Vice Chair Gingrey (R-GA) “Confident” of SGR Fix Passing in Lame Duck Congress Session (jump to story)

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Gingrey “Confident” Lame Duck Congress Will Pass SGR Fix.

Modern Healthcare (11/15, Subscription Publication) reports that Representative Phil Gingrey (R-GA), vice chair of the
House Doctors Caucus said Wednesday that he is “pretty confident” Congress will “approve a one-year freeze in Medicare physician pay rates” during the lame duck session. This so-called “SGR patch” would put off a slated 27.5% cut to Medicare reimbursement rates. He said he believed “Congress would find the $18 billion needed to offset the cost of a one-year payment freeze,” adding that “his caucus plans to focus next year on finding a replacement to the SGR and a way to pay the $300 billion cost of permanently replacing it.”

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CMS Releases Stage 2 Meaningful Use Specification Sheets with Details on Each Measure

CMS has added Stage 2 meaningful use specification sheets for both eligible professionals (EPs) and for eligible hospitals and critical access hospitals (CAHs) to help them participate in Stage 2 of meaningful use in the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs.

The new specification sheets can be found on the Stage 2 page of the EHR website. Each specification sheet includes the objective, measure, and exclusion for each core and menu objective, as well as a definition of terms, attestation requirements, additional information, and the corresponding standards and certification criteria.

You can view the specification sheets in two ways:

- **Use the Stage 2 Specification Sheet Table of Contents** – The Table of Contents lists all the core and menu objectives, with direct links to each individual measure specification sheet. The page contains a Table of Contents for both EPs and for eligible hospitals and CAHs.
Download ALL Stage 2 Specification Sheets – Zip files containing PDFs of all of the core and menu objectives for EPs and for eligible hospitals and CAHs are available for download on the page.

Reminder: The earliest that the Stage 2 criteria will be effective is in fiscal year 2014 for eligible hospitals and CAHs or calendar year 2014 for EPs. All providers must achieve meaningful use under the Stage 1 criteria before moving to Stage 2.

Want more information about the EHR Incentive Programs?
Make sure to visit the Medicare and Medicaid EHR Incentive Programs website for the latest news and updates on the EHR Incentive Programs.

Information on Two Upcoming Webinars from CMS

National Medicare Training Program Update Webinar on Tuesday, November 20.

Attendees will hear information on:

- Flu Vaccine
- Plan Finder
- Innovations Center
- Enrollment Opportunities for People Affected by Hurricane Sandy
- Pharmacy & Provider Access During Federal Disasters and Other Public Health Emergencies

When: Tuesday, November 20, 2012
Make Your Community a Source of Health and Wellness – Establishing a Health Ministry in Your Community Webinar on Thursday, November 29.

Sue Heitmuller, Health Ministry Coordinator for Adventist HealthCare, will speak in-depth on how to lead communities through the process of faithfully establishing health ministries.

The presentation will be followed by a Question & Answer session.

When: Thursday, November 29, 2012

Time: 2:00-3:00 p.m., ET

Guest Consultant Cindy Dunn:
Medical Practices Need to Start Now to Plan for a Happy New Year in 2013

Changes in health-care policy, new regulations, financial incentives and penalties have a direct effect on all healthcare organizations. As we round the corner towards 2013, take a few minutes to create an agenda of Medicare Incentive Programs and a few management initiatives to review with your physicians and leadership team.

Electronic Health Record (EHR)

Most practices have an EHR but often times it is not fully implemented:

- Are all of your physicians using the EHR?
- Do you have the latest version?
- Are all of your employees and providers trained properly?
- Are you utilizing all of the available functionality?

Meaningful Use (MU)

Strive to meet the Meaningful Use criteria. Even if you are unable to implement and attest to Medicare by the end of 2012 to receive the maximum $44,000 over 5 years, by beginning the process and attesting in 2013, you will be eligible for Medicare incentive payments over 5 years totaling $39,000.

If you have physicians receiving 30% of their revenue from Medicaid, they can attest beginning at any time through 2016 and receive $63,750 over the subsequent 6 years.
e-Prescribing (eRX)

If you did not successfully report your eRX efforts in 2011 you are already subject to a Medicare penalty in 2012. In order to prevent the 2013 penalty, each physician needs to report their eRX work on 25 individual patient claims (not 25 e-prescriptions) by December 31, 2012.

If you are unable to eRX because you are in an area with few participating pharmacies, or in a rural area with limited high-speed Internet access, apply for an exemption by January 31, 2013, to avert penalties that begin in 2013.

