SGR Reform Act of 2013
New law includes physician update fix through March 2014
On December 26, 2013, President Obama signed into law the “Pathway for SGR Reform Act of 2013.” This new law prevents a scheduled payment reduction for physicians and other practitioners who treat Medicare patients from taking effect January 1, 2014. The new law provides for a 0.5 percent update for such services through March 31, 2014.

The 2014 conversion factor is $35.8228.

Medicare Physician Payment Update -- as indicated above, the new law provides for a 0.5 percent update for claims with dates of service on or after January 1, 2014, through March 31, 2014.

Extension of Medicare Physician Work Geographic Adjustment Floor -- the existing 1.0 floor on the physician work geographic practice cost index is extended through March 31, 2014. As with the physician payment update, this extension will be reflected in the revised 2014 Medicare Physician Fee Schedule (MPFS).

2014 Anesthesia conversion factors for Florida
The conversion factors for use in calculating payment for anesthesia services (procedure codes 00100 through 01999) for service dates January 1 through December 31, 2014, are as follows:

<table>
<thead>
<tr>
<th>Locality</th>
<th>Participating Physician</th>
<th>Nonparticipating Physician</th>
</tr>
</thead>
<tbody>
<tr>
<td>03</td>
<td>24.42</td>
<td>23.20</td>
</tr>
<tr>
<td>04</td>
<td>25.95</td>
<td>24.65</td>
</tr>
<tr>
<td>99 (01 &amp; 02)</td>
<td>23.37</td>
<td>22.20</td>
</tr>
</tbody>
</table>

The conversion factors for non-medically directed certified registered nurse anesthetists (CRNAs) are identical to the participating physician anesthesia conversion factors for each payment locality.

The conversion factors for medically directed CRNAs (for both physician medical direction and medically directed CRNAs) are based on 50 percent of the sum of the anesthesia base units and time units, multiplied by the appropriate participating physician locality conversion factor (i.e., 50 percent of the sum of (base units + time units) x locality conversion factor = anesthesia allowance). The medical direction 50 percent payment policy applies if both a CRNA (an anesthesia assistant) and an anesthesiologist are involved with the same case.
2014 CPT Code Changes

There are 335 CPT code changes in the 2014 CPT code set. These will reflect the latest technological advances in medical, surgical and diagnostic services. The codes are available for use on or after January 1, 2014.

175 New Codes
107 Revised Codes
53 Deleted Codes

Main Subsections with Changes:
- Digestive System
- Molecular Pathology
- Cardiology & Vascular Embolization Procedures
- Evaluation and Management

Other Section Changes Include:
- Breast Biopsies and Imaging
- Multi-system Image-guided Catheter Drainage
- Musculoskeletal System
- Nervous System
- Speech Language Pathology

Cardiology and Vascular Embolization Procedures

Vascular – There are at least 19 new cardiology procedure codes in 2014. One of the biggest changes for peripheral vascular physicians is the creation of five new codes (37217 and 37236-37239) for peripheral stenting, which bundle radiological supervision and interpretation (S&I) – a revision that could affect the practice’s reimbursements for the procedures. And the addition of eight (8) Category I codes (34841-34848) for fenestrated endovascular aorta repair (FEVAR) could be big news for interventional cardiologist that were reporting the procedure with Category III codes (0978T-0081T). (Category I codes tend to pay more reliably than Category III.)

Expect four new codes (37241-37244) for billing vascular embolization or occlusion, which also bundle S&I, intraprocedural road mapping and image guidance. The codes are divided out for venous; arterial; tumors, organ ischemia or infarction; and arterial or venous with hemorrhage. The codes will replace deleted codes 37204 (Transcatheter occlusion or embolization) and 37210 (Uterine fibroid embolization).

Gastroenterology

Addition of 26 new codes, revision of 41 codes and deletion of 17 codes. For example, in 2014, you’ll select your esophagoscopy codes based on whether the scope is rigid or flexible, transoral or transnasal, in addition to the actual procedure performed. Look for additional changes to the EGD, ERCP and enteroscopy series. Gastroenterology codes capture significant advances in endoscopic technology, devices and techniques. The codes better capture the work involved with sophisticated endoscopic procedures now available to examine the upper gastrointestinal tract and advance the early detection of cancer and digestive disorders.

Molecular Pathology

In diagnostics, the scope of molecular pathology services codes have also been substantially broadened with the addition of 316 molecular tests for detection of genes, somatic disorders and germlines to the nine molecular pathology resource based Tier II codes.

Evaluation and Management Services

E/M – CPT added 4 new codes, 99446-99449, for inter-professional telephonic/Internet assessment and management service provided by a consultative physician, including a verbal or written report to patient’s treating/requesting physician or qualified health care professional. It is not known if Medicare will pay.

- These are time based codes – 99446 is for 5-10 minutes of medical consultative discussion and review, 99447 covers 11-20 minutes, 99448 is for 21-30 minutes and 99449 is for 31 minutes and more.

- Two (2) new add-on codes for hypothermia in a critically ill neonate – 99481 (Total body) and 99482 (Selected head hypothermia). Both codes are billed once per day in conjunction with critical care codes.

Breast Biopsies & Imaging and Abscess Drainage

Breast Biopsies – CPT deletes seven codes and adds 14 new ones for biopsy with placement of localization device (19081-19086) and placement of localization device alone (19281-19288). Next year, you’ll select the code based on the type of imaging used such as stereotactic, ultrasound or magnetic resonance.

New bundled codes will be created to describe breast biopsy procedures that include imaging guidance as well as placement of one or more localization device(s) and imaging of the specimen when performed. Codes 77031, 77032, 76098, 19103, 19290 and 19295 were caught in the 75% screen. New codes also will be created to bill the placement of clips and other breast localization devices without biopsy or during aspiration procedures.

