

# AcSel Advisor

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## Palmetto GBA Medicare

### ATTENTION ALL VIRGINIA, NORTH CAROLINA AND SOUTH CAROLINA PROVIDERS

#### Important Note: Jurisdiction 11 –Medicare Providers

On September 9, 2010, CMS announced that Palmetto GBA will begin implementation of the new Jurisdiction 11 (J11) A/B Medicare Administrative Contract, which includes Virginia, North Carolina, South Carolina, and West Virginia. Recently, you may have received a welcome letter from Palmetto Medicare or a new Electronic Financial Transaction (EFT) agreement forwarded from AcSel for signature. If you have not already done so, please take a moment and sign where appropriate and return to AcSel as soon as possible. Failure to complete the EFT enrollment may lead to the cancellation of your Medicare Provider number.

#### J11 – Palmetto GBA Operational Dates

Per Palmetto GBA, the operational date for Virginia Part B is March 19, 2011 and Part A is May 16, 2011. The North Carolina Part B operational date is May 28, 2011 and South Carolina Part B operational date is June 18, 2011. For more information, go to <http://www.cms.gov/transmittals/downloads/R817OTN.pdf>

#### Palmetto GBA Offers Online Provider Services

Palmetto GBA offers access to provider Medicare information through their Online Provider Services System (OPS). Through the system providers can view beneficiary eligibility, claim status, online remittances and financial information.



To Register for Palmetto's online services go to [https://www5.palmettogba.com/ecx\\_improvev2/](https://www5.palmettogba.com/ecx_improvev2/)

#### Other Palmetto GBA- Self Service Tools

- \* Denial Resolution Tool
- \* EDI System Status
- \* New to Medicare?
- \* Provider Enrollment Application
- \* Modifier Lookup
- \* Redetermination Status Tool
- \* Palmetto GBA Listserv
- \* Interactive Remittance Notice

For more information go to:  
[www.palmettogba.com](http://www.palmettogba.com)



## Medicare- New Annual Wellness Visit

Effective January 1, 2011 Medicare has a new Annual Wellness Visit (AWV) benefit. The AWV is a preventive physical exam that includes personal prevention plan services (PPPS). The AWV is a separate benefit from the initial preventative physical exam (IPPE), sometimes referred to as the “Welcome to Medicare” physical. Medicare will cover an annual wellness visit, including the PPPS, for an individual who is no longer within 12 months after the effective date of his or her first Medicare Part B coverage period, and has not received an IPPE or AWV with PPPS within the past 12 months. Medicare coinsurance and Part B deductibles do not apply.

**Two new HCPCS codes have been developed to describe the AWV:**

**G0438** - Annual wellness visit, including PPPS, first visit

**G0439** - Annual wellness visit, including PPPS, subsequent visit



- \* The first AWV should be billed using HCPCS code G0438. This is a “once-per-beneficiary-per-lifetime allowable Medicare benefit. All subsequent AWV’s should be billed with code G0439. Medicare advises, if a patient selects a new health care professional to complete the subsequent AWV, the new healthcare professional will continue to bill the subsequent AWV.
- \* The AWV may be performed by an MD, DO, NP, PA, CNS or other health professionals (health educator, registered dietitian, nutrition professional or a team of medical professionals) who are working under the direct supervision of a physician.
- \* In the event that the provider performs a medically necessary Evaluation and Management (E/M) Service during the same visit, the modifier 25 should be added to the E/M code to identify the service is a significant, separately identifiable service from the AWV. For more information, go to <http://www.cms.gov/MLN Matters Articles/downloads/MM7079.pdf>

### CMS- Incentive Payment Program for Primary Care Services

The Primary Care Incentive Program (PCIP) provides for an incentive payment for primary care services furnished on or after January 1, 2011, and before January 1, 2016, by a primary care practitioner. The PCIP payment will be paid on a quarterly basis in an amount equal to 10 percent of the payment amount for services under Part B. The PCIP payments will be calculated by the Medicare contractors and made quarterly.

Primary Care Service Codes:

- \* 99201-99215 - new and established patient office or other outpatient E/M visits
- \* 99304-99340 - initial, subsequent, discharge, and other nursing facility E/M services; new and established domiciliary, rest home, or custodial care E/M services; and domiciliary, rest home, or home care plan oversight services
- \* 99341-99350 - for new and established patient home E/M visits

The primary care services must account for at least 60% of the allowed charges under the Part B for the provider in a prior period. If a practice bills for primary care services, the primary care professional service must be rendered by an eligible provider. For more information go to: <http://www.cms.gov/Transmittals/downloads/R2039CP.pdf>

### IMPORTANT REMINDER:

#### CPT 90658 No Longer Valid With Medicare



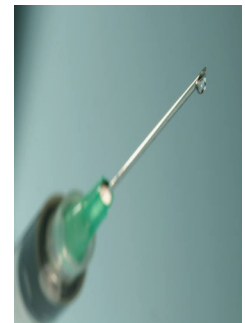
#### New Q Codes for 2010-2011 Seasonal Influenza Vaccines for Medicare Fee for Service Providers

The Centers for Medicare & Medicaid Services (CMS) has created specific HCPCS codes and payment rates for Medicare billing purposes for the 2010-2011 influenza season.

Effective for claims with dates of service on or after January 1, 2011, CPT code 90658 will no longer be payable by Medicare.

