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SGR STATUS UPDATE

A congressional conference committee composed of Senate and House members from both parties will convene the week of Jan. 23 to discuss legislation to prevent the 27.4 percent Medicare physician payment cut scheduled for March 1. The committee will also tackle the more controversial extension of unemployment benefits and a cut in the Social Security payroll tax for another year. Lawmakers could not reach common ground on these issues in December 2011 when they approved a 2-month extension until Feb. 29 to avoid disruptions on Jan. 1 and provide time for further negotiations on a larger legislative package.
TOP 8 GOVERNMENT ISSUES FOR PRACTICE EXECUTIVES TO WATCH IN 2012

1. VERSION 5010 TRANSITION
Jan. 1 was the compliance deadline to use Version 5010 standards for electronic claims and other HIPAA transactions. MGMA research indicated that some practice trading partners, including practice management system vendors and health plans, were not able to meet the deadline. Under pressure from MGMA and others, the Department of Health & Human Services (HHS) provided an enforcement delay and contingency plan for the first quarter of 2012, during which time practices may continue to send HIPAA Version 4010 transactions, under certain circumstances. MGMA continues to urge HHS to monitor industry progress and implement a more robust contingency plan should practices not be ready by Mar. 31. For more information regarding the HHS contingency plan and how to prepare your practice for Version 5010, visit MGMA’s Version 5010 Resource Center or the CMS website.

2. E-PRESCRIBING PENALTIES BEGIN IN 2012
A 1 percent penalty will be levied in 2012 for physicians who are eligible for the Medicare e-prescribing program and did not successfully e-prescribe in 2011 or have a hardship exemption request approved by the Centers for Medicare & Medicaid Services (CMS). E-prescribing penalties increase to 1.5 percent in 2013 and to 2.0 percent in 2014. It is important to note that e-prescribing activity in 2012 can help physicians avoid penalties in 2013 and 2014. CMS finalized different hardship exemptions for 2013 and 2014 from the exemptions available for the 2012 penalty. For the purposes of avoiding the 2013 and 2014 penalty, the agency also removed a requirement that physicians must e-prescribe in association with specific visits or “denominator codes.” Practices should carefully review the criteria from CMS to avoid these penalties.

3. COUNTDOWN TO ICD-10
The healthcare industry has been focused on transitioning to HIPAA Version 5010 electronic transaction standards, but 5010 is only a stepping stone to implement ICD-10, the new diagnosis code set. The industry must transition from ICD-9 to ICD-10 by Oct. 1, 2013. This new code set is vastly more complex than the current ICD-9 system, and transitioning to the expanded code set will have a significant impact on medical practices, both in terms of implementation costs and workflow disruptions.

4. CONTINUED EMPHASIS ON COMPLIANCE
Both Congress and CMS continue to focus on curbing fraud, waste and abuse in public health programs, such as Medicare and Medicaid. Medicare recovers more than $7 for every $1 spent on fraud investigations, according to government data. Group practices should be prepared for new compliance initiatives, such as Medicare enrollment revalidation requirements. Expect more upfront scrutiny instead of so-called “pay and chase” efforts from the government. During 2012, HHS may finalize long-awaited rules on new privacy requirements that stem from the 2009 Health Information Technology for Economic and Clinical Health Act. Additionally, the Recovery Audit Contractor (RAC) program will focus more on Medicare Part B payments as auditors exhaust Medicare Part A audit opportunities.
5. THE SUPREME COURT HEARING ON ACA

Justices will hear challenges to the constitutionality of the 2010 healthcare reform bill, the Patient Protection and Affordable Care Act (ACA). Oral arguments are scheduled for March 26–28, when justices will consider the constitutionality of the individual mandate and related penalties, Medicaid expansion and whether parts of the law could be repealed without striking down the entire law. A decision is expected in June.

6. CMS EXPLORES ALTERNATIVE PAYMENT MODELS

The Center for Medicare & Medicaid Innovation (CMMI) and CMS continue to explore payment models that move away from the current fee-for-service reimbursement method. In 2012, the Medicare Shared Savings Program begins testing the concept of accountable care and provides the first opportunity for broad participation in Medicare accountable care organizations (ACOs). A number of other smaller scale initiatives and demonstrations begin in 2012, such as the Comprehensive Primary Care Initiative, Bundled Payments for Care Improvement Initiative and Pioneer ACO demonstration. Each of these projects will test alternative ways to pay providers and are designed to encourage high quality, coordinated care. These efforts may build a foundation on which to move away from the fee-for-service model. During 2012, CMS and CMMI will also develop a larger scale bundling pilot for acute care, which is mandated in 2013.

7. FOCUS ON SITE OF SERVICE PAYMENT DIFFERENTIALS

The Medicare Payment Advisory Commission and Congress are taking a closer look at payment differences for identical services across delivery settings, including the difference between payments made to hospitals and physician practices. Expect further scrutiny as lawmakers consider reductions to hospital outpatient facility fees in an effort to align payment levels with those for care delivered in physician offices.

8. EHR MEANINGFUL USE INCENTIVES CONTINUE

MEDICAID

CMS releases FAQs on Medicaid RACs

The Centers for Medicare & Medicaid Services (CMS) recently released guidance on the Medicaid Recovery Audit Contractor (RAC) program. The Affordable Care Act contains a provision requiring all state Medicaid programs to establish a RAC program to audit claims for services furnished by Medicaid providers. In its final rule on the issue, CMS requires states to implement their RAC programs by Jan. 1, 2012, meaning the state must have a contract in place with a RAC vendor unless the state applied for an exception. CMS published Frequently Asked Questions to provide operational guidance to the states and share general information about the Medicaid RAC program. Topics covered include the type of information states should furnish to providers regarding their RAC programs, the types of claims to be audited and coordinating Medicaid RAC audits with other government audits.

Fluoride Varnish

Oral evaluation and fluoride varnish application are preventive services which should be provided within six months of eruption of the first primary tooth, especially to high risk patients. Medicaid covers the application of fluoride varnish when provided to Medicaid-eligible children in a physician’s office. Physicians, physician assistants, and advanced registered nurse practitioners may provide this service and bill Medicaid using CPT procedure code 99499 SC.