Abscess Drainage – CPT deleted a handful of codes throughout the code set, including 47011, 48511, 49021, 49041, 49061, 50021 and 58823. In their place, you’ll bill a new integumentary code 10030 (Image-guided fluid collection, drainage by catheter [e.g., abscess, hematoma, seroma, lymphocoele, cyst] soft tissue [e.g., extremity, abdominal wall, neck], percutaneous). The abscess drainage codes and guidance code 75989 will be bundled.
**Musculoskeletal System**

A reorganization of the musculoskeletal system codes for shoulder and elbow prosthesis removal to include debridement and synovectomy, when performed. For shoulders, CPT deleted codes 23331 and 23332 and added three codes (23333-23335) to distinguish foreign body removal from removal of a prosthesis. You’ll be able to code a total shoulder prosthesis removal or either the glenoid or humeral portions. For elbows, CPT simply revised existing codes 24160 and 24164 to specify removal of prosthesis and add debridement and synovectomy as components.

**Nervous Systems**

Elimination of chemodenervation codes for destruction of neck and trunk and extremity muscles (64613-64614, respectively). They will be replaced by eight new codes. For example, CPT code 64613 will be replaced by two codes next year. Bill 64616 for unilateral chemodenervation of the neck muscles excluding the larynx and 64617 for procedures on the larynx. In place of code 64614, you’ll select from four parent and two add-on codes (64642 – 64647). For example, you will use 64642 to bill chemodenervation of one to four muscles in one extremity. Use add-on code 64643 to bill chemodenervation of each additional extremity, one to four muscles.

**Speech Language Pathology**

**New Codes**

92521 Evaluation of speech fluency (e.g., stuttering, cluttering)
92522 Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria);
92523 Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (e.g., receptive and expressive language)
92524 Behavioral and qualitative analysis of voice and resonance

**Deleted Codes**

92506 Evaluation of speech, language, voice, communication, and/or auditory processing CPT 92506 has been replaced with four new evaluation codes related to speech sound production, language, fluency, and voice and resonance. (See new codes above)

**Revised Codes**

No speech-language pathology codes have been revised for 2014.

**Value Based Modifier**

Section 3007 of the Affordable Care Act mandated that, by 2015, CMS begin applying a value modifier under the Medicare Physician Fee Schedule (MPFS). Both cost and quality data are to be included in calculating payments for physicians.

Physicians in groups of 100 or more eligible professionals who submit claims to Medicare under a single tax identification number will be subject to the value modifier in 2015, based on their performance in calendar year 2013.

All physicians who participate in Fee-For-Service Medicare will be impacted by CMS’ emphasis on reporting quality data through PQRS and by 2017 will be affected by the value modifier.

Clarification of revisions to editing of the TC of pathology services

Change request 8399 revised editing to allow the technical component (TC) of a pathology claim when:

- there is a claim in history billed by the same ordering/referring physician for the same date of service as the TC of the pathology claim, and

- when the history claim billed by the ordering/referring physician is not place of service 21 or 22.

This edit will only be bypassed if the rendering provider on history and the referring provider on the TC of the pathology claim is the same provider (not just in the same group). For additional information, please see MM8399.
Coding Guidelines for 3D Mammography

Medicare provides coverage for a screening mammography, which includes the use of three-dimensional (3D) images (breast tomosynthesis) to detect breast cancer.

This technology produces direct digital images and should be reported using one of the three existing healthcare common procedure coding system (HCPCS) codes that describe digital mammography services.

When using these codes to bill a 3D image, the two-dimensional image is included.

Breast tomosynthesis, and all other types of digital mammography, is described using the following HCPCS codes:

- G0202 Screening mammography, producing direct digital image, bilateral, all views
- G0204 Diagnostic mammography, direct digital image, bilateral, all views
- G0206 Diagnostic mammography, producing direct digital image, unilateral, all views

Polysomnography and Sleep Testing – Revision to the Part B LCD

The local coverage determination (LCD) for polysomnography and sleep testing was most recently revised January 1, 2013. Since that time, the LCD has been revised in the “Documentation /Credentialing Requirements” section of the LCD under “Technologist/Technician Credentials/Training” to clarify the credentialing between a technologist and a technician.

The LCD is revised to read as follows: “All technologists and technicians conducting sleep testing who are not registered by the BRPT, ABRET, ABSM, NBRC or other accepted certification body, must be affiliated with an AASM accredited sleep facility or Joint Commissions accredited sleep facility (a Joint Commission accredited sleep laboratory).

Unregistered technologists and technicians must maintain appropriate training and supervision, and, be supervised by a registered and licensed technologist, where license is required by state law. Technologist staffing must be adequate to address the workload of the sleep facility and assure the safety of patients. Additionally, the “Indications and Limitations of Coverage and/or Medical Necessity” section of the LCD under “Accreditation” has also been revised.

Psychological and Neuropsychological Tests

The local coverage determination (LCD) for psychological and neuropsychological tests was effective October 14, 2013. Since that time, the LCD was revised to remove Current Procedural Terminology® (CPT®) code 96125 and add it to the therapy and rehabilitation services LCD. In addition, the coding guidelines attachment was also revised.

This LCD revision is effective for claims processed on or after November 27, 2013, for services rendered on or after October 14, 2013. First Coast Service Options Inc. LCDs are available through the CMS Medicare Coverage Database at http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx.
2014 HCPCS local coverage determination changes

Procedure codes have been added, revised, replaced and deleted accordingly:

**Allergy Testing**

Deleted CPT® code 88342 Added HCPCS codes G0461 and G0462 Removed asterisk (*) from CPT® code 86628 that indicated this service is also listed in the Noncovered Services LCD (Not related to 2014 HCPCS Update)

Bisphosphonates (Intravenous [IV]) and Monoclonal Antibodies in the Treatment of Osteoporosis and Their Other Indications

Deleted HCPCS code Q2051 Added HCPCS code J3489

**Molecular Pathology Procedures for Human Leukocyte Antigen (HLA) Typing**

Descriptor change for CPT® codes 81371, 81376, and 81382

**Noncovered Procedures – Endoscopic Treatment of Gastroesophageal Reflux Disease (GERD)**

Descriptor change for CPT® codes 43201, 43236, 43241, and 43257

**Noncovered Services**

Deleted CPT® codes 0124T (changed to CPT® code 68399), 0183T (replaced with CPT® code 97610), 0185T (changed to CPT® code 99199), and 0186T (changed to CPT® code 67299) Description change for CPT® codes 43206 and 43252

