New Medicare Card and Reason Code N793

If you’ve seen new reason code N793 on your Medicare remittance advice lately and wonder what it is, you now know it relates to the new Medicare card.

The description for N793 is:

**Alert:** CMS is changing from the Medicare Health Insurance Claim Number (HICN aka “hickin”) to the new Medicare Beneficiary Identifier (MBI). You can use either the HICN or MBI during this transition period.

You’ve probably been bombarded with Medicare news releases and Open Door Forums describing the change and the timeline, but if not, here are some helpful links:

CMS Page on the New Card [here](#).

FAQs updated April 4th [here](#).

Signs and widgets for your office and website [here](#).

Timeline for state by state rollout [here](#). (Hint: most states are described only as “After June 2018”)

Electronic Remittance Advice Example [here](#).

**Important Dates for the New Medicare Card**

- CMS accepts MBIs only regardless of the date of service January 1, 2020.
2017 Medicare Deductibles and Premiums

2017 Medicare Parts A & B

Premiums and Deductibles Announced

The Centers for Medicare & Medicaid Services (CMS) announced the 2017 premiums for the Medicare inpatient hospital (Part A) and physician and outpatient hospital services (Part B) programs.

Medicare Part B Premiums/Deductibles

Medicare Part B covers physician services, outpatient hospital services, certain home health services, durable medical equipment, and other items.

On October 18, 2016, the Social Security Administration announced that the cost-of-living adjustment (COLA) for Social Security benefits will be 0.3 percent for 2017. Because of the low Social Security COLA, a statutory “hold harmless” provision designed to protect seniors, will largely prevent Part B premiums from increasing for about 70 percent of beneficiaries. Among this group, the average 2017 premium will be about $109.00, compared to $104.90 for the past four years.

For the remaining roughly 30 percent of beneficiaries, the standard monthly premium for Medicare Part B will be $134.00 for 2017, a 10 percent increase from the 2016 premium of $121.80. Because of the “hold harmless” provision covering the other 70 percent of beneficiaries, premiums for the remaining 30 percent must cover most of the increase in Medicare costs.
for 2017 for all beneficiaries. This year, as in the past, the Secretary has exercised her statutory authority to mitigate projected premium increases for these beneficiaries, while continuing to maintain a prudent level of reserves to protect against unexpected costs. The Department of Health and Human Services (HHS) will work with Congress as it explores budget-neutral solutions to challenges created by the “hold harmless” provision.

“Medicare’s top priority is to ensure that beneficiaries have affordable access to the care they need,” said CMS Acting Administrator Andy Slavitt. “We will continue our efforts to improve affordability, access, and quality in Medicare.”

Medicare Part B beneficiaries not subject to the “hold harmless” provision include beneficiaries who do not receive Social Security benefits, those who enroll in Part B for the first time in 2017, those who are directly billed for their Part B premium, those who are dually eligible for Medicaid and have their premium paid by state Medicaid agencies, and those who pay an income-related premium. These groups represent approximately 30 percent of total Part B beneficiaries.

CMS also announced that the annual deductible for all Medicare Part B beneficiaries will be $183 in 2017 (compared to $166 in 2016).

**Medicare Part A Premiums/Deductibles**

Medicare Part A covers inpatient hospital, skilled nursing facility, and some home health care services. About 99 percent
of Medicare beneficiaries do not have a Part A premium since they have at least 40 quarters of Medicare-covered employment.

The Medicare Part A inpatient hospital deductible that beneficiaries pay when admitted to the hospital will be $1,316 per benefit period in 2017, an increase of $28 from $1,288 in 2016. The Part A deductible covers beneficiaries’ share of costs for the first 60 days of Medicare-covered inpatient hospital care in a benefit period. Beneficiaries must pay a coinsurance amount of $329 per day for the 61st through 90th day of hospitalization ($322 in 2016) in a benefit period and $658 per day for lifetime reserve days ($644 in 2016). For beneficiaries in skilled nursing facilities, the daily coinsurance for days 21 through 100 of extended care services in a benefit period will be $164.50 in 2017 ($161 in 2016).

