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CMS Identifies Most Egregious Errors in New Compliance Report

Compilation of RAC findings, ZPIC audits, and MAC errors shows you which Part B mistakes you should avoid.

Wondering if consolidated billing issues still persist in Medicare’s eyes? CMS’s “Medicare Quarterly Provider Compliance Newsletter” aims to answer that question by outlining common billing errors, and offers some advice on how to rectify them.

Let Modifier 26 be Your Consolidated Billing Friend

If your practice sees a fair amount of skilled nursing facility (SNF) patients, the way you bill their services could be attracting attention from RACs.

Background: Services provided to SNF patients “are bundled into one package, billed by the SNF, and paid to the SNF,” CMS says in its newsletter. “Physicians’ professional services are excluded from the SNF consolidated billing (CB), because physicians are responsible for billing for their own services. However, facility-based components of physician services (e.g., those on a salary or percentage arrangement, lessors of departments, etc., whether or not they bill patients directly) include two distinct elements — the professional component and the provider component.”

When it comes to the provider component, some practices slip up on how to report those services. CMS reminds practices in its newsletter that if the physician performs the professional component of these facility-based services, he should report the appropriate code to the Part B MAC with modifier 26 (Professional component) appended. The technical component is bundled into the SNF CB payment.

Caveat: In some cases, a SNF patient may report to your office with a problem and your physician will order an x-ray to be performed on-site at your practice. In these cases, the MAC will bundle the technical component into the SNF CB payment, so you’ll have to recoup that portion of your reimbursement directly from the SNF.

Example: A patient recovering in an SNF after surgery to repair a hip fracture (733.14) presents to her orthopedist for a follow-up visit, where the practice’s radiology technician x-rays two views of the patient’s hip (73510). The orthopedist reads the x-rays and writes his report, then examines the patient during a level-three E/M service.

The coder should submit the following claim to the patient’s Medicare carrier:

» 73510-26
» 99213 (Office or other outpatient visit ...).
The coder should send a separate claim directly to the SNF listing 73510-TC as the procedure code and 733.14 as the diagnosis, with a letter explaining the situation.

Keep An Eye on Place of Service Codes

As most coders know, Part B typically reimburses physicians at a higher rate for services performed in their offices versus those performed in facility settings. The extra payment accounts for the cost of doing business in the office and covers things like non-reimbursable supplies. However, if you bill a service you performed at the hospital using the site of service code for your outpatient practice, you’ll be erroneously collecting dollars that you don’t deserve.

The CMS newsletter offers the following example: A physician reports 99292 (Critical care, first hour) with place of service code 11 (Office). He collects $260.50 for the service. The RAC later reviews the patient’s file and discovers that the service was actually performed during an inpatient hospital stay — so the physician should have billed using service code 21 (Inpatient hospital) and should have collected only $208.40. This means that the physician earned over $52 more than he should have collected.

Most common errors: CMS most frequently sees this type of site of service error with codes 99292 (Critical care, first hour), 85097 (Bone marrow interpretation), 96118 (Neuropsychological testing), and 90801 (Psychiatric diagnostic interview examination), the newsletter reports.

Best practice: If your physician ever does rounds at the hospital or sees patients at any other off-site location, review each medical record carefully before you bill so you can ensure that you’ve reported the correct site of service location code on your claim.

ICD-10

CMS Is Converting Coverage Decisions to Include ICD-10 Codes

Plus: Medicaid contractors are working to meet ICD-10 deadline.

As we reported earlier, CMS has not instituted any delay or elimination of ICD-10, which means you’ll need to be ready to use the new code set by Oct. 1, 2013 — less than two years away. Fortunately, medical practices aren’t the only ones working hard to meet the deadline. Contractors, vendors, and individual states are steadily readying their systems for ICD-10 claims processing.

Medicaid: Because Medicaid rules and policies vary on a state-by-state basis, some practices may be expecting states to be on different pages when it comes to ICD-10 implementation. But that would be an inaccurate assumption, CMS reps said during a Nov. 17 “ICD-10 Implementation” call.

“I can tell you that most states are still conducting impact analyses and gathering business requirements for the things needed to accommodate the implementation of ICD-10,” said CMS’s Elizabeth Reed during the call.