**Transitional Care Management Codes**

Medicare and other payers will pay for two new CPT codes (99495 and 99496) that are used to report physician or qualifying non-physician practitioner transitional care management (TCM) service for patients, following a discharge from a:

- Hospital
- Skilled Nursing Facility (SNF)
- Community Mental Health Center (CMHC)
- Outpatient observation

**Botulinum Toxins (Coding Guidelines only)**

Deleted CPT® codes 64613 and 64614 Added HCPCS codes 64616, 64617, 64642, 64643, 64644, 64645, 64646, and 64647 Descriptor change for CPT® codes 43201 and 43236

**Cardiovascular Nuclear Imaging Studies**

Deleted HCPCS code J0152 Added HCPCS code J0151

**Diagnostic and Therapeutic Esophagogastroduodenoscopy**

Deleted CPT® code 43258 Added CPT® codes 43233, 43253, 43254, 43266, and 43270 Descriptor change for CPT® codes 43235, 43239, 43241, 43243-43251, and 43255

Deleted CPT® codes 77031 and 77032

**Interferon**

Deleted HCPCS code Q3025 Added HCPCS code Q3027

**Intensity Modulated Radiation Therapy (IMRT)**

Added CPT® code 77293 Descriptor change for CPT® code 77295

**Intravenous Immune Globulin**

Deleted HCPCS code C9130 Added HCPCS code J1556

**Mohs Micrographic Surgery (MMS) (Coding Guidelines only)**

Deleted CPT® code 88342 Added HCPCS codes G0461 and G0462

**Molecular Pathology Procedures Added CPT® code 81287**

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Plerixafor (Mozobil®)

Deleted HCPCS codes J1440 and J1441 Added HCPCS codes J1442 and J1446

Renal Angiography

Deleted HCPCS code G0275

Sacral Neuromodulation (Coding Guidelines only)

Added HCPCS code L8679

Skin Substitutes

Added HCPCS codes Q4137, Q4138, Q4139, Q4140, Q4141, Q4142, Q4143, Q4145, Q4146, Q4147, Q4148, and Q4149 to “The following HCPCS codes are not separately payable and are considered not medically reasonable and necessary products” section of the LCD Added HCPCS codes C5271, C5272, C5273, C5274, C5275, C5276, C5277, and C5278 to the LCD “Coding Guidelines’ attachment. The following change is not related to the 2014 HCPCS Update. Based on CR 8575 the following verbiage was added to the LCD “Coding Guidelines” attachment “Beginning January 1, 2014 ASCs should not separately bill for packaged skin substitutes.”

**Therapy and Rehabilitation Services**

Deleted CPT® code 92506 Added CPT® codes 92521, 92522, 92523, and 92524
Hospital Discharge Day Management Codes 99238 and 99239

Per Medicare guidelines, only one CPT® 99238 or 99239 is payable per patient per hospital stay. The principal physician of record shall append modifier AI (Principal physician of record) to the claim for the initial hospital care code. Modifier AI identifies the physician who oversees the patient’s care from all other physicians who may furnish specialty care. Only the attending physician of record (or the physician or qualified non-physician practitioner acting on the behalf of the attending physician) reports the discharge day management service.

Hospital discharge day management service, CPT® code 99238 or 99239 is described as a face-to-face evaluation and management (E/M) service.

**PLACE OF SERVICE (POS)**

**Claims denied in error**

Due to the clarifications provided in CR 7631, First Coast identified claims that denied incorrectly: Claims billed by independent laboratories for the professional component of certain laboratory and/or pathology codes have denied in error when billed with POS codes:

- Inpatient hospital (21)
- Outpatient hospital (22)
- Emergency room-hospital (23)
- Inpatient psychiatric facility (51)
- Psychiatric facility – partial hospitalization (52)
- Comprehensive inpatient rehabilitation facility (61)
- Comprehensive outpatient rehabilitation facility (62)

2. Claims billed by independent laboratories for certain laboratory and/or pathology codes have denied when billed with POS office (11)

3. Claims billed by physicians for the PC of certain laboratory and/or pathology codes have denied in error when billed with POS independent laboratory (81)

First Coast’s claim processing system has been updated to no longer deny the claims for the situations mentioned above.

**No provider action is necessary as First Coast will adjust the claims that processed on or after April 1, 2012, and denied in error.**

For more information regarding correct POS code assignment, please review the resources provided below.

**Source:** CR 7631; Medicare Claims Processing Manual, Chapter 26
Medicaid

In early 2014, the Fraud Prevention and Compliance Unit expects to conduct statewide compliance reviews in the area of Behavioral Health. Our goal for this project is to help educate Community Behavioral Health providers to be in full compliance with Medicaid policy. While on-site, some of the main issues of focus will be:

- Treatment Plan Development includes amount/frequency/duration.
- Target dates are present on Treatment Plans.
- Treatment Plans demonstrate progress related to goals/objectives.
- Objectives listed on Treatment Plans are measurable.
- Signature of parent/guardian (for minors) is present and written explanation is listed on Treatment Plan.
- Treatment Plan is signed by treating practitioner.
- Treating practitioner of Medicaid recipient is enrolled.

Medicaid Provider Enrollment News

A final area for consideration for providers is to ensure that you keep your provider information up to date with the Agency. This includes ensuring that individuals who are no longer a part of the group are removed in a timely manner. By submitting the appropriate information to the fiscal agent, individuals no longer associated with a Medicaid provider file will be end dated on your file. This can be done by submitting a dated letter on letterhead to the fiscal agent stating which individual has left, the provider ID affected, the individual’s tax ID information as listed on the file, and include a signature by an individual that is currently listed in the panel.

Florida Medicaid 2014 Winter Bulletin

Florida Medicaid Fee Schedules

Beginning February 10, the Secure Provider Online Tool’s (the SPOT) new and improved Payment History feature will make your search for financial data easier than ever before -- and include even more crucial information and export options.

