Updated 2011 CMS Policies: Incentive Payments, GPCI Revisions, Multiple Procedure Payment Reductions for Therapy, and Modification of Multiple Procedure Payment Policy for Advanced Imaging Services

Elimination of Deductible and Coinsurance for Most Preventive Services

Effective January 1, 2011, the Affordable Care Act waives the Part B deductible and the 20 percent coinsurance that would otherwise apply to most preventive services.

Note: I covered this in my post here and it's pretty straightforward.

Coverage of Annual Wellness Visit (AWV) Providing a Personalized Prevention Plan

The Affordable Care Act extends the preventive focus of Medicare coverage, which currently pays for a one-time initial preventive physical examination (IPPE or the "Welcome to

Medicare Visit”), to provide coverage for annual wellness visits in which beneficiaries will receive personalized prevention plan services (PPPS). The law states that the AWV will include at least the following six elements, as determined by the Secretary of Health and Human Services:

- Establish or update the individual’s medical and family history;
- List the individual’s current medical providers and suppliers and all prescribed medications;
- Record measurements of height, weight, body mass index, blood pressure and other routine measurements;
- Detect any cognitive impairment
- Establish or update a screening schedule for the next 5 to 10 years including screenings appropriate for the general population, and any additional screenings that may be appropriate because of the individual patient’s risk factors; and
- Furnish personalized health advice and appropriate referrals to health education or education or preventive services.

CMS has developed two separate Level II HCPCS codes for the first annual wellness visit (G0438 – Annual wellness visit, including personalized prevention plan services, first visit), to be paid at the rate of a level 4 office visit for a new patient (similar to the IPPE), and for subsequent annual wellness visits (G0439 – Annual wellness visit, including personalized prevention plan services, subsequent visit), to be paid at the rate of a level 4 office visit for an established patient.

Note: Payment for annual wellness visits (AWV) is now covered by Medicare and the payment will be equivalent to a established level 4 visit. I’ve received a lot of questions about who can perform the PPPS and CMS says “A medical professional (including a health educator, registered dietitian, or nutrition professional or other licensed

practitioner) or a team of such medical professionals, working under the direct supervision of a physician.”

An evaluation and management code (EM) may be billed with the annual wellness visit if the EM service is medically necessary. If so, a modifier 25 must be appended to the EM service and the documentation for the EM service must have no components of the annual wellness visit used in determining the level of service for the EM visit. A separate note containing the history, exam and medical decision making, relative to the presenting problem, must be separately documented.

Incentive Payments to Primary Care Practitioners for Primary Care Services

The Affordable Care Act provides for incentive payments equal to 10 percent of a primary care practitioner’s allowed charges for primary care services under Part B, furnished on or after January 1, 2011, and before January 1, 2016. Under the final policy, primary care practitioners are: (1) physicians who have a primary specialty designation of family medicine, internal medicine, geriatric medicine, or pediatric medicine; as well as nurse practitioners, clinical nurse specialists, and physician assistants; and (2) for whom primary care services accounted for at least 60 percent of the practitioner’s Medicare Physician Fee Schedule (MPFS) allowed charges for a prior period as determined by the Secretary of Health and Human Services.

The law also defines primary care services as limited to new and established patient office or other outpatient visits (CPT codes 99201 through 99215); nursing facility care visits, and domiciliary, rest home, or home care plan oversight services (CPT codes 99304 through 99340); and patient home visits (CPT codes 99341 through 99350).

In the final rule with comment period, CMS excluded consideration of allowed charges for hospital inpatient care and emergency department visits in determining whether the 60 percent primary care threshold is met. These exclusions will make it easier for practitioners of eligible specialties to become eligible for the payment incentive program. The incentive payments will be made quarterly based on the primary care services furnished in CY 2011 by the primary care practitioner, in addition to any physician bonus payments for services furnished in Health Professional Shortage Areas (HPSAs). CMS will determine a practitioner's eligibility for incentive payments in CY 2011 using claims data and the provider's specialty designation from CY 2009 for practitioners enrolled in CY 2009. For newly enrolled practitioners, CMS will use claims data from CY 2010 to make an eligibility determination regarding CY 2011 incentive payments. For subsequent years, CMS will revise the list of primary care practitioners on a yearly basis, based on updated data regarding an individual's specialty designation and percentage of allowed charges for primary care services.

Note: There is nothing to count or report: the bonuses arrive quarterly. Providers in HPSAs will receive two bonuses. Want to know if you're in a HPSA? Click here.

Incentive Payments for Major Surgical Procedures in Health Professional Shortage Areas

The Affordable Care Act also calls for a payment incentive program to improve access to major surgical procedures "" defined as those with a 10-day or 90-day global period under the MPFS "" that are furnished by physicians in HPSAs on or after January 1, 2011, and before January 1, 2016. To be

eligible for the incentive payment, the physician must be enrolled in Medicare as a general surgeon. The amount of the incentive payment is equal to 10 percent of the MPFS payment for the surgical services furnished by the general surgeon. The incentive payments will be made quarterly to the general surgeon when the major surgical procedure is furnished in a zip code that is located in a HPSA. CMS will use the same list of HPSAs that it has used under the existing HPSA bonus program.

Note: 10% bonus for general surgeons in HPSAs. Want to know if you're in a HPSA? Click here.