Physician Quality Reporting System (PQRS)

PQRS is currently a voluntary program. In the claim based reporting option, in order to receive your 2012 financial incentive, each provider should select and report on at least three applicable quality measures. Reporting is for the entire 2012 year and each provider must report on a minimum of 50% of applicable Medicare Part B patients. Many physicians select their measures but they are not always submitted or properly documented.

The final 2012 Medicare Physician Fee Schedule contained a provision that 2015 program penalties will be based on 2013 performance. Physicians who elect not to participate or are found unsuccessful during the 2013 program year, will receive a 1.5% payment penalty in 2015 and 2% annually in the following years.

Medicare Fee Schedule

What is the impact of the 2013 proposed Medicare Fee Schedule on your patients, staff, and practice? We are all accustomed
to Congress “coming to the rescue” but what if the unthinkable occurs? The proposed conversion factor reflects a 27.4% cut that will take effect on January 1, 2013 and CMS estimates the 2013 MPFS conversion factor will be set at approximately $24.7124 (currently $34.04). Have you reviewed your payer mix, analyzed the receipts and determined the financial impact on your practice? What changes could you make if necessary?

**Physician Compare (Website here)**

Mandated by the Affordable Care Act, the Physician Compare website was created to allow consumers to compare physicians based on quality of care. Currently it is a directory of ~932,000 doctors and other health care providers who accept Medicare patients. It’s searchable by zip code, city, state, and medical specialty.

Patients will eventually be able to see and compare how other patients rate their experience with physicians as well as how physicians perform on a dashboard of clinical and outcome measures. The Affordable Care Act states that beginning no later than January 2013, CMS is to “implement a plan for making publicly available, through Physician Compare information on physician performance that provides comparable information for the public on quality and patient experience measures.”

Have you gone to the website – is your practice and physician information correct? If there are errors you should contact the CMS QualityNet Help Desk at (866) 288-8912 and ask for assistance.

**Optimize Operational Management Strategies**

You find several things in common in the better performing groups: flexible staffing for support staff; cross-training
staff for increased utilization; a patient focused schedule that includes open access for same-day appointments; meticulous tracking of accounts receivable (including aggressive day-of-service collections of estimated co-pays, deductibles & co-insurance); and prompt follow-up with payers and patients owing balances on their bills. Does this sound like your practice? If not what are you doing to make changes?

Measure, measure, measure and share, share, share!

Develop a plan, set goals and share the results with your staff. Staffing ratios, productivity, denials, wait times, patient (customer) satisfaction, quality outcomes and market share are just a few metrics you should monitor.

Resources:

EHR and Meaningful Use Incentive Programs

e-Prescribing

PQRS

Cindy Dunn, RN, FACMPE is the Vice President of Professional Services for Trellis Healthcare

Trellis Healthcare introduces InfoDive®, a web-based business intelligence solution which allows medical practices to quickly and easily analyze internal data and benchmark their practice to others. This enhanced understanding improves the quality and efficiency of business processes and physician performance and answer questions such as: Are your providers
as productive as they should be? Are your payers reimbursing you at the negotiated contract rate? Who’s your best payer? Are you at risk for a RAC audit? What services are being denied? Where are your referrals coming from? Should you open or close an office?

Power Wheelchairs: What the Physician Must Do to Ensure Medicare Coverage

× CMS Finds High Incidence of Improper Payments for Power Wheelchair Claims

Based on the findings of the Comprehensive Error Rate Testing (CERT) program reviews of power wheelchair claims, the Centers for Medicare & Medicaid Services (CMS) conducted a special study of power wheelchair claims.

The power wheelchair categories studied include:

- Group 1: Standard, portable, sling/solid seat/back, capacity up to 300 lbs. (K0813)
- Group 2: Standard, portable, captain’s chair, capacity up to 300 lbs. (K0821)
- Group 2: Standard, sling/solid seat/back, capacity up to 300 lbs. (K0822)
- Group 2: Standard, captain’s chair, capacity up to 300 lbs. (K0823)
What Power Wheelchair Claim Problems Were Found in the Study?

Insufficient Documentation

The majority of power wheelchair errors were due to insufficient documentation errors. Insufficient documentation errors occur when the medical documentation submitted is inadequate to support payment for the services billed. In other words, the medical reviewers could not conclude that some of the allowed services were actually provided, were provided at the level billed, and/or were medically necessary. Claims are also placed into this category when a specific documentation element that is required as a condition of payment is missing. This may include a physician signature on an order, or a form that is required to be completed in its entirety. **EXAMPLE:** Mrs. Smith’s medical record showed that she had a physical condition that led to leg weakness and falls at home. However, the face-to-face examination did not address why her mobility limitations could not be sufficiently and safely resolved by the use of an appropriately fitted cane or walker. This claim was scored as an improper payment due to an insufficient documentation error.