Customizable queries and information displays

The SPOT’s new streamlined Payment History query form allows you to customize your search by specifying either a date range or a specific check/EFT number.

You can even access data for previously submitted inquiries by clicking the Resubmit Query hyperlink in the Previous Queries table.

Once you’ve submitted your query, the SPOT will display a quick “snapshot” of the results of your search in a convenient, sortable summary table.

Payment results: It’s all in the details …

To view any of the payments displayed in greater detail, just click on the corresponding Check/EFT Number hyperlink, and the details will display beneath the summary results table.

Since many of our health care providers have taken advantage of the electronic health records (EHR) initiative, the SPOT now offers you the option to export your payment results to either an Excel spreadsheet or to PDF for future reference.

Coming soon: Changes to ‘Claim Status’

The enhancements to the SPOT’s Payment History interface are only a preview of more exciting changes to come to First Coast’s most popular provider resource. What’s next? Changes to Claim Status will be coming soon and will not only feature more in-depth information but also enhancements to the query form, result displays, and export options.

So, register now, and let the SPOT help you tighten your focus on your bottom line.

Stay connected to 'the SPOT'

Follow us on Twitter @theSPOTportal

Please click here to view First Coast's eNews archive for the SPOT.
ICD-10 NEWS

Claims Submission and Date of Service Reminder

Claims spanning the ICD-10 implementation date is addressed separately below. ICD-9 codes will no longer be accepted on claims (including electronic and paper) with FROM dates of service (on professional and supplier claims) or dates of discharge/through dates (on institutional claims) on or after October 1, 2014.

When to submit ICD9:

For claims with dates of service prior to October 1, 2014, submit with the appropriate ICD-9 procedure code.

Institutional claims:

Institutional claims containing ICD-9 codes for services on or after October 1, 2014, will be return claims as unprocessable.

Professional and Supplier Claims:

Professional and supplier claims containing ICD-9 codes for dates of services on or after October 1, 2014, will also be returned as unprocessable.

Points to Remember:

* Providers will be required to re-submit returned claims with the appropriate ICD-10 code(s).

* A claim cannot contain both ICD-9 codes and ICD-10 codes.

* Medicare will return all claims that are billed with both ICD-9 and ICD-10 procedure codes on the same claim.

* For dates of service prior to October 1, 2014, submit claims with the appropriate ICD-9 diagnosis code.

* For dates of service on or after October 1, 2014, submit with the appropriate ICD-10 diagnosis code.

ICD-10 NEWS, CONT.

Claims Containing Span Dates Through ICD-10 Implementation Date

CMS identified potential claims processing issues for claims that span the implementation date where ICD-9 codes are effective for the portion of the services that were rendered on September 30, 2014, and earlier and where ICD-10 codes are effective for the portion of the services that were rendered October 1, 2014, and later.

In some cases, depending upon the policies associated with those services, there cannot be a break in service or time (i.e., anesthesia) although the new ICD-10 code set must be used effective October 1, 2014.

CLICK HERE and scroll to page 3 - 6 to locate CMS guidance tables providing information related to coding of claims that span the periods where ICD-9 and ICD-10 codes may both be applicable.

2014 OIG Workplan for Hospital and Physicians

OIG releases 2014 work plan
The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 8586 to provide clarification to hospitals regarding the billing of inpatient hospital stays and the 2-Midnight Rule, codified under the Fiscal Year 2014 Inpatient Prospective Payment System Final Rule CMS-1599-F.

The 2-Midnight Rule allows hospitals to account for total hospital time (including outpatient time directly proceeding the inpatient admission) when determining if an inpatient admission order should be written based on the expectation that the beneficiary will stay in the hospital for 2 or more midnights receiving medically necessary care. Because currently the inpatient claim only permits CMS to accurately track inpatient time after formal inpatient order and admission (i.e., utilization days/midnights), CMS would also like to use Occurrence Span Code 72 to track the total, contiguous outpatient care prior to inpatient admission in the hospital. This will enable CMS to identify claims in which the beneficiary received care as an outpatient for 1 or more midnights and was subsequently admitted as an inpatient based on the expectation that the beneficiary would require 2 or more midnights of hospital care.

Go to the link provided above and continue reading.
General Information

CMS Internet-Only Manuals (IOMs) (external link) LCD Reconsideration Process

J5 MAC A Local Coverage Determinations (LCDs)

The official Local Coverage Determination (LCD) is the version on the Medicare Coverage Database at http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx (external link). The Local Coverage Determinations (LCDs) on this website were converted from PDF files to HTML to make it easier to find an LCD using the search function. PDF versions of these LCDs are still available on the CMS website (external link). We recommend you make a note of the document ID before selecting this link as it will enable you to access the policies more quickly.

This table is sortable by LCD Title, CMS ID#, or WPS ID#. In order to sort the table, you will need to actually select the table titles.

Crosswalk to CPT/HCPCS Codes and Associated Coverage Determinations

The following table lists the Coverage Determinations that WPS Medicare currently has available and the CPT/HCPCS codes that can be found within each document. This list assists you with determining whether a procedure code has local coverage limits. All codes are also subject to National Coverage rules, medical necessity and other regulations such as CCI, MUE, ASC, National Lab restrictions, documentation/ signature requirements and other provisions. If a code is available on this list, the Coverage Determination that is associated with the code will present guidance on coverage. This listing is intended to be a helpful tool for search and document retrieval. If you are unable to find the code(s) you are specifically looking for, please review the CMS Coverage Center Website (external link) to research additional resources they have available. Website Tip: For a quick search of the codes below, select the CTRL key and "F" key. It will open a bar within your browser (either at the top or bottom of the page). Enter the code(s) you are looking for, hit the Enter key. This bar will also indicate if any results are available. http://www.wpsmedicare.com/j5macparta/policy/crosswalk-cpthcpcscodes.shtml
Temporary Instructions for Submitting Part B Claims Under Administration Ruling CMS—1455-R

http://www.cms.gov/Provider-Type/Hospital/Other-Content-Types/Quick-Reference-CMS-1455-R.pdf

- On March 13, 2013, the Centers for Medicare & Medicaid Services (CMS) issued Ruling 1455-R which establishes an interim process for hospitals to bill Medicare for Part B services following a denial of a claim for an inpatient admission as not reasonable and necessary. CMS has issued temporary billing instructions for affected providers to follow for both the Part B Types of Bills (TOB), TOB 12x and TOB 13x.