Revisions to the Practice Expense Geographic Adjustment

As required by the Medicare law, CMS adjusts payments under the MPFS to reflect local differences in practice costs. CMS assigns separate geographic practice cost indices (GPCIs) to the work, practice expenses (PE), and malpractice insurance cost components of each of more than 7,000 types of physicians' services. The final rule with comment period discusses CMS' analysis of PE GPCI data and methods, and incorporates new data as part of the sixth GPCI update, while maintaining the current GPCI cost share weights pending the results of further CMS and Institute of Medicine studies.

The Affordable Care Act establishes a permanent 1.0 floor for the PE GPCI for frontier states (currently, Montana, Wyoming, Nevada, North Dakota, and South Dakota). The Affordable Care Act limits recognition of local differences in employee wages and office rents in the PE GPCIs for CYs 2011 and 2012 as compared to the national average. Localities are held harmless for any decrease in CYs 2011 and 2012 in their PE GPCIs that would result from the limited recognition of cost differences. CMS will continue to review the GPCIs in CY 2011, in

accordance with the Affordable Care Act provision that requires the Secretary of Health and Human Services to analyze current methods of establishing PE GPCIs in order to make adjustments that fairly and reliably distinguish the costs of operating a medical practice in the different fee schedule areas.

Note: Check your GPCI (pronounced "gypsy") for changes this year and every year. The GPCI changes the RVU values so they are specific to your location.

Where do I find my GPCI? Click here, click on Physician Fee Schedule Search at the top, click to accept the AMA terms, click on Geographic Practice Cost Index, enter your locality and click submit.

Improved Access to Certified Nurse-Midwife Services

The Affordable Care Act increases the Medicare payment for certified nurse-midwife services from 65 percent of the PFS amount for the same service furnished by a physician to 100 percent of the PFS amount for the same service furnished by a physician (or 80 percent of the actual charge if that is less). The increased payment amount is effective for services furnished on or after Jan. 1, 2011.

Misvalued Codes under the Physician Fee Schedule

The Affordable Care Act requires CMS to periodically review and identify potentially misvalued codes and make appropriate adjustments to the relative values of the services that may be misvalued. CMS has been engaged in a vigorous effort over the past several years to identify and revise potentially misvalued codes. The final rule with comment period identifies additional categories of services that may be misvalued,

including codes with low work RVUs commonly billed in multiple units per single encounter and codes with high volume and low work RVUs. The final rule also includes CMS' response to recommendations from the American Medical Association (AMA) Relative Value Update Committee (RUC) for CY 2011 regarding the work or direct practice expense inputs for 325 CPT codes.

Note: People and organizations are always lobbying to change the work or practice expense component of RVUs and some portion of the codes change every year. Make sure your computer is updated with the correct RVU components and total so your productivity reports are spot on.

Multiple Procedure Payment Reduction Policy for Therapy Services

The Affordable Care Act requires CMS to identify and make adjustments to the relative values for multiple services that are frequently billed together when a comprehensive service is furnished. CMS is adopting a multiple procedure payment reduction (MPPR) policy for therapy services in order to more appropriately recognize the efficiencies when combinations of therapy services are furnished together. The policy, as described in the CY 2011 MPFS final rule with comment period, states that the MPPR for "always" therapy services will reduce by 25 percent the payment for the practice expense component of the second and subsequent therapy services furnished by a single provider to a beneficiary on a single date of service. This policy will apply to all outpatient therapy services paid under Part B, including those furnished in office and facility settings.

Since publication of the CY 2011 MPFS final rule with comment period, this policy has been modified by the Physician Payment and Therapy Relief Act of 2010. Per this Act, CMS will apply the CY 2011 MPFS final rule policy of a 25 percent MPPR to

therapy services furnished in the hospital outpatient department and other facility settings that are paid under section 1834(k) of the Social Security Act (referring to durable medical equipment), and a 20 percent therapy MPPR will apply to therapy services furnished in clinicians’ offices and other settings that are paid under section 1848 (payments to physicians) of the Act.

Note: The reduction applies solely to the practice expense (PE) portion of the fee schedule payment for “Always Therapy Services” when more than one service is provided the same patient on the same day. “Always therapy” services are always considered to be therapy regardless who provides the service (qualified therapist, physician, non-physician practitioner (NPP)). This is the list of services being referred to:

- 92506””Speech /hearing evaluation
- 92507””Speech/hearing therapy
- 92508””Speech/hearing therapy
- 92526””Oral function therapy
- 92597””Oral speech device evaluation
- 92604””Exam for speech device
- 92609””Use of speech device service
- 96125””Standardized cognitive performance test
- 97001””PT evaluation
- 97002””PT re-evaluation
- 97003””OT evaluation
- 97001””OT re-evaluation
- 97012””Mechanical traction
- 97016””Vasopneumatic device
- 97018””Paraffin bath
- 97022””Whirlpool
- 97024””Diathermy (microwave)
- 97026””Infrared
- 97028””Ultraviolet
- 97032””Electrical stimulation
- 97033””Electric current

- 97034””Contrast bath
- 97035””Ultrasound
- 97036””Hydrotherapy
- 97110””Therapeutic exercise
- 97112””Neuromuscular reeducation
- 97113””Aquatic therapy
- 97116””Gait training
- 97124””Massage
- 97140””Manual therapy
- 97150””Group therapeutic
- 97530””Therapeutic activities
- 97533””Sensory integration
- 97535””Self-care management
- 97537””Community work reintegration
- 97542””Wheelchair management
- 97750””Physical performance test
- 97755””Assistive technology assessment
- 97760””Orthotic management & training
- 97761””Prosthetic training
- 97762””Checkout for orthotic or prosthetic use
- G0281””Electrical stimulation for ulcers (unattended)
- G0283””Electrical stimulation other than wound (unattended)
- G0329””Electromagnetic therapy for ulcers

