

# Medicare Update for Oncology Practices

June 17, 2010

July 1, 2010

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*J4 Medicare Medical Director*

# Recent CMS Activities

Education Makes the Difference

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## Payment, Coverage, and Contractor Claim Operation Activities

- Self administered drug exclusion
  - “The term “administered” refers only to the physical process by which the drug enters the patient’s body. It does not refer to whether the process is supervised by a medical professional (for example, to observe proper technique or side-effects of the drug). Injectable drugs, including intravenously administered drugs, are typically eligible for inclusion under the “incident to” benefit. With limited exceptions, other routes of administration including, but not limited to, oral drugs, suppositories, topical medications are considered to be usually self-administered by the patient.”

# Recent CMS Activities

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## Payment, Coverage, and Contractor Claim Operation Activities

- Least Costly Alternative – LCA provisions in LCD went away for DOS on or after 4/19 but claim processing changes didn't take effect till 6/10/10
- Screening for HIV in high risk and pregnant risk persons
- 40 - Discarded Drugs and Biologicals
  - (*Rev.1962, Issued: 04-30-10, Effective: 07-30-10, Implementation: 07-30-10*)

# Recent CMS Activities

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## Payment, Coverage, and Contractor Claim Operation Activities

- NCD
  - PET Scans
    - Final
      - Solid tumors and myeloma (eff early 2010)
      - NaF for bone metastasis (eff 7/6/10).
    - Proposed Decision (Notice)
      - Third reconsideration of NCD for PET Scans for solid tumors and myeloma
      - Removes absolute limit of 1 scan for “initial treatment strategy”
      - Contractor discretion to define circumstances for allowed additional scans.

# Recent CMS Activities

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## Payment, Coverage, and Contractor Claim Operation Activities

- Proposed decision
  - Allogeneic Stem Cell Transplantation
    - *“Allogeneic hematopoietic stem cell transplantation for myelodysplastic syndromes is covered by Medicare only in the context of a prospective controlled clinical study that meets the following standards...”*

# Recent CMS Activities

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## Payment, Coverage, and Contractor Claim Operation Activities

- PECOS requirement regarding ordering and referring practitioners
  - Edits live 1/3/11
  - 26,000 J-4 physicians and practitioners not yet in PECOS
  - Web PECOS enrollment strongly encouraged like....YESTERDAY

# Recent CMS Activities

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## Payment, Coverage, and Contractor Claim Operation Activities

- Provider Enrollment
  - Current application receipts soaring again (partly seasonal and partly due to PECOS)
  - Additional staff
  - Currently pending applications
    - OK pending number 1523
    - CO 2329,
    - NM 1089
    - TX 11,140)
  - Timeliness(% applications over 45 days old)
    - OK 53%
    - CO 58%
    - NM 62%
    - TX 57%

# Recent CMS Activities

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## Payment, Coverage, and Contractor Claim Operation Activities

- Physician Fee schedule
  - Recently legislated fee schedule retroactive to 1 Jan 2010 and lasts through end of year
  - Zero percent update factor
  - MP and PE RVU updates leading to slight increase in conversion factor to \$36.0791 (\$36.0666 in 2009 and \$38.087 in 2008)
  - Fee schedule currently displayed on our web will change a little with awaited new fee schedule containing all of the legislated changes

# Recent CMS Activities

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## Payment, Coverage, and Contractor Claim Operation Activities

- Physician Fee schedule
  - No claims paid at earlier required “21%” reduction
  - Currently holding (until 6/18/10) claims from DOS 6/1/10
    - OK/NM/CO = 181,449
    - TX = 504,409
  - Instructions for handling fee schedule necessitated adjustments pending from CMS. Please don't resubmit claims until/unless instructed.

# Recent TrailBlazer LCD Activities

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# TrailBlazer Medical Review Activities

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- Numerous medical review “probe audits” and pre-payment audits last year on drugs and pharmacologic administration services.
- Significant error rates
- Multiplex nature of errors
  - Medical necessity
  - Incident to violations
  - Failure to document the services to have been performed.
  - Provider identity/signature

# TrailBlazer Medical Review Activities

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<b>WHO</b>	Performing, supervising, and referring practitioners
<b>WHAT</b>	Services and quantities of services performed
<b>WHERE</b>	Place of service
<b>WHEN</b>	Date of service
<b>WHY</b>	Medical necessity and diagnosis

# TrailBlazer Medical Review Activities

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## Performing, Supervising, and Referring Practitioners

