

# AcSel Advisor

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## JUST A REMINDER:



**2012 CPT CHANGES  
EFFECTIVE  
JANUARY 1, 2012**

## CMS ANNOUNCES 2011 ELECTRONIC PRESCRIBING (eRx) INCENTIVE PROGRAM FINAL RULE

The Centers for Medicare and Medicaid Services (CMS) announced changes to the Medicare Electronic Prescribing (eRx) incentive program for Calendar Year 2011. The Final Rule defines what a provider must do to avoid the Medicare Physician Fee Schedule (MPFS) adjustment if they choose not to participate in eRx. For providers that are unable to adopt the program, new “significant hardship” exemptions are defined.

For more information go to: <http://www.cms.gov/ERxIncentive/>

Instructions on how to request a hardship via the web-based tool are available on the eRx Incentive Program website at <http://www.cms.gov/ERXincentive/>

## CMS – NEW ABN FORMS Effective January 1, 2012

Effective January 1, 2012, providers will be required to use the revised Advanced Beneficiary Notice of Noncoverage (ABN) form CMS-R-131.

- The revised form replaces the ABN-G, ABN-L and the NEMB forms.
- The ABN should be used when Medicare payment is expected to be denied.
- To obtain a copy of the new ABN go to: [https://www.cms.gov/BNI/02\\_ABN.asp](https://www.cms.gov/BNI/02_ABN.asp)



## CMS- ICD-10-CM/PCS MYTHS AND FACTS

CMS has released a document entitled “ICD-10-CM/PCS Myths and Facts.” The purpose of this document is to provide correct information in response to some myths regarding the ICD-10-Clinical Modification/ Procedure Coding System (ICD-10-CM/PCS).

### Some examples of common myths:

**MYTH:** Providers can assume that the Department of Health and Human Services (DHHS) will grant and extension beyond the October 1, 2013 compliance date.

**FACT:** DHHS has no plans to extend the compliance date for implementation.

**MYTH:** Non-covered entities, which are not covered by HIPAA such as Workers’ Compensation and auto insurance companies, that use ICD-9-CM may choose not to implement ICD-10-CM/PCS **CONT.**

## Intraoperative Radiation Delivery Treatment and Management – New CPT Codes Effective January 1, 2012

Effective January 1, 2012, there are three new Radiation Oncology codes:

- ◇ 77424 Intraoperative Radiation Treatment delivery, x-ray, single treatment session (technical component)
- ◇ 77425 Intraoperative Radiation Treatment delivery, electrons, single treatment session (technical component)
- ◇ 77469 Intraoperative Radiation Treatment management (professional component)

Special treatment procedure 77470 description has been revised. It now indicates that it no longer includes intraoperative radiation therapy.

- ◇ 77470 Special treatment procedure (e.g. total body irradiation, hemibody radiation, per oral or endocavitary irradiation).

### 5010 – Transition- Patient Registration: Subscriber vs. Patient Clarification

In preparing for the 5010 transitions, providers and their registration staff will need to identify the “subscriber vs. patient” relationship. Providers must check the patient’s insurance card to ensure the information is properly captured for accurate submission in 5010.

With 5010, the insurance plan hierarchy has been clarified. There are two possible situations:

1. If the patient has a unique member identifier assigned by the payer, then the patient is considered to be the plan subscriber and is sent as the subscriber. There is no need to also enter their information in the patient section on the claim.
2. If the patient is a dependant of the plan subscriber and does not have their own unique member identifier, then both the subscriber and patient information will be required on the claim.

### CMS- ICD-10-CM/PCS MYTHS AND FACTS - CONT.

**FACT:** Since ICD-9-CM will no longer be maintained it is in the non-covered entities’ best interest to transition to the ICD-10-CM coding system. CMS is working to encourage their use of ICD-10-CM/PCS.

