Coding Corner –

News and Information for Ophthalmologists and Coding Staff
From the Illinois Association of Ophthalmology
August 2009

CMS Proposes to Eliminate Payment for Consultation Codes Effective January 1, 2010

Joy Newby, LPN, CPC, PCS
Newby Consulting, Inc.

CMS published the 2010 proposed rule for 2010 in the July 13, 2009 *Federal Register*. CMS typically publishes the final rule in the Federal Register in late November, early December. The proposed ruled can be downloaded at http://edocket.access.gpo.gov/2009/pdf/E9-15835.pdf. We will keep you informed.

In the proposed rule, we noted that CMS continues to hear from the AMA and specific national physician specialty representatives that physicians are dissatisfied with Medicare documentation requirements and guidance that distinguish a consultation service from other E/M services such as transfer of care. CMS states that since *CPT* has not clarified transfer of care, many physician groups disagree with CMS requirements for documentation of transfer of care. Interpretation differs from one physician to another as to whether transfer of care should be reported as an initial E/M service or as a consultation service.

According to CMS, the physician community has stated that terms such as referral, transfer and consultation, used interchangeably by physicians in clinical settings, confuse the actual meaning of a consultation service and that interpretation of these words varies greatly among members of that community as some label a transfer as a referral and others label a consultation as a referral.

Under CMS current policy and in the AMA *CPT* definition, a consultation service must have a request from another physician or other professional and be followed by a report to the requesting professional. The AMA *CPT* definition does not state the request must be written in the requesting physician's medical record. However, CMS requires the requesting physician document the request in the requesting physician's plan of care.

Because of the disparity between AMA coding guidance and Medicare policy some physicians state they have difficulty in choosing the appropriate code to bill. The payment for both inpatient consultation and office/outpatient consultation services is higher than for initial hospital care and new patient office/outpatient visits. However, CMS believes the associated physician work is clinically similar.

Beginning January 1, 2010, CMS proposes to budget neutrally eliminate the use of all consultation codes (inpatient and office/outpatient codes for various places of service except for telehealth consultation G-codes) by increasing the work RVUs for new and established office visits, increasing the work RVUs for initial hospital and initial nursing facility visits, and incorporating the increased use of these visits into the PE and malpractice RVU calculations.

Outside the context of telehealth services, physicians will bill an initial hospital care or initial nursing facility care code for their first visit during a patient's admission to the hospital or nursing facility in lieu of the consultation codes these physicians may have previously reported. The CMS proposal states that in lieu of the consultation codes being used in the office and outpatient settings will be reported with new or established codes 99201-99215 depending on whether the patient meets the requirements for reporting a new patient code.

Surety Bond – Updated information

Joy Newby, LPN, CPC, PCS
Newby Consulting, Inc.

Recently the AAO published the following information:

> **CMS Says Eye M.D.s Who Dispense Post-Cataract Glasses are Exempt from DMEPOS Surety Bond**
> A surety bond requirement that goes into effect Oct. 2 does not apply to practices that provide post-cataract glasses to patients, CMS clarified this week, even if the surgery was performed by another ophthalmologist. The agency issued the clarification after the Academy and others raised concerns about the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) requirement. CMS said post-cataract patients would be considered part of the dispensing practice's patient base and therefore exempt. There has been confusion since CMS' May announcement that only physicians who provide DMEPOS for their own patients are exempt from obtaining a surety bond. NOTE: Be sure to maintain enrollment as a supplier with the National Supplier Clearinghouse and report any changes that would affect enrollment status.

Newby Consulting, Inc. (NCI) located the following question and answers on the Palmetto GBA National Supplier Clearinghouse website for Medicare Suppliers
http://www.palmettogba.com/Palmetto/Providers.nsf/files/suretybondfaqs08252009.pdf/$FIle/suretybondfaqs08252009.pdf

27. *Can group practices avail themselves of the exceptions to the surety bond requirements? In other words, are the exemptions for physicians, non-physician practitioners, prosthetists, etc., identified in 42 CFR 424.57(d)(15)(i)(B) through (D) limited to sole proprietorships and solely-owned LLCs and corporations?*
    As a general rule, a group practice is eligible for an exemption to the surety bond if each member of the group would – if he/she was operating as a solo practitioner – qualify for the exemption on his/her own. Thus, for instance, if three prosthetists are in private practice together, each prosthetist must be licensed by the State and have an ownership interest in the business; moreover, the three prosthetists must be the only owners and operators of the business. Likewise, if two physicians operate their own group practice, each physician in the practice must furnish DMEPOS items only to his or her own patients as part of his or her own service in order for the physician group to qualify for the bond exemption.