Medical Necessity

A small proportion of claims in this special study were categorized as medical necessity errors. Medical necessity errors occur when the medical reviewers receive adequate
documentation from the medical records submitted to make an informed decision that the services billed were not medically necessary based upon Medicare coverage policies. A common reason for medical necessity errors was that the face-to-face examination did not support that the beneficiary’s condition required the use of a power wheelchair, such as when they were able to safely ambulate with the use of a walker. **EXAMPLE:** Mr. Jones’ medical record showed that he had a physical condition that led to leg weakness and falls at home. However, the face-to-face examination mentioned that she was safely ambulating around the house with the use of an appropriately fitted walker, but that she wanted the power wheelchair so that she could travel around the neighborhood. This claim was scored as a medical necessity error.

There is currently a prior authorization pilot underway in seven states where CMS will review the patient’s medical record before a device is shipped to ensure they need a wheelchair. The pilot, which started September 1, 2012, is ongoing in California, Illinois, Michigan, New York, North Carolina, Florida, and Texas.

Federal health officials noted that nearly 80 percent of the power wheelchair claims submitted to Medicare don’t meet program requirements. Note that this may mean that the protocol was not followed, as opposed to the patient not being eligible based on medical necessity. That error rate represents more than $492 million in improper payments annually. The cost for the devices ranges from $1,500 for scooters to $3,600 for more complex power wheelchairs over the course of the rental period. Medicare payment can only be made on a rental basis for standard power wheelchairs furnished on or after January 1, 2011.

**What are the Requirements for Medicare**
Coverage for Power Wheelchairs?

Medicare provides coverage for wheelchairs and scooters under its Part B Durable Medical Equipment (DME) benefit. Here are the requirements for Medicare payment:

- The physician or treating practitioner must conduct a face-to-face history and physical examination (the in-person visit and mobility evaluation together are often referred to as the “face-to-face examination”) of the beneficiary and write a prescription for the item. The prescription must include the following seven items:
  1. Beneficiary’s name
  2. Description of the item that is ordered. This may be general – e.g., “power operated vehicle”, “power wheelchair”, or “power mobility device” – or may be more specific.
  3. Date of completion of the face-to-face examination
  4. Pertinent diagnoses/conditions that relate to the need for the POV or power wheelchair
  5. Length of need
  6. Physician’s signature
  7. Date of physician signature
- The beneficiary must show the provider why they cannot use a cane, walker or manually operated wheelchair to effectively perform Mobility-Related Activities of Daily Living (MRADLs) in the home. MRADLs include feeding, dressing, grooming, bathing, and toileting.
- The beneficiary must be able to safely and effectively use the power wheelchair in the home.
- The prescription and medical records documenting the in-person visit and evaluation must be sent to the equipment supplier within 45 days after the completion of the evaluation.
- After the supplier receives the provider’s order and the face-to-face information, they will prepare a detailed product description that describes the item(s) being
provided including all options and accessories. The provider should review it and, if in agreement with what is being provided, sign, date and return it to the supplier. If not in agreement, the provider should contact the supplier to clarify what you want the beneficiary to receive.

Suppliers must meet all documentation requirements included in the power wheelchair Local Coverage Determinations (LCD) issued by the DME Medicare Administrative Contractors (MACs) in order to receive Medicare payment for a power wheelchair. The LCD requires that suppliers maintain a variety of documents that support the beneficiary’s need for, and the appropriateness of, the provided power wheelchair.

**Documentation of the Visit for Your Medical Record (Paper or Electronic) for PWCs**

The face-to-face examination must be relevant to the patient’s mobility needs and include the following elements:

- History of present condition and relevant past medical history, including symptoms that limit ambulation,
- Diagnoses that are responsible for symptoms,
- Medications or other treatment for symptoms,
- Progression of ambulation difficulty over time,
- Other diagnoses that may relate to ambulatory problems,
- Distance patient can walk without stopping,
- Pace of ambulation,
- Ambulatory assistance currently used,
- Change in condition that now requires a PMD
- Description of home setting and ability to perform MRADLs in the home.
- Physical examination relevant to mobility needs,
including height and weight,
• Trunk stability (sitting/standing),
• Cardiopulmonary examination,
• Arm and leg strength and range of motion; and
• Neurological examination, including gait, balance and coordination.