Modification of Equipment Utilization Factor and Modification of Multiple Procedure Payment Policy for Advanced Imaging Services

The Affordable Care Act adjusts the equipment utilization rate assumption for expensive diagnostic imaging equipment. Effective January 1, 2011, CMS will assign a 75 percent equipment utilization rate assumption to expensive diagnostic imaging equipment used in diagnostic computed tomography (CT) and magnetic resonance imaging (MRI) services. In addition,

beginning on July 1, 2010, the Affordable Care Act increased the established MPFS multiple procedure payment reduction for the technical component of certain single-session imaging services to consecutive body areas from 25 to 50 percent for the second and subsequent imaging procedures performed in the same session.

Note: These are the services that were added by this policy:

- 70496-CT angiography, head
- 70498-CT angiography, neck
- 70544-MR angiography head w/o dye
- 70545-MR angiography head w/dye
- 70546-MR angiography head w/o & w/dye
- 70547-MR angiography neck w/o dye
- 70548-MR angiography neck w/dye
- 70549-MR angiography neck w/o & w/dye
- 71275-CT angiography, chest
- 71555- MRI angiography chest w/ or w/o dye
- 72159-MRI angiography spine w/o & w/dye
- 72191-CT angiography, pelvis w/o & w/ dye
- 72198-MRI angiography pelvis w/ or w/o dye
- 73206-CT angio upper extremity w/o & w/dye
- 73225-MR angio upper extremity w/o & w/dye
- 73706-CT angiography lower ext w/o & w/dye
- 73725-MR angio lower extremity w or w/o dye
- 74175-CT angiography, abdomen w/o & w/ dye
- 74185-MRI angiography, abdomen w/ or w/o dye
- 75565-Cardiology MRI velocity flow map add-on
- 75574-CT angiography heart w/3d image
- 75635-CT angiography abdominal arteries
- 76380-CAT scan follow-up study
- 77079-CT bone density, peripheral

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How Do You Get That Stimulus Money for Using an Electronic Medical Record? (You Register!)

Image via Wikipedia

Note: see my latest post on registering and attesting for the EHR Incentive Program [here.](#)

Registration opens on January 3, 2011 for the Medicare and Medicaid EHR Incentive Programs

1. Register as soon as possible after January 3, 2011.
2. You can register before you have a certified EHR, but you will have to have an EHR when you attest.
3. You can register even if you do not have an enrollment record in PECOS.
4. A link to the Incentive Registration will be available **here** when it is published.

5. Not all states will be ready to participate in the Medicaid program on January 3rd. Information by state is **here**.

What do you have to have to register?

1. **A National Provider Identifier (NPI)** All eligible professionals, eligible hospitals, and critical access hospitals (CAHs) must have a National Provider Identifier (NPI) to participate in the Medicare and Medicaid EHR Incentive Programs.
2. **An enrollment record in the Provider Enrollment, Chain and Ownership System (PECOS)** All eligible hospitals and Medicare eligible professionals must have an enrollment record in PECOS to participate in the EHR Incentive Programs. Eligible professionals who are only participating in the Medicaid EHR Incentive Program are not required to be enrolled in PECOS. If you do not have an enrollment record in PECOS, you should still register for the Medicare and Medicaid EHR Incentive Programs.
3. **CMS Identity and Access Management (I&A) User ID and Password**
   - **Eligible Professionals:** Eligible professionals can use the same User ID and Password they use for the National Plan and Provider Enumeration System (NPPES). This is also the same User ID and Password that is used to access PECOS. If you do not have an active User ID and Password for NPPES or PECOS, request them **here**. You will need your type 2 NPI, your Taxpayer Identification Number (TIN), and your address from IRS Form CP-575. You will also need to mail a copy of IRS Form CP-575 as directed.
   - **Hospitals/Critical Access Hospitals:** Authorized Officials can use the same User ID and Password they use to access PECOS. If you do not have an Authorized Official with access to PECOS, request

a User ID and Password here. You will need your type 2 NPI, your Taxpayer Identification Number (TIN), and your address from the IRS Form CP-575. You will need to mail a copy of the IRS Form CP-575 as directed. Additional hospital staff will need to request access to the "EHR Incentive Programs" application here and be approved by the Hospital's Authorized Official.

What else do you need to know about registration?

Hospitals:

1. Hospitals that are eligible for EHR incentive payments under both Medicare and Medicaid should select "Both Medicare and Medicaid" during the registration process, even if they plan to apply only for a Medicaid EHR incentive payment by adopting, implementing, or upgrading certified EHR technology. Dually-eligible hospitals can then attest through CMS for their Medicare EHR incentive payment at a later date, if they so desire. It is important for a dually-eligible hospital to select "Both Medicare and Medicaid" from the start of registration in order to maintain this option.
2. Hospitals that register only for the Medicaid program (or only the Medicare program) will not be able to manually change their registration (i.e., change to "Both Medicare and Medicaid" or from one program to the other) after a payment is initiated and this may cause significant delays in receiving a Medicare EHR incentive payment.

Eligible Professionals:

1. Eligible professionals eligible for both the Medicare and Medicaid EHR Incentive Programs must choose which

incentive program they wish to participate in when they register.
2. Before 2015, an eligible professional may switch programs only once after the first incentive payment is initiated. Most eligible professionals will maximize their incentive payments by participating in the Medicaid EHR Incentive Program.