Enrollees age 65 and over who have fewer than 40 quarters of coverage and certain persons with disabilities pay a monthly premium in order to receive coverage under Medicare Part A. Individuals who had at least 30 quarters of coverage or were married to someone with at least 30 quarters of coverage may buy into Part A at a reduced monthly premium rate, which will be $227 in 2017, a $1 increase from 2016. Uninsured aged and certain individuals with disabilities who have exhausted other entitlement and who have less than 30 quarters of coverage will pay the full premium, which will be $413 a month, a $2 increase from 2016.

Flu Shot Information: 2016 –
CDC Updates Flu Shot Recommendations for 2016-2017 Flu Season

A few things are new this season:

- Only injectable flu shots are recommended for use this season.
- Flu vaccines have been updated to better match circulating viruses.
- There will be some new vaccines on the market this season.
- Live attenuated influenza vaccine (LAIV) – or the nasal spray vaccine – is **not** recommended for use during the 2016-2017 season because of concerns about its effectiveness.
- CPT code 90674 is a new code for 2017, and some code descriptions are revised for 2017 to indicate dosage as opposed to age.
- The recommendations for vaccination of people with egg allergies have changed.

The recommendations for people with egg allergies have been updated for this season:

- People who have experienced only hives after exposure to egg can get any licensed flu vaccine that is otherwise
appropriate for their age and health.

- People who have symptoms other than hives after exposure to eggs, such as angioedema, respiratory distress, lightheadedness, or recurrent emesis; or who have needed epinephrine or another emergency medical intervention, also can get any licensed flu vaccine that is otherwise appropriate for their age and health, but the vaccine should be given in a medical setting and be supervised by a health care provider who is able to recognize and manage severe allergic conditions. (Settings include hospitals, clinics, health departments, and physician offices). People with egg allergies no longer have to wait 30 minutes after receiving their vaccine.

Options this season include:

- Standard dose flu shots. Most are given into the muscle (usually with a needle, but one can be given to some people with a jet injector). One is given into the skin.
- A high-dose shot for older people.
- A shot made with adjuvant for older people.
- A shot made with virus grown in cell culture.
- A shot made using a vaccine production technology (recombinant vaccine) that does not require the use of flu virus.

Medicare and the Flu Shot

The Medicare Part B payment allowance limits for seasonal influenza and pneumococcal vaccines are 95% of the Average Wholesale Price (AWP) as reflected in the published compendia except where the vaccine is furnished in a hospital outpatient department. When the vaccine is furnished in the hospital outpatient department, payment for the vaccine is based on
Providers should note that:

- All physicians, non-physician practitioners and suppliers who administer the influenza virus vaccination and the pneumococcal vaccination must take assignment on the claim for the vaccine.
- The annual Part B deductible and coinsurance amounts do not apply.

Medicare Payment Allowances and Effective Dates for the 2016-2017 Flu Season

**Effective Dates 8/1/2016 – 7/31/2017**

- CPT 90630 Payment allowance is $20.343.
- CPT 90653 Payment allowance is $37.383.
- CPT 90656 Payment allowance is $17.717.
- CPT 90657 Payment allowance is pending.
- CPT 90661 Payment allowance is pending.
- CPT 90662 Payment allowance is $42.722.
- CPT 90672 Payment allowance is $26.876.
- CPT 90673 Payment allowance is $40.613.
- CPT 90674 Payment allowance is $22.936.
- CPT 90685 Payment allowance is $26.268.
- CPT 90686 Payment allowance is $19.032.
- CPT 90687 Payment allowance is $9.403.
- CPT 90688 Payment allowance is $17.835.
- HCPCS Q2035 Payment allowance is $16.284.
- HCPCS Q2037 Payment allowance is $16.284.
- HCPCS Q2039 Flu Vaccine Adult – Not Otherwise Classified payment allowance is to be determined by the local claims processing contractor with effective dates of 8/1/2016-7/31/2017.

[Click here](#) for a handy flu shot chart with CPT codes and
Yesterday the Centers for Medicare & Medicaid Services (CMS) announced the 2016 premiums and deductibles for the Medicare inpatient hospital (Part A) and physician and outpatient hospital services (Part B) programs.

**Part B Premiums/Deductibles**

As the Social Security Administration previously announced, there will be no Social Security cost of living increase for 2016. As a result, by law, most people with Medicare Part B will be “held harmless” from any increase in premiums in 2016 and will pay the same monthly premium as last year, which is **$104.90**.