31. *The exemptions for prosthetists, orthotists, physical therapists and occupational therapists require the individual practitioner to own 100% of the business. Does the physician/non-physician practitioner exemption have a similar ownership requirement?*
    No. The physician/non-physician practitioner need not own the practice in order to qualify for the exemption.

33. *Most of the exceptions to the bond requirement mandate that the individual furnish items and services only to his or her own patients. If the practitioner sees non-Medicare patients, does this disqualify him/her from an exception to the bond requirement?*
    No. The practitioner can still qualify for the exemption if he/she treats non-Medicare patients, even if those patients are not his/her own. The term "patient," as used in the exceptions, is limited to Medicare patients. Thus, in order to satisfy the exceptions, the practitioner must be furnishing services to his/her own Medicare patients.

41. *If I know that I am exempt for the surety bond requirement, must I officially notify the NSC of this?*
    No.

While CMS has not formally issued additional written clarifications, based on the above information, it seems reasonable to assume that ophthalmology owned optical dispensaries are exempt from the surety bond requirement. Based on the response to question 41 above, it is not necessary to notify the NSC you are exempt from the surety bond requirement.

PQRI Teleconference

Joy Newby, LPN, CPC, PCS
Newby Consulting, Inc.

On August 20, 2009, CMS sponsored a 2009 Physician Quality Reporting Initiative National Provider Call. We had the following questions regarding the 2007, 2008, and 2009 PQRI process:

What is the status of the 2007 re-run of data?
The 2007 additional payments and reports will be available in November 2009. CMS plans to run the reports and payments for 2008 before they release the 2007 payments and reports due to the re-run.

When does CMS expect the 2008 reports to be available?
The 2008 payments and reports will be available in October 2009. The reports are going to be different this year. They will have more detail and will be easier to understand. There will be guides on the CMS website that will explain how to interpret the PQRI reports.

What will physicians have to do to obtain the data, if they have already registered on the Individuals Authorized Access to the CMS Computer Services (IACS) and if they aren't already on IACS?
If a group practice wants to access their report by the group Tax ID Number, they will have to go through IACS.

Beginning this year, each individual physician will have an alternative way to access his/her personal reports. CMS is hopeful this process will be available in mid-September. The individual reports will be based on individual NPI. The physician will make a phone call and the report will be sent to him/her via e-mail. So, as an individual physician, they do not have to be on IACS.

See the CMS website for additional information on IACS
http://www.cms.hhs.gov/IACS/01_Overview.asp

Can physicians check their 2009 reporting status and if so how?
Physicians cannot currently check their 2009 status.

Any new information on 2010 PQRI and the future of this "voluntary" program

- 2010 measures will be available in mid November. There are several new measures and several deleted measures. NCI anticipates new a new cataract measure; however, we do not anticipate CMS developing a "measures group" for ophthalmology services.
- Incentive payment remains at two (2) percent of the physician's Medicare approved amounts for paid claims.
- CMS will continue with claims-based reporting and registry-based reporting. New for 2010, CMS is hoping to introduce EHR-based reporting.

CMS is proposing to publicly report as required by the Medicare Improvements for Patients and Providers Act of 2008

- Names of eligible professionals and group practices who satisfactorily report in 2010 PQRI
- Names of eligible professionals and group practices who are successful electronic prescribers

Policies for the 2010 PQRI and Electronic Prescribing Incentive Programs will be finalized in the 2010 Physician Fee Schedule final rule with comment period. The final rule is expected to be published in the *Federal Register* on or around November 1, 2009.

2010 Electronic Prescribing Incentive Program
The CMS teleconference included information on the e-prescribing incentive. For 2010, the incentive payment remains two (2) percent of the physician's Medicare approved amounts for paid claims.

Claims-based reporting will continue and CMS wants to offer registry-based reporting for e-prescribing. CMS is hopeful they will also be able to introduce EHR-based e-prescribing reporting.

CMS is proposing the following Criteria for a "successful electronic prescriber"

- Eliminate the 3 numerator G-codes
- Create a new G-code to indicate that at least one prescription was generated during the visit using a qualified e-prescribing system
- Add home health codes 99341-99345 and 99347-99350; nursing facility codes 99304-99310 and 99315-99316; and one addition psychiatric code 90862
- Revision of the reporting requirements
  - Eliminate requirement to report on 50 percent of the applicable cases during the reporting period
  - Require eligible professionals to report the measure 25 times during the reporting period
- Continue the requirement that to be eligible for the e-prescribing incentive payment the eligible professional's allowed charges for the denominator codes must be equal to or greater than 10 percent of the total 2010 estimated allowed charges

CMS is creating a Group Practice E-Prescribing Reporting option – Proposed at this time, additional information should be available later in 2009.