- Legible identity and signature\*
- Appropriate professional
- Incident to
- (erstwhile) Consultations

# TrailBlazer Medical Review Activities

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## Services Performed

- CPT work codes
- Timed codes
- HCPCS description
  - Quantity billed
  - Wasted drug
- Modifiers

# TrailBlazer Medical Review Activities

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## **Place And Date Of Service Usually Identical In Record And On Claim**

- Technical and professional on different days
- Technical and professional in different locations
- Services performed over more than one day

# TrailBlazer Medical Review Activities

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## **Federal Law Requires Medical Necessity**

In order for a service to be medical necessity it must be all of the following:

- Appropriate in duration and frequency
- Meets but does not exceed patient's medical need
- Provided in accordance with accepted standards of medical practice
- Not experimental or investigational
- Performed by qualified personnel in appropriate setting

# Consultation Questions

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How do we code low level inpatient consultations that don't have the documented work and/or medical necessity required for any of the initial inpatient E/M codes

- Report the services using CPT code 99499©
- Report a subsequent hospital care code that appropriately reflects physician work and medical necessity for the service.

**Reporting a subsequent care code avoids mandatory medical record submission and manual medical review.**

# Consultation Questions

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The initial service E/M codes reimburse much less than the consultation codes did. How will we be able to make up that revenue?

**Code for prolonged services properly when documented and medically appropriate. Use prolonged service add ons only when appropriate to do so.**

# CPT Key Components and Time

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Inpatient Consultations		Initial Hospital Services	
Code	Key Components and Time	Code	Key Components and Time
99255	C/C/H 110 min	99223	C/C/H 70mins
99254	C/C/M 80 min	99222	C/C/M 50 mins
99253	D/D/L 55min	99221	D/D/SF-L 30 mins
99252	EP/EP/SF 40 min	?	?
99251	PF/PF/SF-L 20 min	?	?

# CPT and Medical Necessity

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Inpatient Consultations		Initial Hospital Services	
Code	Nature of Presenting Problem	Code	Nature of Presenting Problem
99255	Moderate to High	99223	High
99254	Moderate to High	99222	Moderate
99253	Moderate	99221	Low
99252	Low	?	?
99251	Self Limited or Minor	?	?

# Consultation Questions

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Do we still need to indicate a referring provider on the claim when using initial service codes for the consultation crosswalk?

**Yes**

# Consultation Questions

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Do we still need to document the referring physician in our records when using initial service codes for the consultation crosswalk?

**Not technically, though it remains good practice to do so.**

# Consultation Questions

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If I bill my “consultation” without the AI, and the admitting physician also bills without the AI, will my claim be denied?

**Not at present.**

# Consultation Questions

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Our physicians who "consult" believe that since they can no longer bill the "consultation" CPT codes, they should no longer title the dictated hospital report (of the visit) a documentation a "Consultation". Is this accurate?

**No**

# Consultation Questions

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Are split/shared consultations still prohibited?

**Not for inpatient services. However, for outpatient new patient visits and established patient visits with patients being seen for a problem that is new to the physician the rules of “incident to” prohibit it.**

# Consultation Questions

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How does CMS' decision about consultations affect my payment from other payers and secondary payers?

**This depends on the payer.**

# Consultation Questions

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If I see my established patient for the first time during a hospital stay, what code is correct to use?

**Report the code that best describes the work documented to have been performed and best fits the patient's clinical needs.**

# Consultation Questions

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Should admitting physicians use modifier AI on all of their visits from admission through discharge?

**No**

# Consultation Questions

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We share call with physicians in other practices. If the on-call doc admits a patient to the hospital and uses the AI modifier on his claim, can we use the initial hospital codes for our services when we assume care?

**No**

# Consultation Questions

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May two providers from the same specialty and group (i.e. endocrinology) now bill an initial/new patient visit when they see a patient in the inpatient or outpatient setting if one acts as the admitting and the other a consultant?

**No**

# Recent CMS Activities

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## Recovery Audit Contractors

Connolly Consulting, Wilton, CT

[http://www.connollyhealthcare.com/RAC/pages/cms\\_RAC\\_Program.aspx](http://www.connollyhealthcare.com/RAC/pages/cms_RAC_Program.aspx)

J2505: Injection, Pegfilgrastim, 6 mg.

[http://www.connollyhealthcare.com/RAC/pages/approved\\_issues.aspx](http://www.connollyhealthcare.com/RAC/pages/approved_issues.aspx)