(Continued on next page)

Looking Ahead: What You Can Expect in 2013

Rumors of ICD-10’s death have been greatly exaggerated.

It isn’t even 2012 yet, but the CPT® Editorial Committee is already looking ahead to 2013. The group is examining which codes to revise, delete, and introduce in the future, and we’ve got a taste of what 2013 could hold for you from both a CPT® and an ICD-10 standpoint.

The CPT® Editorial Committee will continue to monitor which code sections require revisions, but intends to offer special focus to psychiatry services, molecular pathology, and moderate sedation in 2013, said Peter A. Hollmann, MD, chair of the CPT® Editorial Panel, during the CPT® 2012 Annual Symposium in Chicago on Nov. 16.

CMS reps shed some light on potential payment opportunities for molecular pathology services during the meeting, when the agency’s Marc Hartstein said that Medicare’s contractors are currently pricing over 100 codes describing molecular pathology services, which are genetic tests. Although CMS decided not to price new molecular pathology codes under the current Clinical Laboratory Fee Schedule or the Physician Fee Schedule, the agency does intend to establish payment for them in 2013, Hartstein said.

ICD-10: As all coders should be aware, Oct. 1, 2013 will mark the beginning of CMS’s requirement that all practices switch to the ICD-10 system. However, the AMA has taken a stand against the new diagnosis coding system, Hollmann noted. “There’s a lot of anxiety and a lot of stress” about ICD-10, he said, which led the AMA’s House of Delegates to formally request a repeal to ICD-10 during the group’s Nov. 15 meeting.

Keep in mind: This does not mean that ICD-10 won’t go into effect, but it does mean that the AMA is trying to find a workaround to avoid the resources that each practice will have to put into the ICD-10 migration. A formal ICD-10 repeal could only take place following governmental intervention.

CMS’s response: During a Nov. 17 “ICD-10 Implementation” call, CMS’s Denise Buenning responded to a question about whether ICD-10 will actually be delayed or eliminated. “There is no truth to the rumor, there is no pushback — the date for ICD-10 remains Oct. 1, 2013,” she said.

Beyond 2013: CMS reps also illuminated one major change that could be coming up the pike for practices in the future. In 2015, CMS will begin to phase in the use of a value-based modifier that gives a “differential payment to a physician or group of physicians based on the quality of care compared to cost,” said CMS’s Kenneth Simon, MD, during the meeting. In other words, physicians whose patients have better outcomes will get paid more. The initial payments, which will be issued under the 2015 fee schedule, will be based on performance in 2013. ☐
call. “CMS currently conducts bi-weekly calls with the states and is currently offering state-specific technical assistance training. I would encourage providers to get on their respective state list serves to stay in tune with state communications and testing requirements,” she added.

**Procedure coding:** Fortunately, Part B coders won’t have to worry about using the procedural codes, known as ICD-10-PCS, because this code set will only be used for inpatient hospital claims, said CMS’s Pat Brooks during the call.

“ICD-10-PCS will not be used on physician claims, even those for inpatient visits,” Brooks told the callers.

In addition, ICD-10 implementation has “no impact on CPT® or HCPCS coding — they will continue to be used as they are now.”

**Coverage decisions:** One caller to the forum asked whether CMS is working on converting diagnosis codes on the national coverage decisions (NCDs), which are currently listed in ICD-9 format, to ICD-10 codes. Brooks assured the caller that CMS reps are working on such a conversion, but no updates exist on how far along the conversion is at this point.

For more on ICD-10 implementation, visit the CMS Web site at www.cms.gov/ICD10/.

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**Compliance**

It’s The Season For Giving — But Not Too Much

Keep OIG guidance in mind when deciding on your holiday gift list.

With reimbursement challenges continuing to plague therapy practices, you may be considering every option you can to generate referrals. But don’t let that tempt you into furnishing lavish gifts to your referral sources this holiday season.

“Gifts from health care providers to referral sources, patients, vendors and colleagues can create unintentional sticky situations,” cautions attorney Patricia Hofstra with Duane Morris in Chicago. “Many businesses give gifts during the holiday season as a token of friendship and appreciation, but for health care providers, the situation is complicated by the Stark laws and the anti-kickback fraud and abuse prohibitions.”