Examples of vague or subjective descriptions of the patient’s mobility limitations include:

• upper extremity weakness” “poor endurance”
• “gait instability”
• “weakness”
• “abnormality of gait”
• “difficulty walking”
• “SOB on exertion”
• “pain”
• “fatigue”
• “deconditioned”

Acronyms for power wheelchairs:

PWC – power wheelchairs
POV – power-operated vehicle (scooter)
PMD – power mobility device (includes PWCs and POVs)
MAE – mobility assistive equipment (includes the continuum of technology from canes to power wheelchairs)

How to Bill for Examination & Mobility Evaluation for a Power Wheelchair

• In the outpatient setting, bill the appropriate level of service from the codes 99201 – 99205 for new patients
and from the codes 99211 – 99215 for established patients.

- Bill the G0327 for service required to establish and document the need for a power mobility device (the national payment amount for this code is $9.81)
- The diagnosis for the E/M code and the G0327 should be what condition creates medical necessity for the power wheelchair.

 CMS Guidance on Medicare Reimbursement for Fungal Meningitis Treatment

 Announcement from the CDC

The Centers for Disease Control and Prevention (CDC) with state and local health departments and the Food and Drug Administration (FDA) are investigating a multi-state meningitis outbreak of fungal infections among patients who have received a steroid injection of a potentially contaminated product into the spinal area. This form of meningitis is not contagious. The investigation also includes fungal infections associated with injections in a peripheral joint space, such as a knee, shoulder or ankle. The CDC is offering advice online to healthcare professionals here.

 Announcement from CMS

The CDC recommends diagnostic and therapeutic activities for
symptomatic patients who have received a steroid injection of a potentially contaminated product into the spinal area. Symptoms of meningitis include fever, headache, stiff neck, nausea and vomiting, photophobia (sensitivity to light) and altered mental status. Therefore, CMS believes that, aside from oral drugs (Medicare reimbursement from Part D), items and services to diagnose and treat patients who have received contaminated medications qualify for the Medicare Part A or Part B benefit.

The Centers for Medicare & Medicaid Services (CMS) is providing direction to Medicare contractors based on the Centers for Disease Control and Prevention’s (CDC) interim treatment guidance for Central Nervous System (CNS). This guidance is also related to parameningeal infections and septic arthritis associated with contaminated steroid products produced by the New England Compounding Center (NECC).

Due to the severity of this situation, CMS advises providers that Medicare contractors are expected to expedite all coverage determination requests for these items and services to include antifungal medication.

The CDC has identified the following states as having received potentially-contaminated steroid products:

- California
- Michigan
- Pennsylvania
- Connecticut
- Minnesota
- Rhode Island
- Florida
- Nevada
- South Carolina
- Georgia
- New Hampshire
- Tennessee
While clinics in these states received contaminated products, patients in additional states may be affected.

**CDC FAQ**

**Q: How many cases have been reported?**
A: See the CDC’s Meningitis Map [here](#).

**Q: What is causing these infections?**
The infections are caused by a fungus. At this point, the original source of the outbreak has not been determined; however, all infected patients identified thus far have received preservative-free (PF) methylprednisolone acetate (80mg/ml) from among the three lots voluntarily recalled by the New England Compounding Center (NECC) in Framingham, Massachusetts, on September 26, 2012. These three lots are:

- Methylprednisolone Acetate (PF) 80 mg/ml Injection, Lot #05212012@68, BUD 11/17/2012
- Methylprednisolone Acetate (PF) 80 mg/ml Injection, Lot #06292012@26, BUD 12/26/2012
- Methylprednisolone Acetate (PF) 80 mg/ml Injection, Lot #08102012@51, BUD 2/6/2013

These medications were used for other types of injections,
including injections into the joint (e.g., knee). To date, CDC has only identified infections in patients who received epidural steroid injections with these medications. However, patients who received other types of injections with these products may also be at risk.

Q: Are other medications from the New England Compounding Center (NECC) located in Framingham, Massachusetts associated with infections?

To date, CDC has not received reports of infections linked to other products from the New England Compounding Center. However, out of an abundance of caution, CDC recommends that patients cease use of any product produced by the New England Compounding Center until further information is available. A list of products produced by the New England Compounding Center can be found through the FDA website here.

If patients have taken or used medications from New England Compounding Center, and they are worried that they are ill because of use of one of these products, they should seek medical attention. Again, CDC has not received any reports of infection linked to other products from New England Compounding Center.