The Electronic Health Record (EHR) Information Center is open to assist the EHR Provider Community with inquiries.

Hours of operation are:
8:30 a.m. ”“ 4:30 p.m. (Central Time) Monday through Friday (except federal holidays)
1-888-734-6433 (primary number) or 888-734-6563 (TTY number)

Image via Wikipedia

New Deadline (Sigh) Set for Medicare Claim Denial If Ordering/Referring Providers Not in PECOS

NOTE April 2011: CMS recently announced that July 5, 2011 will **not** be the date that claim editing will begin.

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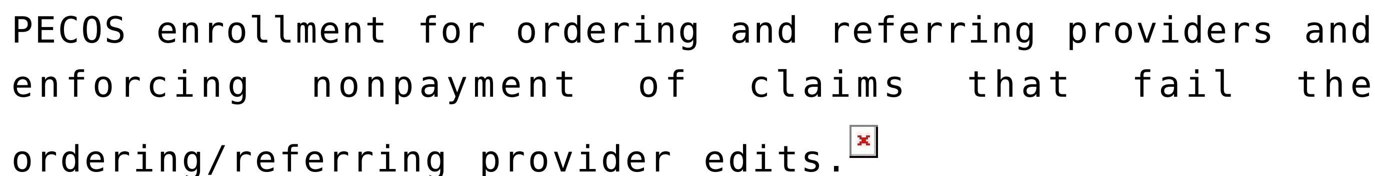
If you **read my post** on November 29th, you already know that CMS delayed pulling the trigger on January 1, 2011 to require

PECOS enrollment for ordering and referring providers and enforcing nonpayment of claims that fail the ordering/referring provider edits.

CMS has just announced a new implementation date (calling it "a placeholder future implementation") of ~~July 5, 2011~~ – unknown.

As a refresher, the only providers who can order/refer Medicare beneficiary services are:

doctor of medicine or osteopathy;
dental medicine;
dental surgery;
podiatric medicine;
optometry;
chiropractic medicine;
physician assistant;
certified clinical nurse specialist;
nurse practitioner;
clinical psychologist;
certified nurse midwife;
clinical social worker

Claims that are the result of an order or a referral must contain the National Provider Identifier (NPI) and the name of the ordering/referring provider and the ordering/referring provider must be in PECOS or in the Medicare carrier's or Part B MAC's claims system with one of the above types/specialties.

The claim editing that will begin on ~~July 5, 2011~~ date not known **will verify the ordering/referring provider on a claim is eligible to order/refer and is enrolled in Medicare.**

The process to be used to determine if the ordering/referring provider on the claim matches the provider in the national PECOS file or in the contractor's master provider file is as follows:

- MCS (Multi-Carrier System) will verify the National Provider Identifier (NPI) of the ordering/referring provider reported on the claim against the national PECOS file.
- If a match is not found, the MCS will verify the NPI of the ordering/referring provider on the claim against the MCS master provider file.
- If a match is found, the MCS will then compare the first letter of the first name and the first 4 letters of the last name of the matched record.
- If the names match, the ordering/referring provider on the claim is considered verified.

If you've not verified that your providers are properly enrolled in PECOS, you have yet another chance to get it figured out.

Here's the Cheat Sheet:

1. Check to see if your provider is enrolled by reviewing the Ordering and Referring file found in the download section of the "OrderingReferringReport" tab (**click here**) on the Medicare Provider and Supplier Web Site. The report is currently more than 15,000 pages but you can view it on the screen.
2. If not enrolled, you can get your provider enrolled by paper or electronically. The Internet-based PECOS application is **here.**
3. After submitting an enrollment application via Internet-based PECOS, you must:
   - Print, sign and date (blue ink recommend) the Certification Statement(s), and
   - Mail the Certification Statement(s) and applicable supporting documentation to the designated Medicare contractor (no later than 7 days after you complete the online portion.)

   NOTE: The Medicare contractor will not be able to begin to process your enrollment application until it receives

a signed and dated Certification Statement.

For more detailed information on PECOS, click on the PECOS category on the right-hand side of this web page.

Medicare Releases New Product-Specific HCPCS Codes for Flu Shots Billed After January 1, 2011

NOTE: The 2012 – 2013 flu shot codes can be found here.

For flu shot updates for the 2011-2012 influenza season, click here.

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Changes in Flu Shot Codes When Billing On/After January 1, 2011

CMS has created specific HCPCS codes and payment allowances to replace CPT code 90658 for Medicare billing purposes for the 2010-2011 influenza season. Note that these HCPCS codes will not be recognized by the Medicare claims processing systems until January 1, 2011, when **CPT code 90658 will no longer be recognized.**

- Q2035 (locally priced)
  - **Afluria** vacc, 3 yrs >, im
  - Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Afluria)
- Q2036 ($7.439 national allowable)
  - **Flulaval** vacc, 3 yrs & >, im
  - Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Flulaval)
- Q2037 ($13.253 national allowable)
  - **Fluvirin** vacc, 3 yrs & >,im
  - Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Fluvirin)
- Q2038 ($12.593 national allowable)
  - **Fluzone** vacc, 3 yrs & >, im
  - Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Fluzone)
- Q2039 (locally priced)
  - **NOS** flu vacc, 3 yrs & >, im
    - Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Not Otherwise Specified)

Other information:

- For dates of service between October 1, 2010 and December 31, 2010, the CPT 90658 and the Q-codes will be valid for billing; however, providers may not bill Medicare for both the CPT 90658 and any of the Q-codes for the same patient for the same date of service. Thus, if a provider vaccinates a beneficiary

on any date between October 1, 2010 and December 31, 2010, the provider may either bill Medicare immediately using CPT 90658, or hold the claim and wait until January 1, 2011 to bill Medicare using the most appropriate Q-code. If a claim has already been submitted and processed using CPT 90658, then there is no need to use the Q-code for that same service. For dates of service on or after January 1, 2011, providers may only bill Medicare for one of the HCPCS codes that appropriately describes the specific vaccine product administered.