Effective for dates of service on or after October 1, 2010, the following new influenza Q codes will be payable by Medicare:

- Q2035 (Afluria)
- Q2036 (Flulaval)
- Q2037 (Fluvirin)
- Q2038 (Fluzone)
- Q2039 (Not Otherwise Specified flu vaccine)





### Code Q2039 for 2010-2011 Seasonal Influenza Vaccines

Trailblazer released a reminder to providers that code Q2039 (Not Otherwise Specified (NOS) flu vaccine) does require additional information to be submitted with the claim to determine payment.

The following information must be submitted:

- Name of vaccine
- National Drug Code (NDC) number
- Route of administration
- Dosage

For electronic claims, this information must be submitted in the narrative field.

### Initial Infusion Service Codes

Trailblazer's reminds providers that Medicare does not allow use of the "initial" infusion service CPT code to be billed more than once a day. Per CMS, the provider should report only one "initial" service code unless protocol requires that two separate IV sites must be used. If more than one "initial" service code is billed per day, report the second initial service code using the modifier 59.

Initial infusion service CPT codes:

- 96360 Hydration IV infusion init.
- 96365 Ther/proph/diag IV inf init.
- 96369 Sc ther infusion up to 1 hr.
- 96409 Chemo IV push sngl drug.
- 96413 Chemo IV infusion 1 hr.

Effective March 14, 2011, Trailblazers will begin to edit and deny the "initial" service codes when they are performed more than once per day unless the 59 modifier is used. For more information, go to: [www.trailblazerhealth.com](http://www.trailblazerhealth.com)



### Coverage Guideline Update Brachytherapy

Effective April 4, 2011, diagnosis codes 185 (malignant neoplasm of prostate) and 223.4 (carcinoma in situ of prostate) will pend for review according to Anthem's medically necessary criteria when billed with CPT codes: 55860, 55862, 55865, 55875, 76873, 77785, 77786, 77787, 76965, 77326, 77327, 77328, 77761, 77762, 77763, 77776, 77777, 77778, 77790, Q3001.


### Anthem – Intensity Modulated Radiation Therapy (IMRT) Update

System claim edits for IMRT were revised. Claims for services for prostate cancer, thyroid cancer and CNS lesions will be reviewed before processing to determine if the service meets Anthem's medical necessity criteria.

Effective April 4, 2011, the diagnosis codes will pend for review when billed with CPT codes 77301, 77338, 77418, or 0073T. Patients in a current course of IMRT for prostate cancer, thyroid cancer or CNS lesions will not be impacted by the criteria review during their course of treatment. The criteria review for these types of cancers will only be applied to patients in a new course of treatment after April 4, 2011.

### BLUE CROSS BLUE SHIELD – NEBRASKA CONSULT CODING CHANGES


Effective on dates of service on or after January 1, 2011 BCBSNE will no longer accept CPT codes 99241-99245 or 99251-99255. The consultation codes will be non-covered as provider liable services. The denial reason will instruct the provider to resubmit with a more appropriate Evaluation and Management code.



**BlueCross BlueShield of North Carolina**

**NC BlueCross BlueShield- 2011 FEP Coverage Guidelines for Morbid Obesity Surgery**

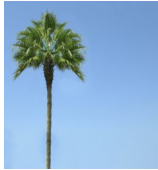
Effective with the 2011 benefit period, prior approval will be required for outpatient surgery for morbid obesity. FEP members must meet specific pre-surgical criteria before receiving surgery for morbid obesity.



For more information on the FEP coverage guideline changes go to: [www.bcbsnc.com](http://www.bcbsnc.com)

*PALMETTO GBA*


*MEDICARE*



**Automatic Denials of Claims Submitted with a GZ HCPCS Modifier**

Palmetto Medicare released an update reminding providers that effective July 1, 2011 contractors have discretion to automatically deny claims billed with the GZ HCPCS modifier. The GZ modifier indicates that an Advance Beneficiary Notice (ABN) was not issued to the beneficiary and signifies that the provider expects the claim to deny for lack of medical necessity based on Medicare policy.

For more information go to: <http://www.palmettogba.com>



**Multiple procedure reductions for CT scans, MRI or Ultrasounds**

Effective February 11, 2011, the policy for multiple procedure reductions for certain diagnostic imaging services will change. The initial CT scan, MRI or ultrasound will be allowed at 100 percent and subsequent scans performed on the same day will be allowed at 50 percent. The reduction will apply to scans performed on contiguous body areas, and technical and global charges.



For more information go to: [www.aetna.com/provider](http://www.aetna.com/provider)

**CMS – Extension of Waiver of Deductible for Colorectal Screening Test that Become Diagnostic or Therapeutic- Modifier PT**

The Part B deductible for colorectal cancer screening tests that becomes diagnostic is waived based on The Affordable Care Act.

Medicare policy states that the deductible is waived for all surgical procedures (CPT codes 10000 to 69999) furnished on the same date and in the same encounter as a colonoscopy, flexible sigmoidoscopy, or barium enema that were initiated as a colorectal cancer screening services.

Effective January 1, 2011 providers should append the modifier “PT” to at least one CPT code in the surgical range of 10000 to 69999 on a claim for services that meets this requirement.

**Can You Code It ...??**

What new E/M CPT codes for 2011 would you use to report Subsequent Observation Care?

**LAST MONTH'S ANSWER:** 61782

**ICD –10 Latest News**

You can find the latest news regarding the ICD-10 transition on the CMS website. There you can find provider resources, compliance timelines, and CMS implementation planning information. Also, subscribe to the CMS ICD-10 Industry Email Updates to obtain outreach materials and information on events.

For more information go to: [www.cms.gov](http://www.cms.gov)