- Only group practices participating in the PQRI group practice reporting option will be able to participate as a group practice for the e-prescribing incentive
- The group practice would be required to report the e-prescribing measure at least 2500 times during the reporting period for the group practice to be considered a successful electronic prescriber
- Incentive payment also only applies to groups whose Medicare allowed charges for services in the e-prescribing measure's denominator is equal to or greater than 10 percent of the group's total estimated allowed charges

Private Fee-For-Service (PFFS) Medicare Advantage Request for Chart Reviews

Connie Woods, CPC, CPC-I, CGSC, OCS
Newby Consulting, Inc.

NCI has received several inquiries from physician offices regarding requests from some of the Private fee-for-service (PFFS) Medicare Advantage plans for in-office chart reviews. Members are asking if they must comply with these requests.

Typically, these requests will include a fax cover sheet requesting that a plan representative be allowed to come to the physician's office to review charts for *ICD-9* diagnosis coding. Usually there is a list of patients sent with the cover sheet identifying the charts they wish to review.

Physicians who are not contracted with a PFFS plan are "deemed" to be participating with the plan on a case-by-case basis for Medicare Advantage fee-for-service patients. Physicians who are deemed providers are required to comply with these requests based on the terms and conditions of payment for this type of a Medicare Advantage plan. These terms and conditions for payment can be found on the website of the individual plans and the provider is responsible for becoming familiar with these terms and conditions.

We found the following is the definition of a deemed provider as defined by the *Medicare Managed Care Manual* Chapter 4 §150.3 - Provider Types---Direct Contracting, Deemed Contracting, Non-Contracting - (Rev. 87; Issued: 06-08-07; Effective/Implementation: 06-08-07)

> When an enrollee in a PFFS plan offered by an MA Organization obtains services from a provider, then for those services, that provider is classified into one of the following three mutually exclusive provider types:
>
> - A provider is a direct-contracting provider if that provider has a direct contract (that is, a signed contract) with the MA Organization;
> - A provider is a deemed-contracting provider if:
>   - The provider is aware in advance of furnishing services, that the person receiving the services is enrolled in a PFFS plan;
>   - The provider has reasonable access to the plan's terms and conditions of payment; and
>   - The service provided is covered by the plan;
> - A provider is non-contracting provider if that provider does not have a direct contract and is not deemed.
>
> A provider is aware in advance of enrollment if notice of enrollment for this enrollee was obtained from:
>
> - The enrollee (e.g., presentation of an enrollment card);
> - CMS;
> - A Medicare intermediary;
> - A carrier; or
> - The MA Organization itself.
>
> A provider has reasonable access to the plan's terms and conditions of payment if the plan makes accessible its terms and conditions of payment through:
>
> - Postal service;
> - Electronic mail;
> - Fax;
> - Telephone; or
> - A plan Web site.

It is then the provider's responsibility to call or fax the PFFS plan or to visit the PFFS Web site to obtain the plan's conditions of participation. However, announcements in newspapers, journals, or magazines or on radio or television are not considered communication of the terms and conditions of payment.

It is important to emphasize that although a provider who does not have a direct contract with the plan may choose to provide, or not to provide services, the provider does not have the option of becoming non-contracting. Rather, once the provider provides services, the provider automatically becomes deemed-contracting provided the deeming conditions listed above have been met.

As an example, Humana's terms and conditions of payment as it pertains to chart reviews can be found on Humana's website at http://www.humana-medicare.com/humana-gold-choice-terms-conditions.asp#6

6. Maintaining medical records and allowing audits
   Deemed providers shall maintain timely and accurate medical, financial and administrative records related to services they render to Humana Gold Choice PFFS or Humana Group Medicare PFFS members. Unless a longer time period is required by applicable statutes or regulations, the provider shall maintain such records for at least 10 years from the date of service.

   Deemed providers must agree to maintain medical records according to industry standards and to provide such records to Humana or a Humana designee upon request and within a reasonable time frame. Deemed providers must provide Humana, the Department of Health and Human Services, the Comptroller General, or their designees access to any books, contracts, medical records, patient care documentation, and other records maintained by the provider pertaining to services rendered to Medicare beneficiaries enrolled in a Medicare Advantage plan, consistent with federal and state privacy laws.