Fluoride varnish may be applied to a child’s teeth at the time of the CHCUP visit. Medicaid reimbursement for 99499 SC is $27.00 for both the application of fluoride varnish and the oral evaluation for a child 6 months to 3 1/2 years of age. The CHCUP visit should also include counseling the child’s caregiver.
**Dental Referrals**
Dental referrals are required beginning at 3 years of age or earlier as medically indicated. CHCUP providers must refer Medicaid children who are 3 years of age and older for an assessment by a dentist and document the referral. The provider may refer a younger child if it is medically necessary. Following the initial dental referral, subsequent visits to a dentist are recommended every 6 months, or more frequently as prescribed by a dentist or other authorized provider.

**Blood Lead Testing**
Performing a blood test for lead is a federal requirement at specific intervals during the CHCUP. This note is to remind you how important it is to document the blood tests you are performing. Failure to provide documentation can lead to a federal audit and the requirement to repay Medicaid for fees received. The federal regulation as referenced in the Child Health Check-Up Coverage and Limitations Handbook, October 2003, pages 2-13, 2-14 and 3-6, requires that all Medicaid children receive a screening blood lead test at the ages of 12 months and 24 months, and between the ages of 36 months and 72 months if they have not been previously screened for lead poisoning. The procedure code for blood lead testing is 83655. You can find more information about this program in the Child Health Check-Up Coverage and Limitations Handbook. [http://portal.flmmis.com/FLPublic/Portals/0/StaticContent/Public/HANDBOOKS/Child_Health_Check-UpHB.pdf](http://portal.flmmis.com/FLPublic/Portals/0/StaticContent/Public/HANDBOOKS/Child_Health_Check-UpHB.pdf)

**2012 ICD-10-CM Code Updates Now Available**
The Centers for Medicare & Medicaid Services (CMS) has posted the 2012 ICD-10-CM code updates to the CMS website, including the 2012 ICD-10-CM index and tabular, code titles, addendum, general equivalence mappings (GEMs), and reimbursement mappings files. The 2012 ICD-10-CM files contain information on the new diagnosis coding system, ICD-10-CM, that is being developed as a replacement for ICD-9-CM, volumes 1 and 2. These files are available on the 2012 ICD-10-CM and GEMs Web page at [http://www.cms.gov/ICD10/11b15_2012_ICD10PCS.asp](http://www.cms.gov/ICD10/11b15_2012_ICD10PCS.asp). To access the files, scroll to the bottom of the page to the “Downloads” section.

**2012 CPT Coding Update for Radiology**
**Sacral Joint Injection**
The description for the SI joint code 27096 has been revised to include imaging guidance, both fluoroscopy and CT, as well as arthrography when performed.

<table>
<thead>
<tr>
<th>SI Joint Injection</th>
<th>27096</th>
<th>Injection procedure for sacroiliac joint, anesthetic/steroid, with image guidance (fluoroscopy or CT) including arthrography when performed.</th>
</tr>
</thead>
</table>

The parenthetical note has also been revised to specify code 27096 is only to be used with CT or fluoroscopic imaging confirmation of intra-articular needle positioning. Because of the revision made to code 27096 “including arthrography when performed”, code 73542 Radiological examination, sacroiliac joint arthrography, radiological supervision and interpretation has been deleted. No changes have been made to the codes for arthograms performed at other sites.
There are several CPT codes that are now marked by a “bulls-eye” indicating that moderate conscious sedation is included in the procedure and is not coded separately.

**PROCEDURES INCLUDING MODERATE SEDATION**

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>32405</td>
<td>Biopsy of lung or mediastinum, percutaneous needle</td>
</tr>
<tr>
<td>36200</td>
<td>Introduction of catheter, aorta</td>
</tr>
<tr>
<td>36245</td>
<td>Selective catheter placement, arterial system; each first order abdominal, pelvic, or lower extremity artery branch, within a vascular family</td>
</tr>
<tr>
<td>36246</td>
<td>Selective catheter placement, arterial system; initial second order abdominal, pelvic, or lower extremity artery branch, within a vascular family</td>
</tr>
<tr>
<td>36247</td>
<td>Selective catheter placement, arterial system; initial third order abdominal, pelvic, or lower extremity artery branch, within a vascular family</td>
</tr>
<tr>
<td>36248</td>
<td>Selective catheter placement, arterial system; additional second order, third order and beyond, abdominal, pelvic, or lower extremity artery branch, within a vascular family</td>
</tr>
<tr>
<td>47000</td>
<td>Biopsy of liver, needle; percutaneous</td>
</tr>
</tbody>
</table>

**LUMBAR X-RAY**

Two of the CPT codes for reporting lumbar x-rays were revised to clearly define the number of views for each code and to accurately reflect the work performed.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>72114</td>
<td>Radiologic examination, spine lumbosacral; complete, including bending views, minimum of 6 views</td>
</tr>
<tr>
<td>72120</td>
<td>Radiologic examination, spine, lumbosacral; bending views only, 2 or 3 views</td>
</tr>
</tbody>
</table>

To report code 72114 the total number of views taken must be at least 6, and of those 6 views bending views must be taken. Bending views are not reported separately and are included in the 6 view study when performed in conjunction with other views. Bending views performed in conjunction with any other types of views are reported with the appropriate code selection determined by the total number of views. For example, if a 5 view study is performed and those views include bending views, code 72110 is reported for a minimum of 4 views study.

For those instances in which only bending views are taken, code 72120 is reported. Note the number of views required to assign code 72120 has been reduced from a minimum of 4 views, to only 2 or 3 views.
Codes 78220 and 78223 were deleted and replaced with 78226 and 78227 because the code descriptions no longer reflect current clinical practice.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>78226</td>
<td>Hepatobiliary system imaging, including gallbladder when present</td>
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<tr>
<td>78227</td>
<td>Hepatobiliary system imaging, including gallbladder when present; with pharmacologic intervention, including quantitative measurement(s) when performed</td>
</tr>
</tbody>
</table>

Code 78227 is assigned when imaging is performed in conjunction with assessment of gallbladder and hepatic function. These studies measure gallbladder ejection fraction, and are commonly referred to as a HIDA scan. Code 78226 is used to report studies where imaging is performed alone.

**Pulmonary Ventilation/Perfusion Imaging**

For 2012, the codes utilized for reporting pulmonary ventilation and perfusion studies have been simplified. There were two purposes for revising these codes – first, to clarify that the codes may be used when imaging is performed with use of either aerosol or gas, and second, to eliminate confusion regarding pulmonary function quantification by differentiating between ventilation studies and perfusion studies. Each of the codes that have been added or revised within this section identify services that should be distinctly identified according to the type of testing that is done (ventilation vs. perfusion) and not according to the type of product being tested (gas vs. aerosol).