**MYTH:** State Medicaid Programs will not be required to update their systems in order to utilize ICD-10-CM/PCS codes.

**FACT:** HIPAA requires one official list of national medical code sets. CMS is working with State Medicaid programs to ensure that the ICD-10-PCS code sets are implemented on time.

To view the entire document go to: <https://www.cms.gov/ICD10/Downloads/ICD-10MythsandFacts.pdf>

### UNITED HEALTHCARE – REVISED COVERAGE DETERMINATION GUIDELINES FOR BREAST REDUCTION

For breast reduction surgery to be performed on or after December 1, 2011, UHC had developed Coverage Determination Guidelines (CDG) outlining the clinical coverage review requirements. UHC has revised the documentation requirement and evaluation criteria that are to be utilized when determining coverage.

To review the coverage guidelines, go to: [UnitedHealthcareOnline.com](http://UnitedHealthcareOnline.com) >Tools& Resources > Policies and Protocols >Medical &Drug Policies and Coverage Determination

### TRICARE - Removes SS#'s from DoD ID Cards

Effective June 2011, The Department of Defense (DoD) no longer prints the sponsor’s Social Security Number (SSN) on any DoD ID card. The SSN has been replaced with the DoD ID Number. Those who are eligible for DoD benefits also have a DoD Benefit Number (DBN) on the back of the card. The DBN may be submitted on the claim instead of the sponsor’s SSN.

**Note to Tricare South Providers:** XpressClaim requires the sponsor’s SSN when submitting claims. Please do not use the DBN until further notice.

For more information and to view a sample of the card go to: [http://www.mytricare.com/Internet/tric/tri/imglib.nsf/\(WebFiles\)/2E2A91D823C6CA628525790A0069F912/\\$FILE/DBN\\_provider%20page.pdf](http://www.mytricare.com/Internet/tric/tri/imglib.nsf/(WebFiles)/2E2A91D823C6CA628525790A0069F912/$FILE/DBN_provider%20page.pdf)

## AETNA – POLICY AND PRACTICE UPDATES

In the September 2011 issue of Aetna OfficeLink Updates, Aetna outlines several new and updated coding and policy changes. Noteworthy, multiple procedure reduction for therapy procedures, maternity coverage proration, radiation treatment management and intensity modulated radiotherapy plan.

Multiple procedure reductions for therapy procedures – Implementation date: November 14, 2011

For non-facility claims only, multiple procedure reductions will be applied to certain therapy procedures. The procedure with the highest RVU will be allowed at 100 percent. The practice expense portion of each additional therapy service will be allowed at 80 percent.

Maternity coverage proration- Implementation date: December 1, 2011

When a patient's coverage during maternity is split between two different carriers; Aetna will only reimburse for services rendered while the patient's Aetna coverage is in effect. Aetna will adjust payment for global maternity care to account for the portion of prenatal care that would have been received prior to becoming covered by Aetna.

Radiation treatment management, 5 treatments- Implementation date: December 1, 2011

77427 will be denied when billed with 77431, 77432 or 77435. Modifier 59 can be used to override this edit when appropriate.

Intensity modulated radiotherapy plan, including dose-volume histograms for target and critical structure partial tolerance specifications – 77301 Implementation date: December 1, 2011

77014, 77421, 77435 will be denied when billed with code 77301. Modifier 59 can be used to override this edit when appropriate.

For the complete list of coding and policy changes go to: <http://www.aetna.com/newsletters/provider/OfficeLinks/2011/September/clinical-coding-changes.html>

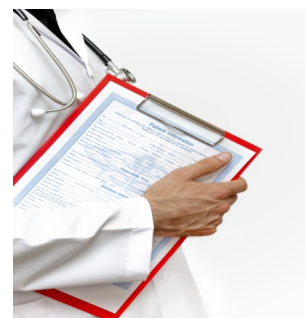
### United Healthcare Online Intensity Modulated Radiation Therapy (IMRT) Data Collection Form Updated

United Healthcare (UHC) has updated the online data collection forms for IMRT. According to UHC, the changes help ensure that the necessary information is obtained in order to improve the UHC review process for IMRT services. IMRT cases submitted without a completed IMRT Data Collection Form may require additional review time. For more information go to: <https://www.unitedhealthcareonline.com>

### United Healthcare Changes to Precertification Guidelines for Polysomnography and Portable Monitoring for Sleep Related Breathing Disorders.