Go to the link provided above and continue reading. http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/Downloads/Accuracy-of-coding-Final-Report.pdf

**Accuracy of Coding in the Hospital-Acquired Conditions—Present on Admission Program**

Under the Hospital-Acquired Conditions—Present on Admission (HAC-POA) program, accurate coding of hospital-acquired conditions (HACs) and present on admission (POA) conditions is critical for correct payment. The purpose of the HAC-POA program, funded by the Centers for Medicare & Medicaid Services (CMS), is to evaluate the HAC-POA payment policy related to preventable HACs. The principal objective of the Accuracy of Coding component, which is the subject of this report, is to determine the level of accuracy of coding for HACs and for POA conditions. This study was conducted jointly by RTI International and Clarity Coding.

For payment purposes, for each condition there are two questions that are key to assessing the accuracy of coding:

1. Is there documented clinical evidence that a condition was present during the hospitalization? We identified unreported cases, where a HAC-associated condition existed but was not reported by the hospital.

2. If yes, was the condition POA? We identified over-reported POA cases, where a HAC-associated secondary diagnosis code was reported as POA when it was not in fact POA.

After considering a wide range of data sources and discussing priorities with the projects’ funders, we focused on three types of POAs for examining under-reporting:

1. Catheter-associated urinary tract infections (CAUTI),
2. Vascular catheter-associated infections (VCAI),
3. Deep vein thrombosis/pulmonary embolisms (DVT/PE); and

Five types of HACs for examining POA over-reporting:

1. CAUTI,
2. VCAI,
3. Falls and trauma,
4. Stage III and IV pressure ulcers, and
5. Extreme manifestations of poor glycemic control.

Go to the link provided above and continue reading.

**FACTORS TO BE CONSIDERED WHEN MAKING THE DECISION TO ADMIT INCLUDE SUCH THINGS AS:**

- The severity of the signs and symptoms exhibited by the patient;
- The medical predictability of something adverse happening to the patient;
- The need for diagnostic studies that appropriately are outpatient services (i.e., their performance does not ordinarily require the patient to remain at the hospital for 24 hours or more) to assist in assessing whether the patient should be admitted; and
- The availability of diagnostic procedures at the time when and at the location where the patient presents.

Admissions of particular patients are not covered or non-covered solely on the basis of the length of time the patient actually spends in the hospital.

Chapter 1, Section 10 of the Medicare Benefit Policy Manual is at http://www.cms.gov/manuals/Downloads/bp102c01.pdf
MANDATORY REPORTING OF 8-DIGIT CLINICAL TRIAL NUMBER

Effective January 1, 2014, it will be mandatory to report a clinical trial number on claims for items and services provided in clinical trials that are qualified for coverage as specified in the Medicare National Coverage Determination (NCD) Manual, Section 310.1.

That is the number assigned by the National Library of Medicine (NLM) http://clinicaltrials.gov/ website when a new study appears in the NLM clinical trials database.

This number is listed prominently on each specific study's page and is always preceded by the letters “NCT.”

The Centers for Medicare & Medicaid Services (CMS) uses this number to identify all items and services provided to beneficiaries during their participation in a clinical trial, clinical study, or registry. Furthermore, this identifier permits CMS to better track Medicare payments, ensure that the information gained from the research is used to inform coverage decisions, and make certain that the research focuses on issues of importance to the Medicare population.

Suppliers may verify the validity of a trial/study/registry by consulting CMS’s clinical trials/registry website at http://www.cms.gov/Medicare/Medicare-General-Information/MedicareApprovedFacilities/index.html

HOSPITAL BILLING REQUIREMENTS:

For institutional paper or direct data entry (DDE) claims, the 8-digit clinical trial number is to be placed in the value amount for paper only value code D4/DDE claim UB-04 (For Locators 39-41) when a clinical trial claim includes:

- Condition code 30;
- ICD-9 code of V70.7/ICD-10 code Z00.6 (in either the primary or secondary positions), and
- Modifier Q0 and/or Q1, as appropriate (outpatient claims only).

For institutional claims that are submitted on the electronic claim 837I, the 8-digit number should be placed in loop 2300 REF02 (REF01=P4) when a clinical trial claim includes:

- ICD-10 code Z00.6 (in either the primary or secondary positions), and
- Modifier Q0 and/or Q1, as appropriate (outpatient claims only).

Professional billing requirements:

For professional claims, the 8-digit clinical trial number preceded by the two alpha characters of CT must be placed in field 19 of the paper claim Form CMS-1500 (e.g., CT12345678) or the electronic equivalent 837P in loop 2300 REF02 (REF01=P4) when a clinical trial claim includes:

- ICD-10 code Z00.6 (in either the primary or secondary positions), and
- Modifier Q0 and/or Q1, as appropriate (outpatient claims only).

Medicare Part B clinical trial/registry/study claims with dates of service on and after January 1, 2014, not containing an 8-digit clinical trial number will be returned as unprocessed.

Note: Clinical trials that are also investigational device exemption (IDE) trials must continue to report the associated IDE number on the claim form as well.

Recovery Audit Contractors have been approved by CMS to review the following topics for 2014.

1. Incorrect Billed Drug and Biological HCPCS Code - Underpayment – Outpatient

Hospitals must report all appropriate HCPCS codes and charges for separately payable drugs, using the correct HCPCS codes for the items used. Medical documentation will be reviewed to determine that the appropriate HCPCS code was billed. (At this time, Medical Necessity will be excluded from this review.)

For claims that have a claim paid date which is less than three years prior to the ADR letter date.