<table>
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<tr>
<th>Code</th>
<th>Description</th>
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<tr>
<td>78579</td>
<td>Pulmonary ventilation imaging (eg, aerosol or gas)</td>
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<tr>
<td>78580</td>
<td>Pulmonary perfusion imaging (eg, particulate)</td>
</tr>
<tr>
<td>78582</td>
<td>Pulmonary ventilation (eg, aerosol or gas) and perfusion imaging</td>
</tr>
<tr>
<td>78597</td>
<td>Quantitative differential pulmonary perfusion, including imaging when performed</td>
</tr>
<tr>
<td>78598</td>
<td>Quantitative differential pulmonary perfusion and ventilation (eg, aerosol, gas) including imaging when performed</td>
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</tbody>
</table>

For 2012, codes in the range from 78584-78596 have been deleted, and several new codes have been introduced to report pulmonary perfusion and ventilation studies. Here is a summary of the work involved with each study:

- Code 78579 is reported for a diagnostic imaging study performed with the use of a radiopharmaceutical that records the bronchopulmonary distribution of an inhaled radioactive aerosol or gas within the lungs. The patient performs breathing according to specific instructions while images are taken in multiple positions.
- Revised code 78580 is reported for an imaging study performed with a radiopharmaceutical that records distribution of pulmonary arterial blood flow in the lungs.
- Code 78552 is a “combination” code representing the work described by both codes 78579 and 78580.
- Code 78597 is reported for a quantitative lung perfusion study performed with the use of a radiopharmaceutical and measures relative distribution of pulmonary arterial blood flow in each lung. Quantitative evaluation of images are reported.
- Code 78598 represents the same work as 78597, only with a ventilation study added.
New introductory language was added to CPT for coding “Diagnostic Studies of AV Shunts for Dialysis” and “Interventions for AV Shunts Created for Dialysis.” The language added to CPT is consistent with the instruction that has been set forth by the Society for Interventional Radiology, American College of Radiology and the American Medical Association in other prior publications.

A few noteworthy points provided for clarification on how to code these interventions are:

- The arterial inflow is considered a separate vessel from the graft; therefore if additional catheter work and imaging must be done for evaluation of a more proximal inflow problem separate from the peri-anastomotic segment, the work is not included in 36147.
- If the catheter is advanced from the AV shunt puncture into the inflow artery, an additional catheterization code (36215) may be reported.

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**Revascularization**

In 2011, there was a complete overhaul of coding for therapeutic interventions performed in the lower extremities. For 2012, there are only some minor changes that were made to the introductory notes for revascularization procedures. Points clarified in the section are:

- The specific types of revascularization procedures represented by these codes:
  - Percutaneous Transluminal Angioplasty: low profile, cutting balloon, cryoplasty
  - Atherectomy: directional, rotational, laser
  - Stenting: balloon-expandable, self-expanding, bare metal, covered, drug eluting
- Closure of arteriotomy by suture is included as well as closure by placement of a closure device.
- Each code includes an angioplasty when performed.
- Extensive repair or replacement of an artery may be additionally reported.
Beginning January 1, 2012, there will be 101 additional molecular pathology procedure test codes released by the American Medical Association. For payment purposes under the clinical laboratory fee schedule, these test codes will be assigned a “B” indicator – “Payment for covered services are always bundled into payment for other services not specified. There will be no RVUs or payment amounts for these codes and no separate payment is ever made. When these services are covered, payment for them is subsumed by the payment for the services to which they are incident (an example is a telephone call from a hospital nurse regarding care of a patient).” However, each of these new molecular pathology Procedure test codes represents a test that is currently being used and which may be billed to Medicare. When these types of tests are billed to Medicare, CMS understands that existing Current Procedural Terminology (CPT) test codes are “stacked” to represent a given test. For example, Laboratory A has a genetic test that is generally billed to Medicare as follows in order to represent the performance of the entire test:
- 83891 (one time) + 83898 (multiple times) + 83904 (multiple times) + 83909 (multiple times) + 83912 (one time).

If the new CPT test coding structure were active, Laboratory A would bill Medicare the new, single CPT test code that corresponds to the test represented by the “stacked” codes in the example above rather than billing each component of the test separately.

As of January 1, 2012, Medicare requests that Medicare claims for Molecular Pathology Procedures reflect both the existing CPT “stacked” test codes that are required for payment and the new single CPT test code that would be used for payment purposes if the new CPT test codes were active. Referring to the example above, Laboratory A would report the existing stacked set of codes that are required to receive payment, as follows:
- 83891 (one time) + 83898 (multiple times) + 83904 (multiple times) + 83909 (multiple times) + 83912 (one time) along with the new, single CPT test code that corresponds to the test represented by the “stacked” test codes.

While the allowed charge amount will be $0.00 for the new molecular pathology procedure test codes that carry the “B” indicator, Medicare requests that Medicare claims also reflect a charge for the non-payable service.

### THE TABLE BELOW CONTAINS THE CY 2012 MOLECULAR PATHOLOGY PROCEDURE TEST CODES:

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### Pricing information

The CY 2012 clinical laboratory fee schedule includes separately payable fees for certain specimen collection methods (codes 36415, P9612, and P9615). The fees have been established in accordance with Section 1833(h) (4)(B) of the Act.
Preventive services educational resources for health care professionals

Educational products for health care professionals

The Medicare Learning Network® (MLN) offers a variety of educational products to help you understand coverage, coding, reimbursement, and billing information related to these services.

1. MLN preventive services products for health care professionals


   • Quick Reference Information: Preventive Services – this educational tool is designed to provide education on the Medicare-covered preventive services. It is available as a downloadable PDF at http://www.cms.gov/MLNProducts/downloadsMPS_QuickReferenceChart_1.pdf.

   • Quick Reference Information: Medicare Part B Immunization Billing – this educational tool is designed to provide education on Medicare-covered preventive immunizations. It is available in print and as a downloadable PDF at http://www.cms.gov/MLNProducts/downloadsqr_immun_bill.pdf.

   • Tobacco-Use Cessation Counseling Services
   
   To view the downloadable PDFs for these products, visit the Preventive Services Educational Products Web page at http://www.cms.gov/MLNProducts/Downloads/education_products_prevserv.pdf.