Beneficiaries not subject to the “hold harmless” provision will pay **$121.80**, as calculated reflecting the provisions of the Bipartisan Budget Act signed into law by President Obama last week. Medicare Part B beneficiaries not subject to the “hold-harmless” provision are those not collecting Social Security benefits, those who will enroll in Part B for the first time in 2016, dual eligible beneficiaries who have their premiums paid by Medicaid, and beneficiaries who pay an additional income-related premium. These groups account for about 30 percent of the 52 million Americans expected to be manufacturers.
enrolled in Medicare Part B in 2016.

“Our goal is to keep Medicare Part B premiums affordable. Thanks to the leadership of Congress and President Obama, the premiums for 52 million Americans enrolled in Medicare Part B will be either flat or substantially less than they otherwise would have been,” said CMS Acting Administrator Andy Slavitt. “Affordability for Medicare enrollees is a key goal of our work building a health care system that delivers better care and spends health care dollars more wisely.”

Because of slow growth in medical costs and inflation, Medicare Part B premiums were unchanged for the 2013, 2014, and 2015 calendar years. The “hold harmless” provision would have required the approximately 30 percent of beneficiaries not held harmless in 2016 to pay an estimated base monthly Part B premium of $159.30 in part to make up for lost contingency reserves, according to the 2015 Trustees Report. However, the Bipartisan Budget Act of 2015 mitigated the Part B premium increase for these beneficiaries and states, which have programs that pay some or all of the premiums and cost-sharing for certain people who have Medicare and limited incomes. The CMS Office of the Actuary estimates that states will save $1.8 billion as a result of this premium mitigation.

CMS also announced that the annual deductible for all Part B beneficiaries will be $166.00 in 2016.

Premiums for Medicare Advantage and Medicare Prescription Drug plans already finalized are unaffected by this announcement.

To get more information about state-by-state savings, visit the CMS website here.

Since 2007, beneficiaries with higher incomes have paid higher Part B monthly premiums. These income-related monthly adjustment amount (IRMAA) affect fewer than 5 percent of
people with Medicare. Under the Part B section of the Bipartisan Budget Act of 2015, high income beneficiaries will pay an additional amount. The IRMAA, additional amounts, and total Part B premiums for high income beneficiaries for 2016 are shown in the following table:

<table>
<thead>
<tr>
<th>IRMAA Additional Amounts</th>
<th>Total Part B Premiums</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0</td>
<td>$1,288.00</td>
</tr>
</tbody>
</table>

Premiums for beneficiaries who are married and lived with their spouse at any time during the taxable year, but file a separate return, are as follows:

Part A Premiums/Deductibles

Medicare Part A covers inpatient hospital, skilled nursing facility, and some home health care services. About 99 percent of Medicare beneficiaries do not pay a Part A premium since they have at least 40 quarters of Medicare-covered employment.

The Medicare Part A annual deductible that beneficiaries pay when admitted to the hospital will be $1,288.00 in 2016, a small increase from $1,260.00 in 2015. The Part A deductible covers beneficiaries’ share of costs for the first 60 days of Medicare-covered inpatient hospital care in a benefit period. The daily coinsurance amounts will be $322 for the 61st through 90th day of hospitalization in a benefit period and $644 for lifetime reserve days. For beneficiaries in skilled nursing facilities, the daily coinsurance for days 21 through 100 in a benefit period will be $161.00 in 2016 ($157.50 in 2015).

Enrollees age 65 and over who have fewer than 40 quarters of coverage and certain persons with disabilities pay a monthly premium in order to receive coverage under Part A. Individuals with 30-39 quarters of coverage may buy into Part A at a reduced monthly premium rate, which will be $226.00 in 2016, a $2.00 increase from 2015. Those with less than 30 quarters of coverage pay the full premium, which will be $411.00 a month, a $4.00 increase from 2015.
Part A Deductibles and Coinsurance for 2016

For more information on the 2016 Medicare Parts A and B premiums and deductibles (CMS-8059-N, CMS-8060-N, and CMS-8061-N), click here.