2. Vertebroplasty (Percutaneous) billed without Guidance

Percutaneous Vertebroplasty is a therapeutic procedure which consists of the injection of a biomaterial (usually polymethylmethacrylate) under imaging guidance (either fluoroscopy or CT) into a cervical, thoracic, or lumbar vertebral body stabilizing the fractured vertebral body which facilitates restoring mobility and decreasing disability and pain.

For claims that have a "claim paid date" which is less than 3 years prior to the Demand Letter date.

3. Excessive Units of Endovascular Revascularization of the Femoral/Popliteal

Only one code within the range of 37220-37235 should be reported for endovascular revascularization for each extremity vessel treated. The entire femoral/popliteal territory in one lower extremity is considered a single vessel for CPT reporting specifically for the endovascular lower extremity revascularization codes 37224-37227. Therefore, CPT codes in this range may only be reported once per lower extremity.

For claims that have a "claim paid date" which is less than 3 years prior to the Demand Letter date.

4. Effective January 1, 2011, HCPCS codes G0431 and G0434 for multiple drug class screenings may only be reported once per patient encounter regardless of the number of drug classes tested.

Dates of service on or after 1/1/2011.

5. Inappropriate Use of Modifier 74

Facilities use modifier 74 to indicate that a surgical procedure was terminated after administration of anesthesia or initiation of the procedure. Facilities use modifier 73 to indicate that the surgical procedure was terminated prior to induction of anesthesia or initiation of the procedure. Procedures with modifier 74 are paid at 100% of the rate and procedures with modifier 73 are paid at 50% of the rate.

Improper payments occur when modifier 74 is billed for procedures that were terminated prior to induction of anesthesia or initiation of the procedure.

Dates of service on or after 1/1/2011.

6. Cancelled Elective Surgeries

When an inpatient hospital admission is based on the expectation that a patient will have elective surgery, but that surgery does not occur, the hospital may bill for the admission only if it remains reasonable and necessary despite the surgery's cancellation.

Claims that have a claim paid date which is less than three years prior to the ADR date.

7. Blepharoplasty - eyelid lifts

Blepharoplasty is the plastic repair of the eyelid, and usually refers to an operation in which redundant skin, muscle, and/or fat are excised. Functional blepharoplasty usually involves the excision of skin and orbicularis muscle. This procedure is usually done to correct a deficit in the upper or peripheral field of vision or as noted on forward gaze by skin resting on the upper eyelashes. When blepharoplasty repair is done for cosmetic purposes it does not meet the criteria of the functional visual impairment parameters and is considered not reasonable and medical necessary and therefore will be denied.

Claims that have a claim paid date which is less than three years prior to the ADR date.

What should you do if you receive a demand letter from First Coast Service Options, Wisconsin Physician Services, Office of Inspector General, Centers for Medicare and Medicaid Services, AHCA, or any other government related demand?

As soon as possible, please contact Lilian Eymann, Associate Director for the Office of Billing Compliance at: leymann@med.miami.edu
8. Intensity-Modulated Radiation Therapy (IMRT)

Intensity-Modulated Radiation Therapy (IMRT) is a computer-based method of planning for, and delivery of, generally narrow, patient-specific and often temporally modulated beams of radiation to solid tumors within a patient. IMRT is only covered for certain diagnosis and when certain conditions are met.

Claims that have a claim paid date which is less than three years prior to the ADR date


In accordance with The American Taxpayer Relief Act of 2012 (ATRA) signed into law by President Obama on January 2, 2013, reviews will be conducted on outpatient therapy claims in Outpatient Rehabilitation Facility settings reaching the $3,700 threshold for PT and SLP services combined and/or $3,700 for OT services. When one or more lines of a claim have reached a therapy threshold, all lines of therapy services on that claim are subject to review.

Dates of service on and after January 1, 2013

CERT finding of improper payments for psychiatry and psychotherapy services


Effective date: n/a
Implementation date: n/a

Summary
The comprehensive error rate testing (CERT) program review of claims for Part B psychiatry and psychotherapy services identified many improper payments, mostly due to updates to billing codes initiated in January 2013. According to the Centers for Medicare & Medicaid Services (CMS), major changes to the American Medical Association’s (AMA) Current Procedural Terminology (CPT®) codes contributed to significant improper payments in evaluation and management services provided Medicare beneficiaries. Most of the errors cited in the CERT review involved the failure to document the time spent on the evaluation and management (E&M) service separately from the time spent on the add-on psychotherapy service. To improve your billing of psychiatry and psychotherapy services, please review special edition MLN Matters® article Go to the link provided above and keep reading.

Transcatheter Aortic Valve Replacement – Permanent Code

http://medicare.fesco.com/Publications_A/265457.pdf

Provider types affected
This MLN Matters® article is intended for physicians, providers, and suppliers submitting claims to Medicare administrative contractors (MACs) for transcatheter aortic valve replacement (TAVR) services to Medicare beneficiaries.

Provider action needed
This article is based on change request (CR) 8537 which informs MACs that the Centers for Medicare & Medicaid Services (CMS) is retiring the remaining temporary Current Procedural Terminology® (CPT®) code 0318T and replacing it with permanent CPT® code 33366, effective January 1, 2014. Make sure that your billing staffs are aware of these changes.

Local Coverage Determinations – Revised, New and Deleted
Refer to our LCDs/Medical coverage Web page at http://medicare.fesco.com/Landing/139800.asp for full-text LCDs, including final LCDs, draft LCDs available for comment, LCD statuses, and LCD comment/response summaries.

Effective and notice dates
Effective dates are provided in each LCD, and are based on the date services are furnished unless otherwise noted in the LCD. Medicare contractors are required to offer a 45-day notice period for LCDs; the date the LCD is posted to the website is considered the notice date.
The full list of I/OCE specifications is available at [http://www.cms.gov/Medicare/Coding/OutpatientCodeEdit/index.html](http://www.cms.gov/Medicare/Coding/OutpatientCodeEdit/index.html) on the Centers for Medicare & Medicaid Services (CMS) website. There is a summary of the changes for January 2014 in Appendix M of Attachment A of CR 8548 and that summary is captured in the following key points.