   • MLN Preventive Services Educational Products Web page – this MLN Web page provides descriptions of all MLN preventive service-related educational products and resources designed specifically for Medicare FFS health care professionals. This Web page is available at http://www.cms.gov/MLNProducts/35_PreventiveServices.asp.

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• Preventive brochures and fact sheets – in addition, the MLN offers the following brochures and fact sheets:
  
  - Annual Wellness Visit
  - Bone Mass-Measurements
  - Cancer Screenings
  - Diabetes-Related Services
  - Expanded Benefits
  - Human Immunodeficiency Virus Screening
  - Mass Immunizers and Roster Billing
  - Preventive Immunizations

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2. Other CMS resources

- Prevention General Information Overview Web page is available at http://www.cms.gov/PrevntionGenInfo.

Screening and behavioral counseling interventions in primary care to reduce alcohol misuse

Effective for claims with dates of service October 14, 2011, and later, CMS shall cover annual alcohol screening, and for those that screen positive, up to four, brief, face-to-face behavioral counseling interventions per year for Medicare beneficiaries, including pregnant women: Who misuse alcohol, but whose levels or patterns of alcohol consumption do not meet criteria for alcohol dependence (defined as at least three of the following: tolerance, withdrawal symptoms, impaired control, preoccupation with acquisition and/or use, persistent desire or unsuccessful efforts to quit, sustains social, occupational, or recreational disability, use continues despite adverse consequences); and,

- Who are competent and alert at the time that counseling is provided; and,
- Whose counseling is furnished by qualified primary care physicians or other primary care practitioners in a primary care setting.

Each of the four behavioral counseling interventions must be consistent with the 5As approach that has been adopted by the USPSTF to describe such services:

1. **Assess**: Ask about/assess behavioral health risk(s) and factors affecting choice of behavior change goals/methods.
2. **Advise**: Give clear, specific, and personalized behavior change advice, including information about personal health harms and benefits.
3. **Agree**: Collaboratively select appropriate treatment goals and methods based on the patient’s interest in and willingness to change the behavior.
4. **Assist**: Using behavior change techniques (self-help and/or counseling), aid the patient in achieving agreed upon goals by acquiring the skills, confidence, and social/environmental supports for behavior change, supplemented with adjunctive medical treatments when appropriate.
5. **Arrange**: Schedule follow-up contacts (in person or by telephone) to provide ongoing assistance/support and to adjust the treatment plan as needed, including referral to more intensive or specialized treatment.

**Note:** Two new G codes, G0442 (annual alcohol misuse screening, 15 minutes), and G0443 (brief face-to-face behavioral counseling for alcohol misuse, 15 minutes), are effective October 14, 2011, and will appear in the January quarterly update of the Medicare physician fee schedule database (MPFSDB) and integrated outpatient code editor (IOCE). For claims with dates of service on or after October 14, 2011, through December 31, 2011, your Medicare contractor will use their pricing to pay for G0442 and/or G0443.

Deductible and coinsurance do not apply. Contractors will hold institutional claims received prior to April 2, 2102, with TOBs 13x, 71x, 77x, and 85x and release those claims beginning April 2, 2012.

For the purposes of this covered service, the following provider specialty types may submit claims for G0442 and G0443:

- 01 – General practice
- 08 – Family practice
- 11 – Internal medicine
- 16 – Obstetrics/gynecology
- 37 – Pediatric medicine
- 38 – Geriatric medicine
- 42 – Certified nurse midwife
- 50 – Nurse practitioner
- 89 – Certified clinical nurse specialist
- 97 – Physician assistant

For purposes of this covered service, the following place of service (POS) codes are applicable:

- 11 – Physician’s office
- 22 – Outpatient hospital
- 49 – Independent clinic
- 71 – State or local public health clinic
Screening for depression in adults

Effective October 14, 2011, Medicare covers annual screening for adults for depression in the primary care setting that has staff-assisted depression care supports in place to assure accurate diagnosis, effective treatment, and follow-up.

Medicare contractors will recognize new Healthcare Common Procedure Coding System (HCPCS) code, G0444, annual depression screening, 15 minutes, as a covered service.

**Note:** This code will appear on the January 2012 Medicare physicians fee schedule update. Beneficiary coinsurance and deductibles do not apply to claim lines with annual depression screening, G0444. For dates of service on or after October 14, 2011, through December 31, 2011, Medicare contractors will use their pricing for paying G0444 and update their HCPCS files accordingly.

The following criteria are met:
- Reasonable and necessary for the prevention or early detection of illness or disability;
- Recommended with a grade of A or B by the United States Preventive Services Task Force (USPSTF); and
- Appropriate for individuals entitled to benefits under Part A or enrolled under Part B.

Screening for depression in adults is recommended with a grade of B by the USPSTF. The CMS reviewed the USPSTF recommendations and supporting evidence for screening depression in adults preventive services and determined that the criteria listed above was met, enabling the CMS to cover these preventive services. Thus, effective October 14, 2011, Medicare covers annual screening for adults for depression in a primary care setting, as defined below, that has staff-assisted depression care supports in place to assure accurate diagnosis, effective treatment, and follow-up. For the purposes of this NCD:

- A primary care setting is defined as one in which there is provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. Emergency departments, inpatient hospital settings, ambulatory surgical centers, independent diagnostic testing facilities, skilled nursing facilities, inpatient rehabilitation facilities, and hospice are not considered primary care settings under this definition.

For effective dates of service on and after April 2, 2012, contractors shall pay for annual depression screening claims, G0444, only when services are provided at the following places of service (POS):

- 11 – Office
- 22 – Outpatient hospital
- 49 – Independent clinic
- 50 – FQHCs
- 71 – State or local public health clinic
- 72 – RHCs
• At a minimum level, staff-assisted depression care supports consist of clinical staff (e.g., nurse, physician assistant) in the primary care office who can advise the physician of screening results and who can facilitate and coordinate referrals to mental health treatment. More comprehensive care supports include a case manager working with the primary care physician; planned collaborative care between the primary care provider and mental health clinicians; patient education and support for patient self-management; plus attention to patient preferences regarding counseling, medications, and referral to mental health professionals with or without continuing involvement by the patient’s primary care physician.

**Note:** Coverage is limited to screening services and does not include treatment options for depression or any diseases, complications, or chronic conditions resulting from depression, nor does it address therapeutic interventions such as pharmacotherapy, combination therapy (counseling and medications), or other interventions for depression. Self-help materials, telephone calls, and Web-based counseling are not separately reimbursable by Medicare and are not part of this NCD.