CMS and AMA Make ICD-10 “Family” Clarification

Clarifying Questions and Answers Related to the July 6, 2015 CMS/AMA Joint Announcement and Guidance Regarding ICD-10 Flexibilities

Question 1:
When will the ICD-10 Ombudsman be in place?

Answer 1:
The Ombudsman will be in place by October 1, 2015.

Question 2:
Does the Guidance mean there is a delay in ICD-10 implementation?

Answer 2:
No. The CMS/AMA Guidance does not mean there is a delay in the
implementation of the ICD-10 code set requirement for Medicare or any other organization. Medicare claims with a date of service on or after October 1, 2015, will be rejected if they do not contain a valid ICD-10 code. The Medicare claims processing systems do not have the capability to accept ICD-9 codes for dates of service after September 30, 2015 or accept claims that contain both ICD-9 and ICD-10 codes for any dates of service. Submitters should follow existing procedures for correcting and resubmitting rejected claims.

**Question 3:**

**What is a valid ICD-10 code?**

**Answer 3:**

ICD-10-CM is composed of codes with 3, 4, 5, 6 or 7 characters. Codes with three characters are included in ICD-10-CM as the heading of a category of codes that may be further subdivided by the use of fourth, fifth, sixth or seventh characters to provide greater specificity. A three-character code is to be used only if it is not further subdivided. To be valid, a code must be coded to the full number of characters required for that code, including the 7th character, if applicable. Many people use the term billable codes to mean valid codes. For example, E10 (Type 1 diabetes mellitus), is a category title that includes a number of specific ICD-10-CM codes for type 1 diabetes. Examples of valid codes within category E10 include E10.21 (Type 1 diabetes mellitus with diabetic nephropathy) which contains five characters and code E10.9 (Type 1 diabetes mellitus without complications) which contains four characters.

A complete list of the 2016 ICD-10-CM valid codes and code titles is posted on the CMS website at http://www.cms.gov/Medicare/Coding/ICD10/2016-ICD-10-CM-and-GE Ms.html. The codes are listed in tabular order (the order found in the ICD-10-CM code book). This list should assist
providers who are unsure as to whether additional characters are needed, such as the addition of a 7th character in order to arrive at a valid code.

**Question 4:** What should I do if my claim is rejected? Will I know whether it was rejected because it is not a valid code versus denied due to a lack of specificity required for a NCD or LCD or other claim edit?

**Answer 4:**

Yes, submitters will know that it was rejected because it was not a valid code versus a denial for lack of specificity required for a NCD or LCD or other claim edit. Submitters should follow existing procedures for correcting and resubmitting rejected claims and issues related to denied claims.

**Question 5:**

What is meant by a family of codes?

**Answer 5:**

“Family of codes” is the same as the ICD-10 three-character category. Codes within a category are clinically related and provide differences in capturing specific information on the type of condition. For instance, category H25 (Age-related cataract) contains a number of specific codes that capture information on the type of cataract as
well as information on the eye involved. Examples include: H25.031 (Anterior subcapsular polar age-related cataract, right eye), which has six characters; H25.22 (Age-related cataract, morgagnian type, left eye), which has five characters; and H25.9 (Unspecified age-related cataract), which has four characters. One must report a valid code and not a category number. In many instances, the code will require more than 3 characters in order to be valid.

Question 6:

Does the recent Guidance mean that no claims will be denied if they are submitted with an ICD-10 code that is not at the maximum level of specificity?

Answer 6:

In certain circumstances, a claim may be denied because the ICD-10 code is not consistent with an applicable policy, such as Local Coverage Determinations or National Coverage Determinations. (See Question 7 for more information about this). This reflects the fact that current automated claims processing edits are not being modified as a result of the guidance.

In addition, the ICD-10 code on a claim must be a valid ICD-10 code. If the submitted code is not recognized as a valid code, the claim will be rejected. The physician can resubmit the claims with a valid code.

Question 7:
National Coverage Determinations (NCD) and Local Coverage Determinations (LCD) often indicate specific diagnosis codes are required. Does the recent Guidance mean the published NCDs and LCDs will be changed to include families of codes rather than specific codes?