Effective January 1, 2014, (except as noted below) Medicare will: Modify extended assessment and management (EAM) composite ambulatory payment classification (APC) assignment criteria (appendix K) by:
- Deleting composite APCs 8002 and 8003
- Adding new EAM composite 8009
- Deactivate special logic to make separate payment for certain skin substitute products when billed with specified skin substitute application procedures (appendix N).
- Implement new edit to require that specific skin substitute products (high cost vs. low cost) be submitted with specific skin substitute application procedures (appendix N). Edit 87 is affected. **Edit description:** Skin substitute application procedure without appropriate skin substitute product code (return to provider (RTP)) **Edit criteria:** A list A skin substitute application procedure is submitted without a list A skin substitute product; or a list B skin substitute application procedure is submitted without a list B skin substitute product on the same date of service.
- Change the status indicator (SI) from N to A for any laboratory code (code list) submitted on 14x bill type. Deactivate the logic for assignment of payment adjustment flags 7 and 8 with modifiers FB and FC for offset payment reduction. Deactivate payment adjustment flags 7 and 8. Modify edit 75 (Incorrect billing of modifier FB or FC) to apply if modifier FB or FC is submitted on any line/any SI on a claim. line/any SI on a claim.
- Deactivate edit 78 (Nuclear medicine)- Claim lacks required radiolabeled product. Deactivate edit 85 (Claim lacks required device code or required procedure code). Add code 97610 to the ‘Sometimes Therapy’ list/logic (Change SI to A if submitted with a therapy revenue code or therapy modifier).
- Implement mid-quarter Food and Drug Administration (FDA) approval coverage for code 90688. Edit 67 is affected.

**CODES**

### BLOOD PRODUCTS


### Coding

**MAJOR CC LIST - FY 2014**

FY2014-FR-MAJOR-CC-LIST-6I-071213.pdf

**Complete CC LIST - FY 2014**


### CODES

**LIST OF MEDICARE SEVERITY DIAGNOSIS-RELATED GROUPS (MS-DRGS), RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—FY 2014 Final**

[http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/FY_14_FR_Table_5.zip](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/FY_14_FR_Table_5.zip)

**CODES**

Transfusion medicine codes are: 86850, 86860, 86870, 86880, 86885, 86886, 86890, 86891, 86900, 86901, 86903, 86904, 86905, 86906, 86920, 86921, 86922, 86923, 86927, 86930, 86931, 86932, 86945, 86950, 86960, 86965, 86970, 86971, 86972, 86975, 86976, 86977, 86978, and 86985.
Compliance Corner

2014 HCPCS local coverage determination changes

Procedure codes have been added, revised, replaced and deleted accordingly:

**LCD Title Changes**

Deleted CPT® code 64613 and 64614
Added CPT® code 64616, Botulinum Toxins (Coding Guidelines only)

Deleted HCPCS code Q2051
Added HCPCS code J3489, the Treatment of Osteoporosis and Their Other Indications

Bisphosphonates (Intravenous [IV]) and Monoclonal Antibodies in the Treatment of Osteoporosis and Their Other Indications

Deleted HCPCS code Q2051 Added HCPCS code J3489

**Botulinum Toxins (Coding Guidelines only)**

Deleted CPT® codes 64613 and 64614
Added CPT® codes 64616, 64617, 64642, 64643, 64644, 64645, 64646, and 64647

Deleted HCPCS code C9130
Added HCPCS code J1556, Intravenous Immune Globulin

Deleted HCPCS code Q3025
Added HCPCS code Q3027, Intensity Modulated Radiation Therapy (IMRT)

Added CPT® code 77293 Descriptor change for CPT® code 77295

Deleted CPT® codes 43255 and 43256, 43266, and 43270
Descriptor change for CPT® codes 43201 and 43236

**CARDIOVASCULAR NUCLEAR IMAGING STUDIES**

Deleted HCPCS code 0152 Added HCPCS code 0151

**Diagnostic and Therapeutic Endoscopy**

Deleted CPT® code 43258 Added CPT® codes 43233, 43253, 43254, 43266, and 43270
Descriptor change for CPT® codes 43235-43239, 43241, 43243-43251, and 43255

Deleted CPT® codes 77031 and 77032

**Botulinum Toxins (Coding Guidelines only)**

Deleted CPT® code 86628

**Single and dual chamber cardiac pacemakers**


As identified through CERT (Comprehensive Error Rate Testing, the Medicare national program to assess claim(s) payment error rates) and First Coast Service Options Inc. (First Coast) pre-payment medical review of claims for single and dual chamber cardiac pacemakers, it is determined that medical documentation of these claims demonstrates patients are not meeting the criteria for coverage for dual chamber cardiac pacemakers as outlined in the National Coverage Determination (NCD) 20.8.

The NCD for cardiac pacemakers includes language for the indications for dual chamber cardiac pacemakers, which requires providers to justify in the medical record the insertion of a dual chamber cardiac pacemaker over a single chamber cardiac pacemaker. The specific coverage criteria for dual chamber cardiac pacemakers are as follows:

1. Patients in whom single chamber (ventricular pacing) at the time of pacemaker insertion elicits a definite drop in blood pressure, retrograde conduction, or discomfort.
2. Patients in whom the pacemaker syndrome (atrial ventricular [AV] asynchrony), with significant symptoms, has already been experienced with a pacemaker that is being replaced.
3. Patients whom even a relatively small increase in cardiac efficiency will importantly improve the quality of life, e.g., patients with congestive heart failure despite adequate other medical measures.
4. Patients in whom the pacemaker syndrome can be anticipated, e.g., in young and active people, etc.

Whenever the following conditions (which represent overriding contraindications) are present, dual chamber pacemakers are not covered:

1. Ineffective atrial contractions (e.g., chronic atrial fibrillation or flutter, or giant left atrium).
2. Frequent or persistent supraventricular tachycardias, except where the pacemaker is specifically for the control of the tachycardia.
3. A clinical condition in which pacing takes place only intermittently and briefly, and which is not associated with a reasonable likelihood that pacing needs will become prolonged, e.g., the occasional patient with hypersensitive carotid sinus syndrome with syncope due to bradycardia and unresponsive to prophylactic medical measures.
4. Prophylactic pacemaker use following recovery from acute myocardial infarction during which there was temporary complete (third-degree) and/or Type II second-degree AV block in association with bundle branch block.