• Screening for depression is non-covered when performed more than one time in a 12-month period. Eleven full months must elapse following the month in which the last annual depression screening took place. Medicare coinsurance and Part B deductible are waived for this preventive service.

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### INTENSIVE BEHAVIORAL THERAPY FOR CARDIOVASCULAR DISEASE

Effective for claims with dates of service on and after November 8, 2011, the Centers for Medicare & Medicaid Services (CMS) covers intensive behavioral therapy (IBT) for cardiovascular disease (CVD), inclusive of one face-to-face CVD risk reduction visit annually.

The Medicare patient receiving this care must be competent and alert at the time the service is rendered and the service must be furnished by a qualified primary care physician or other primary care practitioner in a primary care setting. Ensure that your billing staffs are aware of this update.

Coverage of IBT for CVD, referred to as a CVD risk reduction visit, consists of the following three components:

1. Encouraging aspirin use for the primary prevention of CVD when the benefits outweigh the risks for men age 45-79 years and women 55-79 years;
2. Screening for high blood pressure in adults age 18 years and older; and,
3. Intensive behavioral counseling to promote a healthy diet for adults with hyperlipidemia, hypertension, advancing age, and other known risk factors for cardiovascular and diet-related chronic disease.

**Key points**

• A new HCPCS code, G0446, Annual, face-to-face IBT for CVD, individual, 15 minutes, will be included in the January 2012 updates of the Medicare physician fee schedule database (MPFSDB) and integrated outpatient code editor (IOCE), effective for services on or after November 8, 2011.

• Medicare deductibles and coinsurance do not apply to claim lines containing HCPCS code G0446.

• For these services provided on or after November 8, 2011, through December 31, 2011, Medicare contractors will apply their pricing to claims for G0446 when billed for IBT for CVD.

• Effective for claims with dates of service on and after November 8, 2011, CMS covers one face-to-face CVD risk reduction visit annually for Medicare beneficiaries who are competent and alert at the time that counseling is provided, and whose counseling is furnished by a qualified primary care physician or other primary care practitioner in a primary care setting.
For the purposes of this covered service, a primary care setting is defined as one in which there is provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. The following provider specialty types may submit claims for CVD risk reduction visits:

- 01 – General practice
- 08 – Family practice
- 11 – Internal medicine
- 16 – Obstetrics/gynecology
- 37 – Pediatric medicine
- 38 – Geriatric medicine
- 42 – Certified nurse midwife
- 50 – Nurse practitioner
- 89 – Certified clinical nurse specialist
- 97 – Physician assistant

Medicare contractors will pay claims for G0446 only when services are provided for the following place of service (POS):

- 11 – Physician’s office;
- 22 – Outpatient hospital;
- 49 – Independent clinic; or,
- 71 – State or local public health clinic.

Note: Emergency departments, inpatient hospital settings, ambulatory surgical centers, independent diagnostic testing facilities, skilled nursing facilities, inpatient rehabilitation facilities, and hospices are not considered.

The behavioral counseling intervention for aspirin use and healthy diet should be consistent with the five A’s approach that has been adopted by the USPSTF to describe such services:

- Assess: Ask about/assess behavioral health risk(s) and factors affecting choice of behavior change goals/methods.
- Advise: Give clear, specific, and personalized behavior change advice, including information about personal health harms and benefits.
- Agree: Collaboratively select appropriate treatment goals and methods based on the patient’s interest in and willingness to change the behavior.
- Assist: Using behavior change techniques (self-help and/or counseling), aid the patient in achieving agreed-upon goals by acquiring the skills, confidence, and social/environmental supports for behavior change, supplemented with adjunctive medical treatments when appropriate.
- Arrange: Schedule follow-up contacts (in person or by telephone) to provide ongoing assistance/support and to adjust the treatment plan as needed, including referral to more intensive or specialized treatment.

Medicare contractors do not need to search their files for claims that may have been processed in error. However, contractors may adjust claims that are brought to their attention.
Medicare covers screening and counseling for obesity

Screening for obesity and counseling for eligible beneficiaries by primary care providers in settings such as physicians’ offices are covered under this new benefit. For a beneficiary who screens positive for obesity with a body mass index (BMI) ≥ 30 kg/m², the benefit would include one face-to-face counseling visit each week for one month and one face-to-face counseling visit every other week for an additional five months. The beneficiary may receive one face-to-face counseling visit every month for an additional six months (for a total of 12 months of counseling) if he or she has achieved a weight reduction of at least 6.6 pounds (or 3 kilograms) during the first six months of counseling.

Stay on top of deadlines and action items for version 5010 and ICD-10 by referencing the following resources on the CMS ICD-10 website:

Interactive widget: A user-friendly tool that outlines the steps to take to ensure compliance with version 5010 and ICD-10.

Timelines: Printer-friendly checklists that complement the widget, which are available for:
- Large providers
- Small providers
- Payers, and
- Vendors

Implementation handbooks: Detailed step-by-step guides on how to implement ICD-10, which have been customized for different audiences including:
- Small/medium provider practices
- Large provider practices
- Small hospitals, and
- Payers

Keep up to date on version 5010 and ICD-10. Visit the CMS ICD-10 website for the latest news/resources and to download and share the implementation widget.

Source: CMS PERL 201112-50

MEDICAL POLICY NEWS

64566: Posterior tibial nerve stimulation (PTNS) -- new LCD
Modified: 12/16/2011 Location: FL, PR, USVI Line of Business: Part B

A local coverage determination (LCD) has been developed to give indications and limitations of coverage and/or medical necessity, CPT code, ICD-9-CM codes, documentation requirements, utilization guidelines, and coding guidelines for PTNS.

76376: 3D interpretation and reporting of imaging studies -- new LCD
Modified: 12/16/2011 Location: FL, PR, USVI Line of Business: Part B

A local coverage determination (LCD) has been developed to give indications and limitations of coverage and/or medical necessity, CPT code, ICD-9-CM codes, documentation requirements, utilization guidelines.

93922: Non-invasive physiologic studies of upper or lower extremity arteries -- revision to the LCD
Modified: 12/16/2011 Location: FL, PR, USVI Line of Business: Part B

Revisions have been made to several sections of this LCD.