- For dates of service on or after September 1, 2010, the corrected Medicare Part B payment allowance for CPT 90655 is $14.858.
- Annual Part B deductible and coinsurance amounts do not apply to these vaccines. 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.
- Be aware that Medicare contractors will not search their files to adjust payment on claims paid incorrectly prior to implementing CR7324. However, they will adjust such claims that you bring to their attention.

For additional information on providing the flu shot, see my previous post **here**.

Physicians Have Something to Celebrate as the Medicare Cut is Delayed One Year and Physicians Are Exempt From the Red Flags Rules

Two milestone Acts were approved by Congress this week and both will be presented to President Obama for his signature shortly.

Image via Wikipedia

What he will be signing:

1. The **"Medicare and Medicaid Extenders Act of 2010"** This legislation freezes Medicare physician payments at current rates through the end of 2011. The Act also includes funds for Medicare contractors to pay claims for physician services affected by provisions of the Patient Protection and Affordable Care Act passed last spring. The bill, estimated to cost $19.3 billion over 10 years, will be paid for by changing a provision of the health reform act that provides tax credits for people who buy coverage. President Obama released a statement saying: "It's time for a permanent solution that seniors and their doctors can depend on and I look forward to working with Congress to address this matter once and for all in the coming year.
2. "**Red Flag Program Clarification Act of 2010**" changes the Red Flags Rule's definition of "creditor" and

relieves doctors from complying with the Federal Trade Commission's identity theft prevention law.

White Coat Wednesday: Call Congress November 17th to Protest the Medicare Physician Cuts

Please call the AMA Grassroots Hotline, and have **everyone** in your office/department/building/campus call the Hotline on Wednesday, November 17th (White Coat Wednesday) and every day thereafter until November 30th to insist that Congress vote for the 13-month patch to the SGR formula.

AMA's toll-free Grassroots Hotline – 1.800.833.6354

AMA website discussing the issues here.

AMA flyer to post in your office here.

Medicare 2011: What’s Covered and How Physician Practices Can Deal With the Changes

More information on Medicare wellness visits in 2011 can be found here.

Information on the 2011 Medicare Part A and Part B deductibles and premiums can be found here.

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The extensive changes coming for Medicare Part B coverage in 2011 should have primary care practices and some specialty practices thinking about their current processes. If you meet with your team now to educate them about the Medicare changes and explore process tweaking, you’ll be ready when January 1 rolls around.

Image via Wikipedia

Here are a few areas to think about:

1. Advance Beneficiary Notices (ABNs) – Many practices struggle with the who and when of ABNs and the new coverage might not make it easier. There are lots of services now covered with **new frequency limitations**, so practices must be on their toes to recognize when a service is covered and when it isn’t. Sure, you can ignore ABNs and wait for Medicare to tell you a service is not covered, but then it’s too late to collect from

the patient – not only too late, but also illegal to collect.

2. The annual wellness visit is going to be a special challenge because the timing is precise. Medicare patients will hear "annual visit", but won't realize it will not be paid for if performed within 12 months of a previous wellness visit (Welcome to Medicare exam or annual visit). I've not seen any practice management software that handles this really well, but maybe it's out there. I'd love to see Medicare patients scheduling their **annual visits during their birthday month** so staff would have a fighting chance of identifying the last annual visit and getting the date right. Of course, using your electronic recall will work too if you **schedule the next year's visit when the patient is checking out.** (Do you proactively contact your Medicare patients to invite them to come in for their Welcome to Medicare exam?) Also encourage patients to keep up with the preventive services they are eligible to receive by **registering with the My Medicare website** (https://mymedicare.gov/). This is their personal Medicare website for tracking their Medicare services. It will send them e-mail reminders when they are eligible for Medicare coverage of preventive services. Great idea!
3. **Who will be doing the counseling** about the "preventive services covered by Medicare" during the annual exam? Let's hope Medicare puts out a really great handout!
4. Most EMRs will let you load requirements for services based on diagnosis – for example, diabetes. Make sure you are taking advantage of the EMR's ability to **set up protocols for age, diagnosis and risk factors**. If you are not on EMR yet, use your **appointment schedule or recall system to set reminder appointments** to contact patients for their services.
5. **Don't forget your patients on Medicare who are not yet age 65.** Run a report to find these patients and flag

them to acknowledge that their Medicare services are at different times.

6. **Collections at time of service will change** too, of course, as most services listed below will not be applied to the deductible. Exceptions are glaucoma screening, diabetes monitoring and education, medical nutritional, and smoking cessation. Patients understandably will be confused, so make sure your check-out staff are crystal clear.

Medicare Benefits Beginning January 1, 2011

- **Medicare covers a one-time preventive physical exam within the first twelve months of having Part B**. The exam will include a thorough review of health, education and counseling about the preventive services covered by Medicare and referrals for other care if needed. No Part B deductible and effective January 1, 2011 you pay nothing if the doctor accepts assignment.