Answer 7:

No. As stated in the CMS’ Guidance, for 12 months after ICD-10 implementation, Medicare review contractors will not deny physician or other practitioner claims billed under the Part B physician fee schedule through either automated medical review or complex medical record review based solely on the specificity of the ICD-10 diagnosis code as long as the physician/practitioner used a valid code from the right family of codes. The Medicare review contractors include the Medicare Administrative Contractors, the Recovery Auditors, the Zone Program Integrity Contractors, and the Supplemental Medical Review Contractor.

As such, the recent Guidance does not change the coding specificity required by the NCDs and LCDs. Coverage policies that currently require a specific diagnosis under ICD-9 will continue to require a specific diagnosis under ICD-10. It is important to note that these policies will require no greater specificity in ICD-10 than was required in ICD-9, with the exception of laterality, which does not exist in ICD-9. LCDs and NCDs that contain ICD-10 codes for right side, left side, or bilateral do not allow for unspecified side. The NCDs and LCDs are publicly available and can be found at http://www.cms.gov/medicare-coverage-database/.

Question 8:

Are technical component (TC) only and global claims included in this same CMS/AMA guidance because they are paid under the Part B physician fee schedule?

Answer 8:
Yes, all services paid under the Medicare Fee-for-Service Part B physician fee schedule are covered by the guidance.

Question 9:

Do the ICD-10 audit and quality program flexibilities extend to Medicare fee-for-service prior authorization requests?

Answer 9:

No, the audit and quality program flexibilities only pertain to post payment reviews. ICD-10 codes with the correct level of specificity will be required for prepayment reviews and prior authorization requests.

MEDICAID

Question 10:

If a Medicare paid claim is crossed over to Medicaid for a dual-eligible beneficiary, is Medicaid required to pay the claim?

Answer 10:

State Medicaid programs are required to process submitted claims that include ICD-10 codes for services furnished on or after October 1 in a timely manner. Claims processing verifies that the individual is eligible, the claimed service is covered, and that all administrative requirements for a Medicaid claim have been met. If these tests are met, payment can be made, taking into account the amount paid or payable by Medicare. Consistent with those processes, Medicaid can deny claims based on system edits that indicate that a diagnosis code is not valid.

Question 11:

Does this added ICD-10 flexibility regarding audits only apply to Medicare?
Answer 11:

The official Guidance only applies to Medicare fee-for-service claims from physician or other practitioner claims billed under the Medicare Fee-for-Service Part B physician fee schedule. This Guidance does not apply to claims submitted for beneficiaries with Medicaid coverage, either primary or secondary.

Question 12:

Will CMS permit state Medicaid agencies to issue interim payments to providers unable to submit a claim using valid, billable ICD-10 codes?

Answer 12:

Federal matching funding will not be available for provider payments that are not processed through a compliant MMIS and supported by valid, billable ICD-10 codes.

OTHER PAYERS

Question 13:

Will the commercial payers observe the one-year period of claims payment review leniency for ICD-10 codes that are from the appropriate family of codes?

Answer 13:

The official Guidance only applies to Medicare fee-for-service claims from physician or other practitioner claims billed under the Medicare Fee-for-Service Part B physician fee schedule. Each commercial payer will have to determine whether it will offer similar audit flexibilities.

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On July 9, 2015 the Centers for Medicare & Medicaid Services (CMS) announced the Comprehensive Care for Joint Replacement (CCJR) model, a proposed payment, quality, and care improvement initiative for hip and knee replacements.

The Center for Medicare & Medicaid Innovation (CMS Innovation Center) will host two offerings of a webinar to describe the proposed rule and respond to questions. The dates and registration links for these webinars are as follows:

- **Comprehensive Care for Joint Replacement Model Webinar #1** – Wednesday, July 15 from *1:00pm – 2:00pm EDT:  [https://engage.vevent.com/rt/cmms~071515](https://engage.vevent.com/rt/cmms~071515)

- **Comprehensive Care for Joint Replacement Model Webinar #2** – Thursday, July 16 from *2:00pm – 3:00pm EDT:  [https://engage.vevent.com/rt/cmms~071615](https://engage.vevent.com/rt/cmms~071615)

Additional information on this Model can be accessed through the [CCJR Model web page](#).
which time CMS welcomes the input of stakeholders and the public. You can read the proposed rule in the Federal Register.