93925: Duplex scan of lower extremity arteries -- revision to the LCD
Modified: 12/16/2011 Location: FL, PR, USVI Line of Business: Part B

Important changes have been made to several sections of this LCD.
First Coast Service Options Inc. has revised local coverage determinations (LCDs) impacted by the 2012 Healthcare Common Procedure Coding System (HCPCS) annual update. Procedure codes have been added, revised, replaced and deleted accordingly:

<table>
<thead>
<tr>
<th>LCD Title</th>
<th>Changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>BOTULINUM TOXINS Botulinum Toxins</td>
<td>Deleted HCPCS code Q2040</td>
</tr>
<tr>
<td></td>
<td>Added HCPCS code J0588</td>
</tr>
<tr>
<td>IDTF Independent Diagnostic Testing Facility (IDTF) (Coding Guidelines only)</td>
<td>Deleted CPT codes 73542, 75722, 75724, 77079, 77083, 78220, 78223, 78584, 78585, 78586, 78587, 78588, 78591, 78593, 78594, 78596, 92120, 92130, 93720, 93721, 93875, 94240, 94260, 94350, 94360, 94370, 94720, and 94725 from the “Coding Guidelines” attachment</td>
</tr>
<tr>
<td></td>
<td>Added CPT codes 74174, 78226, 78227, 78579, 78582, 78597, 78598, 94276, 94277, 94728, 94729, 95885, 95886, 95887, 95938, and 95939 to the “Coding Guidelines” attachment</td>
</tr>
<tr>
<td>J0129 Abatacept</td>
<td>Descriptor change for HCPCS code J0129</td>
</tr>
<tr>
<td>J1459 Intravenous Immune Globulin</td>
<td>Deleted HCPCS code C9270</td>
</tr>
<tr>
<td></td>
<td>Added HCPCS code J1557</td>
</tr>
<tr>
<td>J1740 Bisphosphonates (Intravenous [IV]) and Monoclonal Antibodies in the Treatment of Osteoporosis and Their Other Indications</td>
<td>Deleted HCPCS code C9272</td>
</tr>
<tr>
<td></td>
<td>Removed HCPCS code J3590</td>
</tr>
<tr>
<td></td>
<td>Added HCPCS code J0897</td>
</tr>
<tr>
<td></td>
<td>Changed “Contractor’s Determination Number” to J0897</td>
</tr>
<tr>
<td>J7187 Hemophilia Clotting Factors</td>
<td>Deleted HCPCS code Q2041</td>
</tr>
<tr>
<td></td>
<td>Added HCPCS code J7183</td>
</tr>
<tr>
<td></td>
<td>Changed “Contractor’s Determination Number” to J7183</td>
</tr>
<tr>
<td>NCSVCS Noncovered Services</td>
<td>Descriptor change for CPT codes 90581, 90644, 90667, and 90868</td>
</tr>
<tr>
<td></td>
<td>Deleted CPT codes 0155T, 0156T, 0157T, and 0158T (replaced with CPT code 43659) and CPT code 0168T (replaced with CPT code 30999)</td>
</tr>
<tr>
<td></td>
<td>Removed CPT code 46999 and replaced with CPT code 0288T</td>
</tr>
<tr>
<td></td>
<td>Added CPT code 90869</td>
</tr>
<tr>
<td>PULMDIAGSVCS Pulmonary Diagnostic Services</td>
<td>Deleted CPT codes 93720, 93721, 93722, 94240, 94260, 94350, 94360, 94370, 94720, and 94725</td>
</tr>
<tr>
<td></td>
<td>Added CPT codes 94726, 94727, 94728, and 94729</td>
</tr>
</tbody>
</table>
### SKINSUB Skin Substitutes
- Deleted HCPCS code C9365
- Added HCPCS code Q4124
- Added HCPCS codes C9366, Q4122, Q4123, Q4125, Q4126, Q4127, Q4128, Q4129, and Q4130 to “The following HCPCS codes are not separately payable and are considered not medically reasonable and necessary products” section of the LCD
- Deleted application CPT code range 15100-15431, CPT codes 15170, 15171, 15175, 15176, 15340, 15341, 15360, 15361, 15365, 15366, 15430, and 15431 and HCPCS codes G0440 and G0441 from the “Coding Guidelines” attachment
- Added CPT codes 15271-15278 to the “Coding Guidelines” attachment

### THERSVCS Therapy and Rehabilitation Services
- Descriptor change for CPT code 96111
- Added information related to therapy cap (Change Request 7529)

### Xiaflex® Collagenase clostridium histolyticum (Xiaflex®)
- Removed CPT code 26989
- Added CPT codes 20527 and 26341

### 01991 Monitored Anesthesia Care (MAC) for Certain Interventional Pain Management Services (Coding Guidelines only)
- Descriptor change for CPT codes 27096, 62310 and 62311

### 22520 Percutaneous Vertebroplasty
- Descriptor change for CPT codes 22520, 22521, and 22522

### 22533 Lumbar Spinal Fusion for Instability and Degenerative Disc Disease
- Descriptor change for CPT code 22612
- Added CPT codes 22633 and 22634

### 27096 Sacroiliac Joint Injection
- Descriptor change for CPT code 27096
- Deleted CPT code 73542
- Removed CPT code 77003 based on descriptor change for CPT code 27096

### 32491 Lung Volume Reduction Surgery
- Descriptor change for CPT code 32491

### 61885 Vagal Nerve Stimulation (VNS) for Intractable Depression
- Descriptor change for CPT codes 64585, 95970, 95974, and 95975

### 62310 Epidural
- Descriptor change for CPT codes 62310 and 62311

### 64561 Sacral Neuromodulation
- Descriptor change for CPT codes 64561 and 64581
- Descriptor change for CPT code 64585 in the “Coding Guidelines” attachment

### 64622 Destruction of Paravertebral Facet Joint Nerve(s)
- Deleted CPT codes 64622, 64623, 64626, and 64627
- Added CPT codes 64633, 64634, 64635, and 64636
- Changed “Contractor’s Determination Number” to 64633

### 75722 Renal Angiography
- Deleted CPT codes 75722 and 75724
- Added CPT codes 36251, 36252, 36253, and 36254
- Changed “Contractor’s Determination Number” to 36251

### 77078 Bone Mineral Density Studies
- Deleted CPT codes 77079 and 77083

### 86849 Circulating Tumor Cell Testing
- Removed CPT code 86849
- Added CPT codes 0279T and 0280T
- Changed “Contractor’s Determination Number” to 0279T

### 93875 Non-invasive Extracranial Arterial Studies
- Deleted CPT code 93875
- Changed “Contractor’s Determination Number” to 93880

### 95860 Electromyography and Nerve Conduction Studies
- Added CPT codes 95885, 95886, and 95887

### 95925 Somatosensory Testing
- Added CPT code 95938

### 95990 Implantable Infusion Pump for the Treatment of Chronic Intractable Pain
- Descriptor change for CPT codes 62367, 95990, and 95991
- Added CPT codes 62369 and 62370
**YERVOY™ (ipilimumab)**

Melanomas are malignant neoplasms of melanocytes developing predominantly in the skin, but occasionally arising from eyes, mucous membranes, and the central nervous system (CNS). Melanocytes are responsible for providing pigment to the skin (eyes, mucous membranes and CNS). Among the three types of skin cancer, melanoma is the most aggressive and also the most serious. Metastatic melanoma refers to a disease that has spread from its original lesion site to deeper parts of the skin, and eventually to other parts of the body distant to the primary lesion site.