Providers “should look to avoid any gift giving that could be viewed as inducement to a referral source,” experts advise. “The federal government has repeatedly advised that providers should not utilize prohibited or inappropriate conduct (e.g., offer free gifts or services to patients) to carry out their initiatives and activities designed to maximize business growth and patient retention.”

That may mean you have to put the kibosh on any luxurious gift baskets you were planning to give your favorite physicians. “Certain small gifts such as pens or coffee mugs are permissible, other larger gifts are not,” Hofstra counsels.

The HHS Office of Inspector General has made clear that its bright line for gift giving is no more than $10 per gift and $50 per year, points out attorney Kendra Conover with Hall Render in Indianapolis.

It’s also a good idea to only give gifts as part of “generally accepted practice,” Conover adds. But holiday gifts fall pretty squarely into that category.

**Important:** You should have a corporate compliance policy that includes your gift-giving procedures, Conover recommends. And you should have legal counsel review any gift-giving arrangements to referral sources, she urges.

**Bottom line:** “Health care providers should consult with counsel and exercise caution when giving gifts during the holidays or at any time to avoid the appearance of impropriety and potential prosecution for legal and regulatory violations,” Hofstra counsels.

**What About Accepting Gifts?**

You should exercise similar caution when it comes to accepting gifts, whether they come from referral sources, colleagues, or patients, suggests attorney Ross Lanzafame with Harter Secrest & Emery in Rochester, N.Y.

Gifts from colleagues and patients can be particularly problematic, Lanzafame worries. That’s because “although the gift may appear innocent, the act of giving
and accepting a gift can potentially create a conflict of interest for the recipient,” he says.

**What’s the problem?** “When someone gives a gift, the social construct within which we generally operate is that the gift will in some way be reciprocated. It is the polite thing to do,” Lanzafame explains. “This social construct can potentially tempt the recipient to make decisions not motivated by objective factors, but rather based on the subjective in order to reciprocate.”

**For example:** “With a patient that might create a temptation to understate progress and overstate need” so she can qualify for more services, Lanzafame tells Eli.

While it won’t be a popular decision, “my rule of thumb, as difficult as it may be, is not to accept gifts,” Lanzafame says. “Consider advising patients and colleagues who desire to give gifts to make a donation to some public charity instead.”

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**Rural Care**

**Protect Your Bottom Line: Implement These Revalidation Letter Requirements**

Here’s the lowdown on how these CMS changes apply to your practice.

If you’re a rural healthcare provider, you’ll want to know the latest news CMS officials discussed during an Open Door Forum call on October 18. Read on for a few highlights about revalidation letters that your practice might need to know.

**Watch for Your Revalidation Letter From CMS**

As part of the Patient Care and Affordable Care Act (section 6401(a)), all new and existing Medicare providers must be reevaluated under new screening criteria that went into effect March 25, 2011. All enrolled providers and suppliers must revalidate their enrollment information every five years, to ensure that Medicare has the most current information on file.

“If your physician is newly enrolled on or after March 25, 2011, you’re not affected by this effort,” Sabeen Chong, CPI, said during the call.

Revalidation letters will be sent on a regular basis over the next year or more. “Phase one is in effect and the first group of providers and suppliers have received their letters,” Chong said.

**Consequence:** Failure to submit complete enrollment application(s) and supporting documentation within 60 calendar days of receiving your revalidation letter could result in Medicare billing privileges being deactivated. Physicians shouldn’t be so anxious to comply that they jump the gun, however.

“Don’t try to revalidate until you hear from your contractor,” Chong warned. “If you respond in a timely manner once you hear from the contractor, it shouldn’t interrupt your payment cycle.”

Providers and suppliers can enroll in the Medicare program by paper application or by using the Internet-based Provider Enrollment, Chain, and Ownership System (PECOS).

**Follow up:** CMS will be posting a list of providers who should have received their notices on the CMS website. “You can check the list to be sure you’re acting on things appropriately,” Chong said. A listing of providers who have been sent a letter as part of Phase I is currently available in the “Downloads” section of the following web page: www.cms.gov/MedicareProviderSupEnroll/11_Revalidations.asp#TopOfPage The list includes provider names, NPIs, and dates the letters were mailed.