We encourage all interested parties to submit comments to the rule electronically through the CMS e-Regulation website at http://www.cms.gov/Regulations-and-Guidance/Regulations-and-Policies/eRulemaking/index.html?redirect=/eRulemaking or on paper by following the instructions included in the proposed rule. Submissions must be received by September 8, 2015.

*Large audiences are anticipated. Plan on joining a few minutes early.

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CMS Hospital Compare: Patient Experience Translated Into Stars

Hospital Compare is a consumer-oriented website that provides information on how well hospitals provide care to their patients. It allows consumers to select multiple hospitals and directly compare performance measure information related to heart attack, heart failure, pneumonia, surgery and other conditions.
What Is HCAHPS?

The HCAHPS – pronounced “H-CAPS” – (Hospital Consumer Assessment of Healthcare Providers and Systems) Survey is a standardized questionnaire that measures patient perspectives of hospital care. HCAHPS results posted on Hospital Compare provide ratings, including comparisons to state and national averages, that help consumers understand how hospitals perform.

HCAHPS Star Ratings

On April 16, 2015, the Centers for Medicare & Medicaid Services (CMS) added HCAHPS Star Ratings to the Hospital Compare website as part of the initiative to add 5-star quality ratings to its Compare websites. CMS believes that star ratings spotlight excellence in health care quality and make it easier for consumers to use the information on the Compare websites. The ratings also support using quality measures as a key driver of health care system improvement.

Twelve HCAHPS Star Ratings appear on Hospital Compare: one for each of the 11 publicly reported HCAHPS measures, plus the new HCAHPS Summary Star Rating. HCAHPS Star Ratings are the first star ratings to appear on Hospital Compare and CMS plans to update the HCAHPS Star Ratings each quarter.

HCAHPS Measures Used to Determine Star Ratings

There is a star rating for each of the following HCAHPS measures:

- HCAHPS Composites Measures
  - Communication with Nurses (Q1, Q2, Q3)
  - Communication with Doctors (Q5, Q6, Q7)
Responsiveness of Hospital Staff (Q4, Q11)
- Pain Management (Q13, Q14)
- Communication about Medicines (Q16, Q17)
- Discharge Information (Q19, Q20)
- Care Transition (Q23, Q24, Q25)

- HCAHPS Individual Items
  - Cleanliness of Hospital Environment (Q8)
  - Quietness of Hospital Environment (Q9)

- HCAHPS Global Items
  - Overall Hospital Rating (Q21)
  - Recommend the Hospital (Q22)

Other “Compares” with Stars

CMS already uses star ratings in other Compare websites:

- [Nursing Home Compare](#)
- [Physician Compare](#)
- [Dialysis Facility Compare](#)
- [Home Health Compare](#) (stars coming later this year)
- [Medicare Plan Finder](#) uses star ratings to help beneficiaries select parts C and D plans. These star ratings also determine quality bonus payments for plans.

Why Can’t I Find My Hospital?

All hospitals that participate in the HCAHPS Survey are eligible to receive HCAHPS Star Ratings, which includes both Inpatient Prospective Payment System (IPPS) hospitals and Critical Access Hospitals (CAH). IPPS hospitals are required to report HCAHPS as part of the Hospital Inpatient Quality Reporting (IQR) Program and CAHs voluntarily participate.

In addition, hospitals must have at least 100 completed surveys in the 12-month reporting period and be eligible for public reporting in order to receive HCAHPS Star Ratings.
Exploring Hospital Compare

If you or a loved one has had a hospital experience recently, go to Hospital Compare and see if your experience correlates with other patient feedback. Please share your comparison in the comments!

This post was originally published on the LinkedIn Pulse as part of the LI Influencer program.

Photo Credit: Carol Green via Compfight cc

New “One Patient” MU Rule Brings Relief

Last week, CMS published a new proposed rule for Meaningful (MU). This rule strives to “…align Meaningful Use (MU) Stage
1 and Stage 2 objectives and measures with the long-term proposals for Stage 3...”. In other words, make the program simpler and make it easier to achieve.