Advice to Healthcare Professionals

FDA advises healthcare professionals to follow-up with patients who have been administered an injectable product shipped by NECC on or after May 21, 2012, including an ophthalmic drug that is injectable or used in conjunction with eye surgery, or a cardioplegic solution. FDA does not urge patient follow-up at this time for NECC products of lower risk such as topicals (for example, lotions, creams, eyedrops not used in conjunction with surgery) and suppositories, or for patients who may have received an NECC product in these categories before May 21, 2012. Patients who received an NECC product prior to May 21, 2012 and who have not experienced
symptoms of infection to date are at less risk of infection because of the amount of time that has elapsed since that date. FDA is not recommending that healthcare providers follow-up with these patients unless they have reported symptoms of infection.

Health care professionals should retain and secure all remaining products purchased from NECC. All NECC products are subject to voluntary recall. Clinics or customers with product on hand should contact NECC at 1-800-994-6322 or via fax at 508-820-1616 to obtain instructions on how to return products to NECC.

Clinicians and patients are also requested to report any suspected adverse events following use of these products to FDA’s MedWatch program at 1-800-332-1088 or www.fda.gov/medwatch.

Healthcare professionals and patients may dial FDA’s Drug Information Line at 855-543-DRUG (3784) and press * to get the most recent information regarding the meningitis recall and speak directly to a pharmacist.

If you have identified NECC customers who received product that do not appear on these lists, please contact FDA’s Drug Information Line to report this problem.

FDA continues its investigation and may issue additional public communications as appropriate.

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**Physicians! Another Chance to**
Avoid a 1.5% Reduction of All Medicare Payments in 2013

The Centers for Medicare and Medicaid Services (CMS) just announced that the Quality Reporting Communication Support Page (where you go to apply for one of the four hardship exemptions from the 2013 1.5% Medicare payment reduction) will re-open November 1, 2012 through January 31, 2013 for Medicare 2013 Electronic Prescribing (eRx) Payment Adjustment Hardship Exemption Requests.

Beginning November 1, 2012, CMS will re-open the Quality Reporting Communication Support Page to allow individual eligible professionals and CMS-selected group practices the opportunity to request a significant hardship exemption for the 2013 eRx payment adjustment. Significant hardship request should be submitted via the Quality Reporting Communication Support Page (Communication Support Page) on or between November 1, 2012 and January 31, 2012. CMS will review these requests on a case-by-case basis. All decisions on significant hardship exemption requests will be final.

Important – Please note that this is for the 2013 eRx payment adjustment only. Hardship exemption requests for the 2014 payment adjustment will be accepted during a separate time frame later in calendar year 2013.

Are you already exempt from the 2013 1.5% payment cut?

The 2013 eRx payment adjustment only applies to certain individual eligible professionals. CMS will automatically exclude those individual eligible professionals who meet the
following criteria:

- The eligible professional was a successful electronic prescriber during the 2011 (yes, 2011!) eRx 12-month reporting period (January 1, 2011 through December 31, 2011).
- The eligible professional is not an MD, DO, podiatrist, Nurse Practitioner, or Physician Assistant by June 30, 2012, based on primary taxonomy code in the National Plan and Provider Enumeration System (NPPES).
- The eligible professional does not have at least 100 Medicare Physician Fee Schedule (MPFS) cases containing an encounter code in the measure’s denominator for dates of service from January 1, 2012 through June 30, 2012.
- The eligible professional does not have 10% or more of their MPFS allowable charges (per TIN) for encounter codes in the measure’s denominator for dates of service from January 1, 2012 through June 30, 2012.
- The eligible professional does not have prescribing privileges and reported G8644 on a billable Medicare Part B service at least once on a claim between January 1, 2012 and June 30, 2012.

Avoiding the 2013 eRx payment adjustment through hardship exemptions

CMS may exempt individual eligible professionals and group practices participating in eRx GPRO from the 2013 eRx payment adjustment if it is determined that compliance with the requirements for becoming a successful electronic prescriber would result in a significant hardship.

Significant Hardships

The significant hardship categories are as follows:
The eligible professional is unable to electronically prescribe due to local, state, or federal law, or regulation

The eligible professional has or will prescribe fewer than 100 prescriptions during a 6-month reporting period (January 1 through June 30, 2012)

The eligible professional practices in a rural area without sufficient high-speed Internet access

The eligible professional practices in an area without sufficient available pharmacies for electronic prescribing

**Submitting a Significant Hardship Request**

To request a significant hardship, individual eligible professionals and group practices participating in eRx GPRO must submit their significant hardship exemption requests through the [Quality Reporting Communication Support Page](#) (Communication Support Page) on or between November 1, 2012 and December 31, 2012.