   Such records may be used for activities in the following situations: Centers for Medicare & Medicaid Services and Humana audits of risk adjustment data; CMS audits; fraud and abuse; compliance with federal regulations; Humana determinations of whether services are covered under the plan, are reasonable and medically necessary, whether the plan was billed correctly for the service; whether the service is coded properly; and in order to make advance coverage determinations.

   Humana will not use medical record reviews to create artificial barriers that would delay payments to providers. Both voluntary and mandatory provision of medical records must be consistent with HIPAA privacy law requirements.

HIPAA privacy requirements limiting disclosure to these requesting plans apply. Physician practices need to be sure they disclose only the minimum necessary to comply with the request. If the practice is mailing records, they should not send copies of the whole chart. Send only the sections covered in the request.

Physicians who are contracted with these Medicare Advantage plans should review their contracts. The contract will probably include a clause that states providers must comply with record requests.

Recovery Audit Contractors Post First Set of Issues to be Reviewed

Joy Newby, LPN, CPC, PCS
Newby Consulting, Inc.

CGI Federal, the Recovery Audit Contractor (RAC) for Region b, has a new website for information specific to their organization (http://racb.cgi.com/Default.aspx). We encourage you to visit this website often to stay up-to-date with RAC activities in your region.

The following issues have been approved by CMS for RAC review in Indiana, Michigan, and Minnesota

Issue Details	
Name	Blood Transfusions
Number	B000052009
Description	Blood Transfusions – should be billed with a maximum of (1) unit per patient per date of service (outpatient/physician)
Claim Type	Outpatient Hospital, Physician
Codes Affected	36430, 36440, 36450, 36455, 36460
Overpayment or Underpayment	Overpayment
Dates of Service	10/1/2007 - Open
States	Indiana, Michigan, Minnesota
Policy Related Links	CMS Pub 100-04, Ch. 4, § 231.8, Program Memorandum Intermediaries, Transmittal A-01-50, April 12, 2001, page 1, *Federal Register*, Vol73, No 223, page 69016
Date Approved	8/14/2009

Issue Details	
Name	IV-Hydration
Number	B000072009
Description	IV-Hydration- should be billed with a maximum number of units (1) per patient per date of service
Claim Type	Outpatient Hospital, Physician
Codes Affected	90760 (10/2007-12/31/08),96360 (1/1/09-present)
Overpayment or Underpayment	Overpayment
Dates of Service	10/1/2007 - Open
States	Indiana, Michigan, Minnesota
Policy Related Links	CMS Pub 100-4 Ch. 12, pages 31-32 , CMS Pub100-20, Transmittal

	419, page 7, MLN Matters, MM6349 R/T CR Release Date 12.19.08, page 4
Date Approved	8/14/2009

Issue Details	
Name	Bronchoscopy Services
Number	B000062009
Description	Bronchoscopy Services - should be billed with a maximum of (1) unit per patient per date of service (outpatient hospital/physician)
Claim Type	Outpatient Hospital, Physician
Codes Affected	31625, 31628, 31629
Overpayment or Underpayment	Overpayment
Dates of Service	10/1/2007 - Open
States	Indiana, Michigan, Minnesota
Policy Related Links	American Medical Association (AMA), *Current Procedural Terminology* (*CPT*), *Federal Register*, Volume 67, No. 251, page 8., *American Thoracic Society Coding 2005 Update*
Date Approved	8/14/2009

Although none of the issues are pertinent to ophthalmology, they do give insight on what types of problems could be reviewed. When reviewing the issues, consider whether there are any analogies to your services. For example

- Age appropriate codes – Be sure your superbill is up-to-date and, if applicable, that you are correctly reporting the services based on the patient's age.
- Once-in-a-Lifetime procedures – Good reminder to always include informational modifiers, e.g., -LT, -RT, E1-E4, etc. Again, review your superbill to be sure the descriptions on the form match the assigned codes.
- Excessive Units of Service – Are you correctly using units of service? Be careful using units of service on surgical procedure codes. If the service is not an "add-on" code, you may not be able to correctly report units of service. Are you using the -50 modifier on a procedure code and also reporting 2 units of service? Reporting more than one unit of service for bilateral tests, e.g., fundus photos? If you have an optical dispensary, verify you are correctly using units of service.
- Medication – Are you using the correct *HCPCS* code? Verify the dosage considered 1 unit of service. Are you using the correct code and units of service? If the description of the code includes dosage, does the physician's progress note verify the dosage injected and not just the amount, e.g., 10 mg instead of 1 cc? If you have to discard a portion of a single dose vial, are you correctly documenting the discarded portion in the patient's progress note? Is this information included on the patient's claim?