The proposed rule would simplify MU by:

- Reducing the overall number of objectives;
- Removing measures that have become redundant, duplicative or have reached wide-spread adoption;
- Allowing a 90 day reporting period in 2015 to accommodate the implementation of these proposed changes in 2015, and possibly of the greatest interest to medical practice,
- Remove the 5 percent threshold for Measure 2 from the EP Stage 2 Patient Electronic Access objective, requiring that at least (only) 1 patient seen by the provider during the EHR reporting period views, downloads, or transmits his or her health information to a third party.

This last one is extremely important as practices have spent much time and money trying to encourage patients to use their portals to fulfill the view/download/transmit requirement. As a patient, I understand this. I only use my PCP’s portal a couple of times a year, so I invariably forget my user ID and password (yes, I do know there are programs to store and retrieve these for me, but that’s a conversation for a totally different post) and it all ends up just being a big pain. My health is important to me, but I don’t have reason to get on the portal on a regular basis, and practices are finding out that many patients just don’t care to use the portal or don’t have a need.

More light reading on the proposed rule is available here in the Federal Register.
Medicare recently started denying an increased number of claims because documentation submitted for diagnostic tests does not include signed test orders or evidence of intent (MD progress notes listing tests needed) and evidence of medical necessity (description of clinical conditions and treatment showing the need for the testing.)

Most of us who have gone through the implementation of a EMR realize that electronic medical records (EMRs) do not always “tell the story” of a visit in the way that paper records used to. Encounters are documented without the glue that allows an auditor to understand what went on during the visit. Here are three ways to make sure that your documentation meets requirement for Medicare and other payers.

Establish Medical Necessity: Make sure the test is attached to the right diagnosis

Some providers attach all diagnoses assigned to a visit to any/every test ordered and performed. This is incorrect. All diagnoses can be attached to the Evaluation & Management (E/M) code, since all were addressed during the visit. Don’t list any diagnoses from previous visits that were not addressed at the current visit unless you note their impact on your decisions for care at the current visit.

Remember that screening tests and diagnostic tests are two
different things. A **screening test** is ordered when you are looking for something with no provocation. [Wikipedia](https://en.wikipedia.org) states that a screening test “may be performed to monitor disease prevalence, manage epidemiology, aid in prevention, or strictly for statistical purposes.”

A **diagnostic test** is ordered when there is a sign or symptom that prompts the provider to look for the cause. [Wikipedia](https://en.wikipedia.org) defines a diagnostic test as “a procedure performed to confirm, or determine the presence of disease in an individual suspected of having the disease, usually following the report of symptoms, or based on the results of other medical tests.”

According to [Medscape](https://www.medscape.com), the 5 main reasons for any test are as follows:

- **Screening**: Screen for disease in asymptomatic patients. For example, a prostate-specific antigen (PSA) test in men older than 50 years.
- **Screening**: A test may be performed to confirm that a person is free from a disease or condition. For example, a pregnancy test to exclude the diagnosis of ectopic pregnancy.
- **Diagnostic**: Establish a diagnosis in symptomatic patients. For example, an ECG to diagnose ST-elevation myocardial infarction (STEMI) in patients with chest pain.
- **Diagnostic**: Provide prognostic information in patients with established disease. For example, a CD4 count in patients with HIV.
- **Diagnostic**: Monitor therapy by either benefits or side effects. For example, measuring the international normalized ratio (INR) in patients taking warfarin.
Reveal your decision making in the record

- Need add’l tests to est. xxxxxx. Plan to...
- Return in 3 wks and repeat test to establish...
- DM worsening – will...
- Consider d/c xxxxxx medication if fatigue persists.
- Hypothyroidism vs. anemia?
- Fatigue most likely sec. to HTN meds – r/o electrolyte abn.
- DM stable, continue current regimen, recheck in 3 months.

Don’t forget the signatures!

A signature log can be as simple as entries on a document such as:

Provider Name (printed): ______________________

Full signature (written by provider): ______________

Initials (written by provider): ___________________

(Photo Credit: deadstar 2.1 via Compfight cc)

FAQ for New CMS Rules for
Place of Service Codes (POS) on Claims for Services After April 1, 2013

CMS has clarified the Place of Service (POS) codes that Physicians/Providers are to use on claims for services to patients starting April 1, 2013. This is more than a simple technical requirement, however. The correct place of service is directly tied to how much a physician/provider is compensated. Keep in mind that the professional fee (the physician/provider part) is different based on whether the service is provided in a non-facility setting (not the hospital) or a facility setting (the hospital.)