Significant hardships associated with one of the four above reasons may be submitted ONLY via the Communication Support Page.

For more information on how to navigate the Communication Support Page, please reference the following documents:

- [Quality Reporting Communication Support Page User Guide](#)
- [Tips for Using the Quality Reporting Communication Support Page](#)

For additional information and resources, please [visit the E-Prescribing Incentive Program web page](#).

If you have questions regarding the eRx Incentive Program, eRx payment adjustments, or need assistance submitting a hardship exemption request, please contact the QualityNet Help Desk at [866-288-8912](tel:866-288-8912) (TTY [877-715-6222](tel:877-715-6222)) or via [qnetsupport@sdps.org](mailto:qnetsupport@sdps.org).
They are available Monday through Friday from 7am to 7pm CST.

The 2013 Work Plan for the OIG has been released and here are some of the top items that relate to medical practices. This is a great list to use for review and discussion – Is your medical practice doing this correctly?

Incident-To Services Performed by Nonphysicians

Reasons why practices are not billing these services
correctly:

- Lack of understanding of incident-to
- Trying to avoid the 15% reduction in reimbursement for services provided by credentialed nonphysicians
- Difficulty in documenting who provided the services for charge entry

The OIG Workplan says: We will review physician billing for “incident-to” services to determine whether payment for such services had a higher error rate than that for non-incident-to services. We will also assess Medicare’s ability to monitor services billed as “incident-to.” Medicare Part B pays for certain services billed by physicians that are performed by nonphysicians incident to a physician office visit. A 2009 OIG review found that when Medicare allowed physicians’ billings for more than 24 hours of services in a day, half of the services were not performed by a physician. We also found that unqualified nonphysicians performed 21 percent of the services that physicians did not personally perform. Incident-to services are a program vulnerability in that they do not appear in claims data and can be identified only by reviewing the medical record. They may also be vulnerable to overutilization and expose beneficiaries to care that does not meet professional standards of quality. Medicare’s Part B coverage of services and supplies that are performed incident to the professional services of a physician is in the Social Security Act, § 1861(s)(2)(A). Medicare requires providers to furnish such information as may be necessary to determine the amounts due to receive payment. (Social Security Act, § 1833(e).) (OEI; 00-00-00000; expected issue date: FY 2014; new start)

Place-of-Service (POS) Coding
Errors

Reasons why practices are not billing these services correctly:

- Confusion over place of service when the practice is owned by a hospital
- Confusion over place of service when the technical and professional components of a service are performed in two different places (NOTE: this will be somewhat rectified in April 2013 when new POS rules for Medicare will be in effect)
- Confusion over place of service when a nursing facility has several different places of services within one facility
- Providing services (or saying you are) wherever the reimbursement rate is highest

The OIG Workplan says: We will review physicians’ coding on Medicare Part B claims for services performed in ambulatory surgical centers and hospital outpatient departments to determine whether they properly coded the places of service. Federal regulations provide for different levels of payments to physicians depending on where services are performed. (42 CFR § 414.32.) Medicare pays a physician a higher amount when a service is performed in a nonfacility setting, such as a physician’s office, than it does when the service is performed in a hospital outpatient department or, with certain exceptions, in an ambulatory surgical center. (OAS; W-00-11-35113; various reviews; expected issue date: FY 2013; work in progress)

Evaluation and Management Services – Potentially Inappropriate
Payments in 2010

Reasons why practices are not billing these services correctly:

- Confusion by physicians and other providers on how to document properly and how to choose a code based on what has been documented
- Over-reliance on EMR templating and macros to paste the same or very similar verbiage into the medical records of all or most patients seen by the same provider

The OIG Workplan says: We will determine the extent to which CMS made potentially inappropriate payments for E/M services in 2010 and the consistency of E/M medical review determinations. We will also review multiple E/M services for the same providers and beneficiaries to identify electronic health records (EHR) documentation practices associated with potentially improper payments. Medicare contractors have noted an increased frequency of medical records with identical documentation across services. Medicare requires providers to select the code for the service on the basis of the content of the service and have documentation to support the level of service reported. (CMS’s Medicare Claims Processing Manual, Pub. No. 100-04, ch. 12, § 30.6.1.) (OEI; 04-10-00181; 04-10-00182; expected issue date: FY 2013; work in progress)

Evaluation and Management Services – Use of Modifiers During the Global Surgery Period

Reasons why practices are not billing these services correctly:

- Confusion over the length of the global period
- Confusion over what services are included in the global
package and what services can be legitimately charged with a modifier as distinct from the global package