YERVOY™ (ipilimumab) is indicated by the Food and Drug Administration (FDA) for the treatment of unresectable or metastatic melanoma.

The recommended dose of YERVOY (ipilimumab) is 3 mg/kg administered intravenously over 90 minutes every three weeks for a total of four doses.

The Medicare administrative contractor (MAC) for jurisdiction 9 (J9) has a local coverage determination (LCD) for “label and off-label coverage of outpatient drugs and biologicals.” This LCD outlines general coverage criteria for drugs approved for marketing by the FDA labeled use, as well as the off-labeled use in the absence of a national coverage determination (NCD) or a MAC J9 LCD addressing a specific drug. Currently there is not a MAC J9 LCD for YERVOY™ (ipilimumab).

Effective for claims with dates of service March 25, 2011, through October 15, 2011, YERVOY can be considered for coverage, assuming documentation supports the reasonable and necessary indications when requested for the following ICD-9-CM codes:

**ICD-9-CM codes Descriptors for ICD-9-CM codes**

<table>
<thead>
<tr>
<th>ICD-9-CM codes</th>
<th>Descriptors</th>
</tr>
</thead>
<tbody>
<tr>
<td>154.2</td>
<td>Malignant neoplasm of anal canal</td>
</tr>
<tr>
<td>154.3</td>
<td>Malignant neoplasm of anus, unspecified</td>
</tr>
<tr>
<td>172.0-172.9</td>
<td>Malignant melanoma of skin</td>
</tr>
<tr>
<td>184.0</td>
<td>Malignant neoplasm of vagina</td>
</tr>
<tr>
<td>184.1</td>
<td>Malignant neoplasm of labia majora</td>
</tr>
<tr>
<td>184.2</td>
<td>Malignant neoplasm of labia minora</td>
</tr>
<tr>
<td>187.1</td>
<td>Malignant neoplasm of prepuce</td>
</tr>
<tr>
<td>187.4</td>
<td>Malignant neoplasm of penis, part unspecified</td>
</tr>
<tr>
<td>187.7</td>
<td>Malignant neoplasm of scrotum</td>
</tr>
<tr>
<td>187.9</td>
<td>Malignant neoplasm of male genital organ, site unspecified</td>
</tr>
<tr>
<td>190.0</td>
<td>Malignant neoplasm of eyeball, except conjunctiva, cornea, retina, and choroid</td>
</tr>
<tr>
<td>190.1</td>
<td>Malignant neoplasm of orbit</td>
</tr>
<tr>
<td>190.2</td>
<td>Malignant neoplasm of lacrimal gland</td>
</tr>
<tr>
<td>190.3</td>
<td>Malignant neoplasm of conjunctiva</td>
</tr>
<tr>
<td>190.5</td>
<td>Malignant neoplasm of retina</td>
</tr>
<tr>
<td>190.6</td>
<td>Malignant neoplasm of choroid</td>
</tr>
<tr>
<td>190.9</td>
<td>Malignant neoplasm of eye, part unspecified</td>
</tr>
</tbody>
</table>

Effective for claims with dates of service March 25, 2011, through October 15, 2011, in addition to consideration for coverage for the above indications and above ICD-9-CM codes, the following compendia indications and additional ICD-9-CM codes will also be considered for coverage for YERVOY (ipilimumab) as a single agent:

- Unresectable stage III intransit metastases
- Local/satellite and/or intransit unresectable recurrence
- Incompletely resected nodal recurrence
- Limited recurrence or metastatic disease
- Disseminated recurrence or metastatic disease in patients with good performance status
- Reinduction in select patients who experience no significant systemic toxicity during prior ipilimumab therapy and who relapse after initial clinical response or progress after stable disease greater than three months.
ICD-9-CM CODES DESCRIPTORS FOR ICD-9-CM CODES

198.3 Secondary malignant neoplasm of brain and spinal cord

199.0 Malignant neoplasm without specification of site, disseminated

199.1 Other malignant neoplasm without specification of site

V10.82 Personal history of malignant neoplasm of malignant melanoma of skin

For dates of service prior to January 1, 2012, the unlisted HCPCS codes J3490, J3590, J9999, or HCPCS code C9284 should be billed for YERVOY™ (ipilimumab). On or after date of service January 1, 2012, HCPCS code J9228 should be billed for YERVOY™ (ipilimumab).

INPATIENT DRGS SUBJECT TO PREPAYMENT MEDICAL REVIEW

Note: First Coast Service Options Inc. (FCSO) prepayment medical review plans as outlined below are on schedule with implementation. Though the Centers for Medicare & Medicaid Services (CMS) recently announced delay of the implementation of the recovery auditor (RAC) demo, that is a separate CMS initiative.

FCSO recently provided information concerning improper payments and inpatient prepayment medical review of 15 inpatient Medicare severity-related diagnosis-related groups (MS-DRGs). (See http://medicare.fcso.com/CERT/226222.asp). Since that information was released, FCSO has received a number of questions regarding the percentage of claims subject to prepayment review for each DRG, and the dates on which these reviews will commence.

The following schedule outlines FCSO’s staggered approach to implementing MS-DRG prepayment edits. FCSO will provide information regarding prepayment review error rates through future articles and other education and outreach forums. Notice will also be provided for future changes to prepayment review activities (e.g., increase in percentage of review).