So, while you are waiting for your letter, check the list periodically (once a month or so) to see if it’s been mailed and keep your eyes open for such a letter from your MAC. When you do receive your letter, respond promptly (i.e., within 60 days) by completing the necessary enrollment application, either virtually in PECOS or on paper, if necessary. If you’re on the list and have not received your letter, then contact your MAC immediately for more information on what you should do and ask them to possibly fax or e-mail you a copy of the letter in this regard.

**Cost:** Prepare now for a bottom-line hit when your practice goes through the Medicare revalidation process. “It will cost about $500 per provider,” says Barbara Berg, clinic administrator for Lake Chelan Clinic in Chelan, Wash.
What are the rules for physical presence in a teaching setting?

Question:
We are getting a lot of feedback that our emergency physician faculty members, who are supervising residents, can’t report procedures that allow “supervision of key components.” Rather, we are told that they must remain at the bedside the entire time in order to bill for the procedure. For many procedures, this isn’t a problem, but watching a 1st year resident sew up a 15cm laceration for an hour isn’t practical in a busy ED. Of course, the physicians are always within the department, but do they have to remain at the bedside for the entire procedure? Our charting system offers two check boxes: 1. “I was present for and supervised the entire procedure” and 2. “I was present for key components of the procedure.” For number 2, we aren’t billing. While we are on that topic, what exactly is “present”? Does it mean in the same room, in the department, or in the hospital?

Answer:
You should question the source of that information. For Medicare patients, the answer to your questions can be found in Transmittal 1780 and Transmittal 811. These transmittals contain rules about the level of supervision required for various procedures performed in a teaching setting.

In general, Medicare will pay for physician E/M services furnished in a teaching setting under the Physician Fee Schedule only if the services are furnished by a resident seeing a patient in the “physical presence” of a teaching physician who documents his or her presence during the performance of the critical or key portions of the service and participation in the management of the patient.

Alternatively the teaching physician and the resident may be seeing the patient at different times during a visit, provided the teaching physician independently performs the critical or key portions of the service.

For procedures, a distinction is made by Medicare between minor procedures (those lasting less than 5 minutes) and major procedures which typically take longer than 5 minutes. Basically, the teaching physician must be physically present at the bedside for the entire time in order report a minor procedure, defined as one that takes three to five minutes to complete.

On the other hand, major procedures (defined as anything taking longer than five minutes) require only that the attending or teaching physician be present for the key aspects of the procedure and it is up to the attending to determine the key aspects of the service. Very few procedures involving a resident performed in an academic setting take less than five minutes to complete.

For those procedures where they are not physically present for the entire service, the teaching physician must be immediately available to assist as needed. Be sure the chart documentation supports the teaching physicians’ actual involvement in the case and the other documentation requirements are met before reporting the service.

Submit 95250, Then 95251 for Glucose Monitoring

Question:
What is the best way to bill for continuous glucose monitoring? Do we bill for the initial visit and when the patient returns to the office after five days of monitoring, or report only one visit?

Answer:
You can bill for both dates of service related to continuous glucose monitoring (CGM). The codes are:

» 95250 – Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; sensor placement, hook-up, calibration of monitor, patient training, removal of sensor, and printout of recording

» 95251 – Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; interpretation and report.

Initial day: Report 95250 for the initial placement of the CGM and related patient training. If a significant, separately identifiable E/M service is provided at the same encounter, you may also submit the appropriate E/M code, such as 99211 (Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician …).

Follow up: When the patient returns, report 95251 for the interpretation and report. Do not report 95250 again,
because the removal and printout are already covered by your previous reporting of this code. As with the initial visit, include the appropriate office visit E/M code from 99211-99215 (Office or other outpatient visit for the evaluation and management of an established patient …) if there is a significant, separately identifiable E/M service (such as, for the time your provider takes to explain the results to the patient).

Industry Notes

CMS to Cover Obesity Screening and Counseling

This holiday season, CMS has given several gifts that should keep on giving to your practice long into 2012 and beyond. Not only does Medicare plan to start covering annual cardiovascular disease prevention, depression screenings, and alcohol misuse screenings, but the agency also recently announced that it will cover obesity screening and counseling as well.

On Nov. 30, CMS said that Medicare “is adding coverage for preventive services to reduce obesity” in an effort to prevent 1 million heart attacks and strokes over the next five years.