The OIG Workplan says: We will review the appropriateness of the use of certain claims modifier codes during the global surgery period and determine whether Medicare payments for claims with modifiers used during such a period were in accordance with Medicare requirements. Prior OIG work found that improper use of modifiers during the global surgery period resulted in inappropriate payments. The global surgery payment includes a surgical service and related preoperative and postoperative E/M services provided during the global surgery period. (CMS’s Medicare Claims Processing Manual, Pub. 100-04, ch. 12, § 40.1.) Guidance for the use of modifiers for global surgeries is in CMS’s Medicare Claims Processing Manual, Pub. 100-04, ch. 12, § 30. (OAS; W-00-13-35607; various reviews; expected issue date: FY 2013; new start)

Non-Hospital-Owned Physician Practices Using Provider-Based Status (New)

Reasons why practices are not billing these services correctly:

- Confusion over split billing – billing separately for the professional fee and the facility fee
- Confusion over the term “provider-based status”

The OIG Workplan says: We will determine the impact of non-hospital-owned physician practices billing Medicare as provider-based physician practices. We will also determine the extent to which practices using the provider-based status met CMS billing requirements. Provider-based status allows a
subordinate facility to bill as part of the main provider. Provider-based status can result in additional Medicare payments for services furnished at provider-based facilities and may also increase beneficiaries’ coinsurance liabilities. In 2011, the Medicare Payment Advisory Commission (MedPAC) expressed concerns about the financial incentives presented by provider-based status and stated that Medicare should seek to pay similar amounts for similar services. (OEI; 04-12-00380; 04-12-00381; expected issue date: FY 2013; work in progress)

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**Medicare Pricing Released for Most Flu Vaccine Codes**

- Medicare pricing for flu vaccines were released September 28th and appear below for all HCPCS codes which were published with fees. For more information on billing for these vaccines, see our post [here](#).

**NEW for 2012-2013! 90653** – Influenza virus vaccine, inactivated, subunit, adjuvanted, for intramuscular use (Medicare reimbursement not yet published)

90654 Influenza virus vaccine, split virus, preservative-free, for intradermal use (Medicare reimbursement $18.91)

90655 Influenza virus vaccine, trivalent, preservative free, when administered to children 6-35 months of age, for intramuscular use (Medicare reimbursement $16.45) single dose syringe

90656 Influenza virus vaccine, trivalent, preservative free,
when administered to individuals 3 years and older, for intramuscular use (Use for Medicare flu shots using the vaccine Fluarix) (Medicare reimbursement $12.39) single dose syringe

90657 Influenza virus vaccine, trivalent, when administered to children 6-35 months of age, for intramuscular use (Medicare reimbursement $6.02) multi-dose vial

90658 Influenza virus vaccine, trivalent, when administered to individuals 3 years and older, for intramuscular use (not recognized by Medicare) multi-dose vial

90660 Influenza virus vaccine, live, for intranasal use (Medicare reimbursement $23.45)

90662 Influenza virus vaccine, trivalent, preservative free, enhanced immunogenicity via increased antigen content, for intramuscular use (Medicare reimbursement $30.92) high dose

90672 Influenza virus vaccine, quadrivalent, live, for intranasal use (not recognized by Medicare)

90685 Influenza virus vaccine, quadrivalent, preservative free, when administered to children 6-35 months of age, for intramuscular use (not recognized by Medicare)

90686 Influenza virus vaccine, quadrivalent, preservative free, when administered to individuals 3 years and older, for intramuscular use (not recognized by Medicare)

90687 Influenza virus vaccine, quadrivalent, when administered to children 6-35 months of age, for intramuscular use (not recognized by Medicare)

90688 Influenza virus vaccine, quadrivalent, when administered to individuals 3 years and older, for intramuscular use (not recognized by Medicare)
Only for Medicare Patients:
NEW for 2012-2013! Q2034 Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Agriflu) (Medicare reimbursement not released)

Q2035 Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Afluria) (Medicare reimbursement $11.54)

Q2036 Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Flulaval) (Medicare reimbursement $9.83)

Q2037 Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Fluvirun) (Medicare reimbursement $14.05)

Q2038 Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Fluzone) (Medicare reimbursement $12.04)

Q2039 Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Not Otherwise Specified) (No reimbursement rate specified)

Faced a RAC Recovery Audit? Take Frank Cohen’s Survey!