- **Abdominal Aortic Aneurysm Screening** – People at risk for abdominal aortic aneurysms may get a referral for a one-time screening ultrasound at their "Welcome to Medicare" physical exam. Effective January 1, 2011 no deductible and no copayment.

- **New Annual Wellness Visit** – Effective January 1, 2011 Medicare will cover an Annual Wellness Visit that includes a thorough review of health, education and counseling about the preventive services covered by Medicare and referrals for other care if you need it. It is available every 12 months (after first 12 months of Part B coverage) but not within 12 months of receiving either a "Welcome to Medicare" physical exam or another Annual Wellness Visit. No Part B deductible ”“ Medicare pays 100% of the approved amount.

- **Cardiovascular Screening Blood Tests** – Medicare covers cardiovascular screening tests that check cholesterol and other blood fat (lipid) levels every 5 years. Includes:
  - Total Cholesterol Test
  - Cholesterol Test for High Density Lipoproteins; and
  - Triglycerides Test
  - No Part B deductible ”“ Medicare pays 100% of approved amount.

- **Diabetes Screening Tests** – Anyone enrolled in Medicare identified as “high risk” for diabetes will be able to receive screening tests to detect diabetes early. Covers up to two screenings each year. Includes:
  - Fasting plasma glucose test
  - Post-glucose challenge test
  - No Part B deductible ”“ Medicare pays 100% of approved amount
- **Glaucoma Screening** – Must be done or supervised by an eye doctor (optometrist or ophthalmologist). Covered annually for:
  - Those with diabetes
  - Those with a family history of glaucoma
  - African-Americans age 50 and older
  - Hispanic-Americans age 65 and older
  - Other high risk individuals
  - Medicare pays 80% of the approved amount after you meet the yearly Part B deductible.
- **Bone Mass Measurement –** For those enrolled in Medicare at high risk for losing bone mass. Effective January 1, 2011 no Part B deductible ”“ Medicare pays 100% of approved amount.

- **Screening Mammography** (including new digital technologies) – For women age 40 and older enrolled in Medicare:

- Covered annually
- No Part B deductible ”“ Medicare pays 100% of approved amount beginning January 1, 2011.

- **Screening Pap Test & Pelvic Examination** (Includes clinical breast examination) – For all women enrolled in Medicare:
    - Covered once every two years for most
    - Covered annually for women at high risk
    - No Part B deductible ”“ Medicare pays 100% of approved amount for Pap test and effective January 1, 2011 pays 100% of approved amount for pelvic and breast exam.
- **Colorectal Cancer Screening** – For all those enrolled in Medicare age 50 and older:
    - Fecal-Occult blood test covered annually ”“ No Part B deductible & Medicare pays 100% of approved amount.
    - Flexible sigmoidoscopy once every four years or 10 years after a previous screening colonoscopy”“ No Part B deductible or copayment starting January 1, 2011.
    - Barium enema can be substituted for sigmoidoscopy or colonoscopy ”“ No Part B deductible – Medicare pays 80% of the approved amount. You will pay a higher coinsurance if the test is done in a hospital outpatient department.
    - Colonoscopy for any age enrolled in Medicare
    - Average risk – Once every ten years, but not within four years after a screening flexible sigmoidoscopy
    - High-risk – Once every two years
    - No Part B deductible and effective January 1, 2011 Medicare pays 100%.
- **Prostate Cancer Screening Tests** -For all men enrolled in Medicare age 50 and older:
    - Covered annually
    - Digital rectal exam ”“ Medicare pays 80% of the

approved amount after the deductible
  - Prostate Specific Antigen (PSA) test
  - No Part B deductible – Medicare pays 100% of approved amount.
- **Diabetes Monitoring and Education** – Covers Type I and Type II diabetics enrolled in Medicare who must monitor blood sugar (Not paid for those in a nursing home) Covered services:
  - Glucose-monitoring devices, lancets & strips
  - Education & training to help control diabetes
  - Foot care once every 6 months for those with peripheral neuropathy
  - Medicare pays 80% of the approved amount after you meet the yearly Part B deductible.
- **Medical Nutritional Therapy** – Covered for those with diabetes or kidney disease. Includes diagnosis of special nutrition needs, therapy and counseling services to help you manage your disease. Medicare pays 80% of the approved amount after you meet the yearly Part B deductible.

- **Smoking Cessation Services** – Medicare will cover up to 8 counseling sessions per year for individuals who have an illness caused or complicated by tobacco use or you take medication affected by tobacco use. Medicare pays 80% of the approved amount after you meet the yearly Part B deductible.
- **Flu Vaccination Annually** (Medicare pays once per season. You do not have to wait 365 days since your last one.) No Part B deductible ”“ you pay nothing if your doctor accepts assignment. My post on billing for the flu shot is **here.**
- **H1N1 Flu Vaccine** Medicare covers the administration of the H1N1 flu shot. You cannot be charged for the

vaccine. No Part B deductible or co-insurance.

- **Pneumococcal Pneumonia Vaccination**– Once per lifetime for all enrolled in Medicare. (A doctor may order additional ones for those with certain health problems.) No Part B deductible ”“ Medicare pays 100% of approved amount.
- **Hepatitis B Shots** – Covered for those who are at medium or high risk. Effective January 1, 2011, there will be no Part B deductible and Medicare pays 100%.