“Obesity is a challenge faced by Americans of all ages, and prevention is crucial for the management and elimination of obesity in our country,” CMS’s Donald M. Berwick said in a statement.

Under the new decision, primary care providers who screen patients positive for obesity with a BMI of 30 kg/m2 or greater will be eligible for a face-to-face counseling visit each week for a month, followed by face-to-face counseling visits every other week for another five months. If the patient loses at least 6.6 pounds over the first six months, the patient can continue to see the physician for additional obesity counseling once a month for another six months, totaling 12 months of counseling.

To read CMS’s coverage decision, visit www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?&NcaName=Intensive%20Behavioral%20Therapy%20for%20Obesity&bc=ACAAAAAI1AA&NCAId=253&.

Part B Practices are still looking at a 27 percent potential Medicare pay cut on Jan. 1

When it comes to looming Medicare pay cuts, the government sure likes taking things down to the wire.

Part B practices are facing a 27 percent cut to Medicare rates effective Jan. 1 unless Congress steps in and reverses that cut, which it has done in prior years. However, the recent failure of the country’s deficit committee means that the government has not yet instituted any solutions to the issue.

“The AMA is deeply concerned that continued instability in the Medicare program, including the looming 27 percent cut scheduled for January 1, will force many physicians to limit the number of Medicare and TRICARE patients they can care for in their practices,” said AMA president Peter W. Carmel, MD, in a Nov. 21 statement. “Congress has ignored the reality that short-term patches have grown the problem immensely. The cost of repealing the formula has grown 525 percent in the past five years and will double again in the next five years.”

Keep an eye on this space as we move closer to the Jan. 1 deadline and determine whether cuts will go into effect as planned, or whether Congress will stave them off for another year.

Entire Home Health Episode Payments Wiped Out

Denials for claims that have ineligible physicians can have a big financial impact, warns consultant Judy Adams with Adams Home Care Consulting in Chapel Hill, N.C. That’s because “agencies stand to have all reimbursement for episodes certified by a non-enrolled physician denied, since the MD was not qualified to certify a home health patient,” Adams says.

HHAs have a longstanding requirement to check physicians’ eligibility, reminds Chicago-based regulatory consultant Rebecca Friedman Zuber. For many years, “agencies have been responsible for ensuring that the physicians from whom they accept referrals and orders are appropriately licensed and have not been excluded from Medicare,” Zuber says.

When agencies fail to make the checks or a physician slips through the cracks, HHAs have to eat the costs of the related episodes, says consultant Tom Boyd with Rohnert Park, Calif.-based Boyd & Nicholas.

(Continued on next page)
Chiropractors May Face Delayed Reimbursement When Billing 98941

Part B practices that report chiropractic manipulative treatment code 98941 shouldn’t be too eager to collect their reimbursement, thanks to a new prepayment review that this code will trigger when submitted to National Government Services, a Part B payer in Connecticut and New York.

Thanks to a previous review of this code that yielded an alarming 80 percent denial rate, NGS is taking no chances on paying erroneous submissions of 98941. “Medical records will be requested to verify medical necessity of the services provided, and that services were billed according to Medicare Program guidelines,” NGS says in its review notice. “If the submitted documentation does not support 98941, the services will either be correctly coded to an appropriate/lower level (98940) or denied,” the directive notes.

To read the complete prepayment notice, visit www.ngsmedicare.com.

Check Your Docs Carefully Or Risk Losing Reimbursement

If you’re lax about checking the credentials of your referring physicians, you may soon pay a big price. Sixty-nine home health agencies in the Houston area are already paying it, thanks to submitting claims that listed a physician who was ineligible to enroll in Medicare, according to the Centers for Medicare & Medicaid Services.

Under its new predictive modeling fraud data program, CMS identified claims with 86 such ineligible physicians, a CMS rep tells Eli. And in late August, CMS sent letters to 69 HHAs telling them claims from just one such ineligible physician would be denied starting Sept. 2. After starting with this one case, there are “about 85 similar circumstances that we will also be addressing,” the CMS source pledges.

Since its initial run, CMS’s Center for Program Integrity has also found more ineligible physicians, the rep adds. CMS can’t release the names of the physicians due to HIPAA concerns. Watch for a “second batch” of letters on this topic to go out, the CMS rep says. But CMS will consult with the industry before sending them out.

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