If you have, please consider taking a few minutes to fill out the post-Audit survey being compiled and made available free by the Frank Cohen Group. This is the last week the survey is being offered, so hurry!
“Just a reminder that the RAC audits and appeals survey will close on Monday the 17th – so if you haven’t responded, please do so as soon as possible. The results of this survey will be passed along to congressional representatives to aid in their case for creating an accountability provision for the RAC auditors. It has become quite obvious that RACs have become far too aggressive and zealous with regard to their audit tactics and findings, invalidating their original purpose. The concern is that, by acting in an abusive manner, RACs are actually adding to the cost of healthcare, not reducing it.

The survey is only six questions and takes less than three minutes to complete; so I urge anyone who has been subject to a RAC audit in the past year to please respond. You can access the survey at www.FrankCohenGroup.com by clicking on the Surveys tab.

Thanks again for your help. I will be publishing the results shortly after the survey has closed.”

Taking the survey is a great, quick way to have your voice as a medical practice manager heard by policymakers and the voting public at large. Take advantage of it!

Medicare Reimbursement Codes for Alcohol Misuse and
Depression Screening

CMS sponsored a conference call last week to make sure that Part B providers are aware of new services payable by Medicare. These services were in effect late in 2011, but most providers are not aware of their existence. Is your practice using these new Medicare reimbursement codes?

Screening & Counseling for Alcohol Misuse

Why does CMS consider alcohol misuse screening and counseling important for Medicare patients?

According to the USPSTF (2004), alcohol misuse includes risky/hazardous and harmful drinking which place individuals at risk for future problems; and in the general adult population, risky or hazardous drinking is defined as >7 drinks per week or >3 drinks per occasion for women, and >14 drinks per week or >4 drinks per occasion for men. Harmful drinking describes those persons currently experiencing physical, social or psychological harm from alcohol use, but who do not meet criteria for dependence.

Which providers can provide alcohol misuse screening and counseling for Medicare patients?

- 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
New code G0442 – screening for alcohol misuse, is available once every 12 months, 15 minutes

National Payment Rates

- $17.36 Physician (non-facility)
- $9.19 Physician (facility)
- $35.69 Hospital/Outpatient
- No beneficiary co-insurance/deductible

New code G0443 – Brief face-to-face behavioral counseling, is available four times every 12 months, 15 minutes each visit

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.

**National Payment Rates**

- $25.19 Physician (non-facility)
- $23.15 Physician (facility)
- $35.69 Hospital/Outpatient

No beneficiary co-insurance/deductible

Can this service be provided at the same time as another service? Typically it would be bundled into another visit (such as the patient coming in to discuss a problem with alcohol), however, it can be provided at the same time but charged additionally to a Welcome to Medicare Visit (G0402) and services with modifier 59. Modifier 59 may be used when procedures (not E/M codes) that are normally bundled should both be reported because of a specific circumstance.

**Screening for Depression**

**New Code G0444 — Annual depression screening, no more than once in a 12-month period**

**Why does CMS consider depression screening important for Medicare patients?**

Among persons older than 65 years, one in six suffers from depression. Depression in older adults is estimated to occur in 25% of those with other illness including cancer, arthritis, stroke, chronic lung disease, and cardiovascular disease. Other stressful events, such as the loss of friends and loved ones, are also risk factors for depression. Opportunities are missed to improve health outcomes when mental illness is under-recognized and under-treated in
primary care settings. Older adults have the highest risk of suicide of all age groups. These patients are important in the primary care setting because 50-75% of older adults who commit suicide saw their medical doctor during the prior month for general medical care, and 39% were seen during the week prior to their death. Symptoms of major depression that are felt nearly every day include, but are not limited to, feeling sad or empty; less interest in daily activities; weight loss or gain when not dieting; less ability to think or concentrate; tearfulness, feelings of worthlessness, and thoughts of death or suicide.

Who can provide depression screening for Medicare patients?

This service must be provided 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.

What tool does Medicare want providers to use for depression screening?

Various screening tools are available for screening for depression. CMS does not identify specific depression screening tools. Rather, the decision to use a specific tool is at the discretion of the clinician in a primary care setting.
Does Medicare cover treatment for depression under this code or related codes?

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. Note: Eleven full months must elapse following the month in which the last annual depression screening took place.

**National Payment Rates**

- $17.36 Physician (non-facility)
- $9.19 Physician (facility)
- $35.69 Hospital/Outpatient
- No beneficiary co-insurance/deductible

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**Video – The Manager’s Minute**

**Episode #6 – Daily Reconciliation**

Check out the latest Manager’s Minute from Manage My Practice!

In Episode #6, Mary Pat explains how to do a Daily Reconciliation of your practice’s charges and payments.

And click below to download our free Daily Reconciliation form!