Providing and Billing for the Flu Vaccine: Guidance from CMS, the CDC and the Affordable Care Act

Update posted 8-14-2012: For flu shot updates for the 2012-2013 influenza season, click here.

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Update posted 9-22-2011: For flu shot updates for the 2011-2012 influenza season, click here.

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Update Posted 12-20-2010 – Medicare posted code changes for flu vaccines billed to Medicare after January 1, 2011. Click here for the changes.

For dates of service on or after September 1, 2010, the corrected Medicare Part B payment allowance for CPT 90655 is

$14.858.

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It’s that time again, and despite delayed deliveries to some hospitals and practices, the word on the street is that there will be enough flu vaccine (171 million doses) this year for all who want a flu shot.

Image via Wikipedia

The Center for Disease Control (CDC) recommends that everyone 6 months and older get a flu shot. Each year’s flu vaccine cocktail is unique and this season’s (2010-2011) flu vaccine will protect against three different flu viruses: an H3N2 virus, an influenza B virus and the H1N1 virus that caused so much illness last season.

The Affordable Care Act and the Influenza Vaccine

Just in time for flu season is the Affordable Care Act’s emphasis on preventive care. The ACA states:

> *This influenza season, children 6 months through 18 years, certain high-risk adults 19 through 49 years, and adults 50 years and older who are enrolled in **new** group and individual health plans will be eligible to receive the seasonal flu vaccine **without cost-sharing** when provided by an in-network provider. Beginning in the plan year that starts after March 2, 2011, all adults 19-49 years of age will be eligible to receive the seasonal flu vaccine with no cost-sharing requirements when provided by an in-network provider.*

This is great news for the patient and for healthcare in general. <u>You</u> may consider it good news or bad news, depending on your view of the whole flu shot process. Here's how it works in many practices:

1. The vaccine is ordered in the spring, with everyone trying hard to guess correctly how many patients will want flu shots in 6 months.
2. The vaccine arrives in the fall and the first hurdle is pricing it, as you will have to decide how much to mark it up to cover the cost of the ordering, handling and stocking and possibly a teeny profit.
3. The administration of the vaccine also has to be priced to cover the cost of supplies (syringe, alcohol swab, sometimes a bandaid, printed Vaccine Administration Sheets) and the cost of labor (assessing the patient to make sure they can get the flu shot, giving the shot, and documenting the lot numbers in case of a recall.)
4. The next decision is disbursement. Do you have a flu shot clinic and have people get in line for the flu shot, or do you take flu shot appointments, do you give flu shots during regular appointments, or some combination thereof? What about drive-through flu clinics? Do people sit in the parking lot for 15 minutes to make sure there are no bad after-effects? How do you let patients know about your flu shot plans without costly postcards or advertisements?
5. Then, there is policy setting for patients whose insurance covers the flu shot and for patients whose insurance does not. Do you collect and refund if necessary, or do you not collect and bill the patient after insurance responds (Jaws theme music here, please.)

Does Medicare pay for flu shots?

Medicare pays 100% of the allowable for influenza vaccine (and

pneumococcal vaccines) and the administration of the vaccines without any out-of-pocket costs to the patient. One flu vaccine is allowable per flu season, but Medicare will pay for a second flu shot if a physician determines and documents the medical necessity. A physician's order is not necessary and a physician's supervision is not necessary – that's why patients are able to get a flu shot at the drugstore. A patient can receive a flu shot twice in one calendar year by getting a flu shot late in one season and getting a flu shot early in the next season.

How should a provider that is not enrolled in Medicare bill for the flu vaccine?

CMS typically does not allow non-enrolled providers to treat Medicare beneficiaries, however, CMS is allowing them to give flu shots this year. Beneficiaries can receive a flu vaccine from any licensed physician or provider. However, the billing procedure will vary depending on whether the physician or provider is enrolled in the Medicare Program.

If you are not a Medicare-enrolled physician or provider who gives a flu vaccine to a Medicare beneficiary, you can ask the beneficiary for payment at the time of service. The beneficiary can then request Medicare reimbursement. Medicare reimbursement will be approximately $18 for each flu vaccine.

Image via Wikipedia

To request reimbursement, the beneficiary will need to obtain and complete form **CMS 1490S**. So the beneficiary may receive reimbursement, you will need to provide the beneficiary with a receipt for the flu vaccine that has the following information written or printed on it:
”¢ The doctor’s or provider’s name and address
”¢ Service provided (“flu vaccine”)
”¢ Date flu vaccine received
”¢ Amount paid

What codes are used for flu shots?

For flu vaccine and vaccine administration, the following codes are used.

Effective September 1, 2009, (no 2010 changes have been announced) the Medicare Part B payment allowances for influenza vaccines are as follows:

- For HCPCS 9**0655**, the payment will be $15.447: Influenza virus vaccine, split virus, preservative free, for children 6- 35 months of age, for intramuscular use
- For HCPCS code **90656**, the payment will be $12.541: Influenza virus vaccine, split virus, preservative free, for use in individuals 3 years and above, for intramuscular use
- For HCPCS code **90657**, the payment will be $15.684: Influenza virus vaccine, split virus, for children 6-35 months of age, for intramuscular use;
- For HCPCS code **90658**, the payment will be $11.368: Influenza virus vaccine, split virus, for use in individuals 3 years of age and above, for intramuscular use
- HCPCS **90660** (FluMist, a nasal influenza vaccine) may be covered if the local Medicare contractor determines its use is medically reasonable and necessary for the beneficiary. When payment is based on 95 percent of the Average Wholesale Price (AWP), the Medicare Part B payment allowance for CPT 90660 is $22.316 (effective September 1, 2009).