Effective Oct 1, 2011, United Healthcare (UHC) will implement a policy revision that allows testing for Obstructive Sleep Apnea (OSA), when appropriate, in patient's homes. According to the UHC, home sleep testing along with the use of auto-adjusting positive airway pressure (APAP) devices in the self-adjusting mode for unattended treatment is an alternative to continuous positive airway pressure (CPAP) in patients without complex sleep disorders or significant co-morbidities.

For details regarding this program and to obtain the precertification guidelines go to: <https://www.unitedhealthcareonline.com>



## OPTIMA - DISCONTINUES MEDICARE ADVANTAGE PLANS

On December 31, 2011, Optima Health will discontinue the Medicare Advantage plans. According to Optima, this change will not affect their other plans or products.



## OPTIMA - RENAMES CHOICE CARE

On July 1, 2011 Optima renamed Choice Care to Choice Strategies. Choice Care Card is an employer sponsored healthcare debit card.

The Choice Strategies logo will gradually replace the Choice Care Card logo and existing HRA debit cards will be updated with the Choice Strategies as current member's cards expire.

For more information go to: <http://providers.optimahealth.com>

## MODIFIER 58 –

**Staged or Related procedure or service by same physician during the postoperative period**

## MODIFIER CORNER



### Guidelines/Instructions:

Modifier 58 is used to indicate that a procedure or service performed during the postoperative period was staged (planned or anticipated), more extensive than the original procedure, or for therapy following a surgical procedure. For treatment for an unanticipated return to the operating/procedure room, see modifier 78.

The planned surgical procedure starts a new global period.

Do not report modifier 58 with modifiers 78 or 79.

### Examples:

Palmetto GBA has the following clinical examples posted on their website of correct submission of CPT Modifier 58:

**Example 1:** A staged or planned procedure. A patient has a large sacral ulcer. Debridement of the ulcer (CPT code 11043) is performed on May 1, 2010. At the time of this debridement, the surgeon plans to treat the ulcer with a skin graft at a later date. On May 8, 2010, a split thickness graft (CPT code 15100) is performed to treat the ulcer site. Submit CPT modifier 58 with CPT code 15100.

**Example 2:** More extensive procedure. A right breast biopsy (CPT code 19125) is performed on May 1, 2010. As a result of the biopsy (which was positive for cancer), on May 8, 2010, (within the global period of the previous surgery), a modified radical mastectomy including axillary lymph nodes, with or without pectoralis minor muscle (CPT code 19307) was performed. Submit CPT modifier 58 with CPT code 19307, since the mastectomy procedure was a more extensive procedure than the biopsy.

**Example 3:** Planned additional therapy, two different physicians: an incisional biopsy of the prostate (CPT code 55705) was performed on May 1, 2010. On May 8, 2010, the patient was returned to the O/R for further treatment to place interstitial radiation (CPT code 77778) at the site of the prostate cancer. One surgeon performed the biopsy; a different surgeon performed the other procedure. Unless the surgeons are of the same specialty and same provider group, CPT modifier 58 is not needed.

For more information on the correct usage of modifier 58, go to: <http://www.palmettogba.com/palmetto/providers.nsf/docsCat/Providers~Railroad%20Medicare~Articles~Modifier%20Lookup~CPT%20Modifier%2058?open>



## Can You Code It ...??

What new DX code for 2012 would you choose to describe squamous cell carcinoma of skin; shoulder?

### LAST MONTHS ANSWER:

596.82 Mechanical complication of cystostomy