 2010 Outpatient Code Editor and the January 2011 Clinical Laboratory Fee Schedule (CLFS) updates:

- G0432 - Infectious agent antigen detection by enzyme immunoassay (EIA) technique, qualitative or semi-quantitative, multiple-step method, HIV-1 or HIV-2, screening
- G0433 - Infectious agent antigen detection by enzyme-linked immunosorbent assay (ELISA) technique, antibody, HIV-1 or HIV-2, screening
- G0435 - Infectious agent antigen detection by rapid antibody test of oral mucosa transudate, HIV-1 or HIV-2, screening

Claims for the annual HIV screening must contain one of the new HCPCS codes along with a primary diagnosis code of V73.89 (Special screening for other specified viral disease), and when increased risk factors are reported, a secondary diagnosis code of V69.8 (Other problems related to lifestyle).

For claims for pregnant women, one of the new HCPCS codes must be reported with a primary diagnosis code of V73.89 and one secondary diagnosis code of either V22.0 (Supervision of normal first pregnancy), V22.1 (Supervision of other normal pregnancy), or V23.9 (Supervision of unspecified high-risk pregnancy).

When claims for HIV screening are denied because they are not billed with the proper diagnosis code(s) and/or HCPCS codes, Medicare will use a claim adjustment reason code (CARC) of 167 (This (these) diagnosis(es) is (are) not covered). Where claims are denied because of edits regarding frequency of the tests, a CARC of 119 (Benefit maximum for this time period or occurrence has been reached) will be used.

Prior to inclusion of the new G Codes on the CLFS, the above codes will be contractor-priced. Also, for dates of service between December 8, 2009, and April 4, 2010, unlisted procedure code 87999 may be used when paying for these services.

See CR 6786 at <http://www.cms.gov/Transmittals/downloads/R1935CP.pdf> for further information.

HIPAA and Technology

In today's fast paced world and modern technology it is extremely important to be aware of how we communicate with other health care professionals. We need to understand that our actions can potentially violate a patient's privacy rights. Did you know that sending alpha pages and text messages, which identify patients, to pagers and cell phones is **not a secure method** of communication? This is true even if the pager is issued by Community Hospital. However, you can use these devices and still protect the patient's privacy by not identifying any specific patient information in the text or page. For example:

- Call 621-XXXX STAT regarding critical lab value
- Call 621-XXXX Need med change due to allergy

If you have any questions please consult your clinical / regulatory consultant.

IMM's Newest Billing and Coding Member

Please join us in welcoming Traci Snider to the IMM Billing Service as our new Patient Account Rep effective May 17th. Traci comes to us from Physician Billing Services where she has been working as an Accounts Receivable Specialist II. We are glad to have Traci join our team!