<table>
<thead>
<tr>
<th>MS-DRG</th>
<th>Percentage of review</th>
<th>Date prepayment implemented</th>
<th>FISS reason code</th>
</tr>
</thead>
<tbody>
<tr>
<td>226</td>
<td>30%</td>
<td>January 1, 2012</td>
<td>5D104</td>
</tr>
<tr>
<td>227</td>
<td>30%</td>
<td>January 1, 2012</td>
<td>5D105</td>
</tr>
<tr>
<td>242</td>
<td>30%</td>
<td>February 1, 2012</td>
<td>5D111</td>
</tr>
<tr>
<td>243</td>
<td>30%</td>
<td>January 1, 2012</td>
<td>5D112</td>
</tr>
<tr>
<td>244</td>
<td>30%</td>
<td>January 1, 2012</td>
<td>5D113</td>
</tr>
<tr>
<td>245</td>
<td>30%</td>
<td>January 1, 2012</td>
<td>5D106</td>
</tr>
<tr>
<td>247</td>
<td>30%</td>
<td>February 1, 2012</td>
<td>5D108</td>
</tr>
<tr>
<td>251</td>
<td>30%</td>
<td>January 1, 2012</td>
<td>5D109</td>
</tr>
<tr>
<td>253</td>
<td>30%</td>
<td>February 1, 2012</td>
<td>To be announced</td>
</tr>
<tr>
<td>264</td>
<td>30%</td>
<td>February 1, 2012</td>
<td>To be announced</td>
</tr>
<tr>
<td>287</td>
<td>30%</td>
<td>February 1, 2012</td>
<td>To be announced</td>
</tr>
<tr>
<td>458</td>
<td>30%</td>
<td>January 1, 2012</td>
<td>5D107</td>
</tr>
<tr>
<td>460</td>
<td>30%</td>
<td>June 1, 2011</td>
<td>5D100</td>
</tr>
<tr>
<td>470</td>
<td>50%</td>
<td>Increased to 50 percent January 1, 2012</td>
<td>5D101</td>
</tr>
<tr>
<td>490</td>
<td>30%</td>
<td>January 1, 2012</td>
<td>5D110</td>
</tr>
</tbody>
</table>

The percentage of prepayment review is based on the average of DRG receipts received in the Fiscal Intermediary Standard System (FISS).

This initiative is applicable to hospitals in Medicare administrative contractor (MAC) jurisdiction 9 (J9), excluding those in Puerto Rico and the U.S. Virgin Islands.
BUNDLING PAYMENTS FOR SERVICES PROVIDED TO OUTPATIENTS WHO LATER ARE ADMITTED AS INPATIENTS

Effective Date: January 1, 2012
Implementation Date: January 3, 2012

Summary
Under the "3-day payment window," a hospital (or an entity that is wholly owned or wholly operated by the hospital) must include on the inpatient claim for a Medicare beneficiary’s inpatient stay, the technical portion of all outpatient diagnostic services and admission-related non-diagnostic services provided during the payment window.

A new payment modifier PD (Diagnostic or related non-diagnostic item or service provided in a wholly owned or operated entity to a patient who is admitted as an inpatient within 3 days) is required on the entity’s preadmission diagnostic and admission-related non-diagnostic services that are subject to the 3-day payment window policy.

Here is the link to the article MM7502.

INFORMATION FOR OUTPATIENT PROSPECTIVE PAYMENT SYSTEM PROVIDERS REGARDING THE BILLING OF CPT® CODE 33249

The Centers for Medicare & Medicaid Services (CMS) has identified that an update to the integrated outpatient code editor (I/OCE) is necessary to allow payment for Current Procedural Terminology® (CPT) code 33249. CMS has provided direction to Medicare claims administration contractors to hold outpatient prospective payment system (OPPS) claims containing CPT® code 33249, effective Sunday, January 1, 2012, until the I/OCE has been updated with this payment information. The held claims should be released on or about Monday, February 6, 2012.
To learn about our department visit the Office of Billing Compliance Web Page at [www.umdme.com](http://www.umdme.com) and click Administration.

If you have any questions on Coding, Billing and Documentation you may email us by accessing Outlook and typing Office of Billing Compliance or [officeofbillingcompliance@med.miami.edu](mailto:officeofbillingcompliance@med.miami.edu)

To Report Billing Compliance Issues, Fraud, Waste and Abuse Concerns or Violations visit the Cane Watch website at [www.canewatch.ethicspoint.com](http://www.canewatch.ethicspoint.com) or call toll free 1-877-415-4357 (24 hours a day, seven days a week).

Calls May Remain Anonymous.

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Our Billing Compliance Educational Program is now online by accessing the Ulearn website at: [www.Ulearn.miami.edu](http://www.Ulearn.miami.edu).

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

- Billing Compliance Training/Fraud, 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/CriticalCareServiceWeb/index.html)
- [http://pdto.miami.edu/external/compliance/EMServices_Module1Web/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/EMServices_Module2Web/index.html)
- [http://pdto.miami.edu/external/compliance/MajorSurgeryGlobalFeeWeb/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/MedicareRuleWeb/index.html)
- [http://pdto.miami.edu/external/compliance/PsychiatryWeb/index.html](http://pdto.miami.edu/external/compliance/PsychiatryWeb/index.html)

**Hospital Compliance Training Modules (CBLS)**

- Hospital Compliance Orientation
- Billing Compliance Training/Fraud, Abuse
- Observation Billing & Documentation Guidelines
- Facility Fee – Clinic Visits Billing & Documentation Guidelines
- An Important Message from Medicare
- Inpatient Hospital Services
- Advanced Beneficiary Notice (ABN)
**LiveScan Fingerprinting System Now Available for Miller School/UHealth Employees**

LiveScan, a device that captures fingerprints through a scanner, is now available for UM employees who are required to be fingerprinted for background screening, licensure or Medicaid provider enrollment. The fingerprinting service is offered by the Office of Billing Compliance in the Professional Arts Center, suite 404. To make an appointment, call 305-243-9144.

The device provides faster results, better quality prints, no ink smudging, and electronic transmission of results for providers enrolling in Medicaid to the Agency for Healthcare Administration or a corresponding agency.

For Medicaid Provider Enrollment and Medical Licensure through DOH, fingerprints will be electronically submitted to Florida Department of Law Enforcement. The screening fee is $43.25 and the processing fee is $6.75. For all other reasons for electronic submission of fingerprints, please contact the Office of Billing Compliance at 305-243-9144 for pricing.

Departments are required to submit an Interdepartmental Requisition with their account number and a description of the reason for the fingerprinting.