G0008 is the Medicare HCPCS for Administration of influenza virus vaccine, including FluMist. Other payers usually require use of 90465, 90466, 90467, 90468, 90471, 90472, 90473 or 90474 for administration of the vaccine.

The associated ICD-9 codes for flu shots are:

V04.81   Influenza
V06.6   Pneumococcus and Influenza (both vaccines at one visit)

Other resources:

- Get your practice and your staff ready for flu season by following the guidelines I write about **here**.
- Free downloads from the CDC **here.**

- MedLine Plus Articles, Downloads and Resources **here**
- Article: **Mandating Influenza Vaccine – One Hospital's Experience** (MedScape free account required)
- National Foundation for Infectious Diseases: **Influenza**
- National Influenza Vaccine Summit: **Prevent Influenza**
- Vaccine Education Center at Children's Hospital of Philadelphia (CHOP) -Influenza: What You Should Know (pdf) **EnglishSpanish**
- Medicare Preventive Services Quick Reference Information Chart: Medicare Part B Immunization Billing (Influenza, Pneumococcal, and Hepatitis B) is available **here** (pdf.)
- For information on roster billing (billing for many patients at one time) see the Medicare Claims Processing Manual for Preventive and Screening Services (Chapter 18) **here** (pdf) Section 10-3.

NOTE: Beneficiaries have been advised to contact the Inspector General hotline at 1-800-HHS-TIPS (1-800-447-8477) to file a complaint if they believe their physician or provider charged an unfair amount for a flu vaccine.

Related articles

- Providing and Billing for the Flu Vaccine: Guidance from CMS, the CDC and the Affordable Care Act (managemypractice.com)

New Medicare Waived CLIA Laboratory Tests Published

The CLIA regulations require a facility to be appropriately certified for each test performed. To ensure that the Medicare

and Medicaid programs only pay for laboratory tests categorized as waived complexity under CLIA in facilities with a CLIA certificate of waiver, laboratory claims are currently edited at the CLIA
certificate level.

New test list here (pdf.)

All CLIA waived tests here (pdf.) – updated July 6, 2010

A Perfect Day in Your Medical Practice: The Efficient and Well-Run Medical Office

Image via Wikipedia

- All available appointments are full.
- All staff showed up for their shifts.
- No one burns toast in the toaster oven and sets off the fire alarm.
- None of the staff show up to work wearing flip-flops or pink underwear beneath their white scrubs.
- All patients have been reminded about their appointments so they all show up.
- Patients calling for same-day appointments are able to be worked-in appropriately.
- No patients give false information at check-in.
- Established patients arrive on time with their insurance

information and co-pay.

- New patients arrive on time to complete their paperwork, and give their insurance card, photo ID and co-pay to the receptionist.
- Patients with x-rays or other imaging studies bring the films or a CD.
- Patients with fasting appointments arrive having fasted.
- All patients arrive bringing their bag of medications.
- Patients in wheelchairs and with difficulty ambulating are accompanied by caregivers.
- Patients who do not speak English or are deaf have notified the office prior to the appointment and the appropriate technology or interpreters are available for the appointment.
- Patients with procedure appointments have followed their pre-procedure instructions.
- Patients with procedures have been pre-authorized by their insurance carrier and their personal financial responsibility has been discussed with them and payment arrangements have been made.
- Patient eligibility has been checked and those unable to be authorized have been called before their appointment to gain further information about their payer source.
- If computers go down, there are paper procedures in place to enable staff to continue seeing patients.
- No patients arrive saying “I forgot to tell you, this is Worker’s Comp/ an auto accident/ a liability case and I was told by my lawyer not to pay anything.”
- None of the patients pee on a waiting room chair.
- Neither JCAHO nor any state or federal officers show up.
- The copiers and faxes all work.
- No subpoenas come in the mail.

Image by Smithsonian Institution via Flickr

- It’s not your very first day live on electronic medical records.
- All phone calls are answered before the third ring and no one has to leave a message.
- No patients walk in the door with severe chest pains and say “I knew the doctor would want to see me.”
- Patients remember to call the pharmacy for refills.
- Providers all run on time and seem in particularly good moods.
- Patients get their questions answered with callbacks within two hours.
- Someone delivers sandwiches, drinks and brownies to the practice for lunch. There is enough for everyone.
- No bounced checks come in the mail.
- Providers spend so much time in the exam room listening to their patients that the patients leave feeling that every question they had (and a few they didn’t know they had) was answered.
- Providers circle the services and write the diagnosis codes numerically on the encounter form, remembering that Medicare doesn’t pay for consults any more.
- Sample medications that providers want to give patients are in the sample closet.

- Records that providers want to reference are in the chart and are highlighted.
- No one calls urgently for old medical records that are in the storage unit across town.
- There are no duplicate medical records.
- Patients checking out never say “But he was only in the room for 5 minutes!”
- The patient restrooms don’t run out of toilet paper.
- No bankruptcy notices come in the mail.
- All phlebotomists get blood on the first stick.
- No kids cry.
- The HVAC system works beautifully, keeping it cool where it needs to be cool, and warm where it needs to be warm.
- Congress announces that the SGR formula has been revoked and a new reasonable model for paying physicians has been discovered.
- Everyone goes home at 5:00 p.m., glad to have a job, glad to be of service, and happy with their paychecks.