All other indications for dual chamber cardiac pacing for which the Centers for Medicare & Medicaid Services (CMS) has not specifically indicated coverage remain nationally non-covered, except for Category B Investigational Device Exemptions (IDE) clinical trials, or as routine costs of dual chamber cardiac pacing associated with clinical trials, in accordance with CMS Clinical Trial Policy contained in the Medicare NCD Manual, CMS Internet-only manual (IOM) Publication 100-03, chapter 1, section 310.1 on the CMS website.

Providers can also access the CMS CERT Cardiac Pacemaker Fact Sheet released in December 2010.

First Coast, the Jurisdiction 9 Medicare administrative contractor (J9 MAC) recommends physician and allied health providers be familiar with the language in the NCD when determining the need for and when documenting the medical justification for insertion of a dual chamber versus single chamber cardiac pacemaker.
For more resources, you may visit the Office of Billing Compliance Web Page at www.obc.com

If you have any questions on Coding, Billing and Documentation or compliance concerns you may call our office at 305-243-5842

Email address: officeofbillingcompliance@med.miami.edu

or call our Toll Free 1-877-415-HELP(4357).

Calls may remain anonymous.

Our On-line Billing Compliance Educational Program by accessing the Ulearn website at: www.Ulearn.miami.edu.

Coding, Billing and Documentation Training Modules (CBLs) available of the Professional Component:

- Billing Compliance Training Fraud Waste and Abuse
- Critical Care Services
- Evaluation and Management (E&M) Services Module I
- Evaluation and Management (E&M) Services Module II
- Major Surgery Global Fee and Minor Surgery Rules
- Medicare Rule for Teaching Physicians
- Psychiatry Services
- Routine Costs in Clinical Trials Billing Guidelines
- Diagnostic Tests Billing Guidelines

For Residents, Fellows and other non-UM employees the links to the CBLs are as follows:

- http://pdto.miami.edu/external/compliance CriticalCareServiceWeb/index.html
- http://pdto.miami.edu/external/compliance/EMServices_Module1Web/index.html
- http://pdto.miami.edu/external/compliance/EMServices_Module2Web/index.html
- http://pdto.miami.edu/external/compliance/MajorSurgeryGlobalFeeWeb/index.html
- http://pdto.miami.edu/external/compliance/MedicareRuleWeb/index.html
- http://pdto.miami.edu/external/compliance/PsychiatryWeb/index.html

Hospital Compliance Training Modules (CBLs)

- Hospital Compliance Orientation
- Billing Compliance Training
- Observation Billing & Documentation Guidelines
- Facility Fee – Clinic Visits Billing & Documentation Guidelines
- An Important Message from Medicare
- Inpatient Hospital Services
- Advanced Beneficiary Notice (ABN)
Live Coding, Billing and Documentation Educational Sessions

February 25, 2014 from 7am to 8am at the Mailman Center 8th Floor Auditorium — Medicine: Gastroenterology
February 25, 2014 from 5pm to 6pm at the Mailman Center 8th Floor Auditorium — Medicine: Cardiology
February 26, 2014 from 7am to 8am at the JMH West Wing 279 Auditorium — Interventional Radiology
February 26, 2014 from 9:15am to 10:15am at the Highland Professional Building, Classroom 418 — Family Medicine
February 26, 2014 from 5pm to 6pm at the Mailman Center 8th Floor Auditorium — General Medicine and all Other Specialties
March 5, 2014 from 7am to 8am at the Mailman Center 8th Floor Auditorium — Medicine: Hematology/Oncology
March 5, 2014 from 12pm to 1pm at SCCC 1537 — Radiation/Oncology
March 6, 2014 from 7am to 8am at CRB 989 — Otolaryngology
March 6, 2014 from 5pm to 6pm at the Mailman Center 8th Floor Auditorium — Ortho/Rehab
March 7, 2014 from 7am to 8am at CRB 989 — Interventional Radiology
March 7, 2014 from 12pm to 1pm at CRB 989 — UMH Primary Care
March 7, 2014 from 4pm to 5pm at CRB 989 — Neurology
March 17, 2014 from 7am to 8am at the Mailman Center 8th Floor Auditorium — Diagnostic Radiology
March 17, 2014 from 12pm to 1pm at the Mailman Center 8th Floor Auditorium — Pediatrics
March 17, 2014 from 5pm to 6pm at the Mailman Center 8th Floor Auditorium — Rehab Medicine
March 18, 2014 from 8am to 9am at SCCC 1537 — Radiation/Oncology
March 19, 2014 from 7am to 8am at the Mailman Center 8th Floor Auditorium — Diagnostic Radiology
March 19, 2014 from 12pm to 1pm at the Mailman Center 8th Floor Auditorium — Pediatrics
April 14, 2014 from 3pm to 4pm at the Mailman Center 8th Floor Auditorium — Surgery
April 15, 2014 from 8:30am to 9:30am at the Mailman Center 8th Floor Auditorium — Psychiatry
April 15, 2014 from 4pm to 5pm at the Mailman Center 8th Floor Auditorium — Surgery
April 28, 2014 from 12pm to 1pm at the Holtz Large Conference Room 2034 — Pathology
April 28, 2014 from 3pm to 4pm at the Mailman Center 8th Floor Auditorium — Surgery
April 29, 2014 from 7am to 8am at the Mailman Center 8th Floor Auditorium — Medicine
April 29, 2014 from 12pm to 1pm at the Mailman Center 8th Floor Auditorium — Pediatrics
April 29, 2014 from 4pm to 5pm at the Mailman Center 8th Floor Auditorium — Genetics
April 30, 2014 from 7am to 8am at CRB 1179 Conference Room — OBGYN
April 30, 2014 from 5pm to 6pm at the Mailman Center 8th Floor Auditorium — Ortho/Rehab