**Q: What is the rule for choosing the POS for physician services?**

**A:** The POS code to be used by the physician and other suppliers will be the same setting in which the beneficiary received the face-to-face service.

**Q: How does the rule apply to the interpretation (reading) of diagnostic tests?**

**A:** When a physician/practitioner provides the Professional Component (PC)/interpretation of a diagnostic test from a different/distant site, the POS code assigned by the physician/practitioner will be the setting in which the beneficiary received the Technical Component (TC) of the service.

**Example:** A patient receives an MRI at an outpatient hospital near his/her home. The hospital submits a claim that would correspond to the TC portion of the MRI. The physician furnishes the PC portion of the beneficiary’s MRI from his/her
office location – POS code 22 will be used on the physician’s claim for the PC to indicate that the beneficiary received the face-to-face portion of the MRI, the TC, at the outpatient hospital.

**Q: Are there any exceptions to the rule?**

**A:** There are two exceptions: The physician should always use the POS code where the beneficiary is receiving care as a hospital inpatient (POS code 21) or an outpatient of a hospital (POS code 22) regardless of where the beneficiary encounters the face-to-face service. The Medicare Claims Processing Manual already requires this for physician services (and for certain independent laboratory services) provided to beneficiaries in the inpatient hospital; the new policy clarifies this exception and extends it to beneficiaries of the outpatient hospital, as well.

In other words, reporting the inpatient hospital POS code 21 or the outpatient hospital POS code 22, is a minimum requirement for purposes of triggering the facility payment under the PFS when services are provided to a registered inpatient or an outpatient of a hospital respectively.

The list of settings where a physician’s services are paid at the facility rate include:

- Inpatient Hospital (POS code 21)
- Outpatient Hospital (POS code 22)
- Emergency Room-Hospital (POS code 23)
- Medicare-participating Ambulatory Surgical Center (ASC) for a Healthcare Common Procedure Coding System (HCPCS) code included on the ASC approved list of procedures (POS code 24)
- Medicare-participating ASC for a procedure not on the ASC list of approved procedures with dates of service on or after January 1, 2008. (POS code 24)
- Military Treatment Facility (POS code 26)
- Skilled Nursing Facility (SNF) for a Part A resident (POS code 31)
- Hospice – for inpatient care (POS code 34)
- Ambulance – Land (POS code 41)
- Ambulance – Air or Water (POS code 42)
- Inpatient Psychiatric Facility (POS code 51)
- Psychiatric Facility – Partial Hospitalization (POS code 52)
- Community Mental Health Center (POS code 53)
- Psychiatric Residential Treatment Center (POS code 56)
- Comprehensive Inpatient Rehabilitation Facility (POS code 61)

The list of settings where a **physician's services are paid at the non-facility rate** include:

- Pharmacy (POS code 01)
- School (POS code 03)
- Homeless Shelter (POS code 04)
- Prison/Correctional Facility (POS code 09)
- Office (POS code 11)
- Home or Private Residence of Patient (POS code 12)
- Assisted Living Facility (POS code 13)
- Group Home (POS code 14)
- Mobile Unit (POS code 15)
- Temporary Lodging (POS code 16)
- Walk-in Retail Health Clinic (POS code 17)
- Urgent Care Facility (POS code 20)
- Birthing Center (POS code 25)
- Nursing Facility and Skilled Nursing Facilities (SNFs) to Part B residents – (POS code 32)
- Custodial Care Facility (POS code 33)
- Independent Clinic (POS code 49)
- Federally Qualified Health Center (POS code 50)
- Intermediate Health Care Facility/Mentally Retarded (POS code 54)
- Residential Substance Abuse Treatment Facility (POS code 58)
55) Non-Residential Substance Abuse Treatment Facility (POS code 57)
   Mass Immunization Center (POS code 60)
   Comprehensive Outpatient Rehabilitation Facility (POS code 62)
   End-Stage Renal Disease Treatment Facility (POS code 65)
   State or Local Health Clinic (POS code 71)
   Rural Health Clinic (POS code 72)
   Independent Laboratory (POS code 81)
   Other Place of Service (POS code 99)