Medicare Fair

Contractor Comment: Thank you for attending the NHIC, Corp. Medicare Fair in Norwood, MA on May 13, 2009 and Manchester, NH on June 10, 2009. Below are the questions that needed clarification or further research. Please note that the questions may have been edited to allow for the greatest dissemination of information to the widest audience.

Evaluation and Management

Question 1. The 1997 E/M guidelines allow you to complete an EXTENDED HPI by commenting on the status of three or more “chronic or inactive problems." Can we also use this rule when completing the HPI using the 1995 E/M guidelines (Or do we have to use FOUR comorbidities as outlined in the official 1995 rules)? Also, no mention is made of using "chronic or inactive problems" to complete a BRIEF HPI. Is it correct to assume that if you comment on one to two problems that you can qualify for a BRIEF HPI. Can we use this for both the 1997 and the 1995 E/M guidelines? Finally, what is meant by "chronic or inactive problems?" If we are writing a progress note for a patient in the hospital, can we use the problems we are addressing from day to day to care for the patient--even though they are technically neither "chronic" nor "inactive?"

Answer 1. The status of three or more chronic or inactive conditions does qualify as an extended HPI under the 95 guidelines as well as the 97 guidelines. There is no distinction that states that the status of 1 or 2 chronic or inactive conditions would qualify for a brief HPI. However, identifying a problem/condition is sufficient to meet the brief HPI. This qualifies for both the 95 and 97 guidelines. A provider is not expected to continue listing inactive conditions when a patient is being seen daily (or subsequently) in a hospital. The progress note should address the relevant problem(s) and any changes since the last visit. The subsequent visits allow an interval history (i.e., any changes since the last note).

Question 2. If I document the most pertinent systems under the ROS, is it okay to say, "All other systems reviewed and are negative?"

Answer 2. Per the American Medical Association (AMA) Documentation Guidelines for Evaluation and Management Services, ROS inquires about the system(s) directly related to the problem(s) identified in the HPI plus additional body systems. At a minimum the patient’s positive and pertinent negative responses should be documented. For services that require a complete ROS at least 10 organ systems must be reviewed with positive or pertinent negative responses individually documented. For the remaining systems, a notation indicating “all other

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systems are negative" is permissible. In the absence of such a notation, at least 10 systems must be individually documented.

Question 3. Is it okay for me to refer to an earlier note's PFSH and ROS when I see the patient in the office? If so, what do I have to document?

Answer 3. A ROS and or a PFSH obtained during an earlier encounter do not need to be re-recorded if there is evidence that the physician reviewed and updated the previous information. This may occur when a physician updates his/her own record or in an institutional setting or a group practice where physicians use a common record. The review and update may be documented by describing any new ROS and/or PFSH or noting that there has been no change in the information. The provider must also note the date and location of the earlier ROS and/or PFSH.

Question 4. What is required for a comprehensive physical exam using the 1995 E/M guidelines? Do you have to have eight or more organ systems or can you use the body areas?

Answer 4. A general multisystem exam or complete exam of a single organ system. Eight or more organ systems, not body areas.

Question 5. How do your auditors tell the difference between and EPF exam and a detailed exam using the 1995 E/M guidelines?

Answer 5. The difference is that the detailed exam must have detailed documentation on at least 1 affected body area (BA) or organ system (OS) and comments on other areas/systems. Do not use constitutional as the 1 BA or OS.

Question 6. When using the 1995 guidelines for the physical exam, can I say "unremarkable" if an organ system has normal findings?

Answer 6. Unremarkable is acceptable related to unaffected area(s) or asymptomatic organ system(s).

Question 7. Can I say "non-contributory" when completing the FH if the information obtained is not germane to the clinical problems at hand?

Answer 7. Family history becomes important if the nature of the chief complaint(s) / symptom(s) on the date of service is such that a family history would be relevant. To Medical Review, the word "noncontributory" is a value judgment, meaning that there is an inference that the provider did give family history some consideration in order to decide it was not relevant. As reviewers, credit is given to all areas that are considered and documented by the provider. Our medical review team prefers providers stay away from this terminology.

Question 8. What exactly is meant by prescription drug management in the table of risk? Do I have to add, stop or adjust a drug?

Answer 8. Prescription drug management in the risk table is very easily defined and described. It can be a simple monitoring or a prescription drug (any single drug), assessing the need for the continued use in the plan of care and assessing the need for a change in drug, dose or discontinuing it altogether. There does not need to be a change of any kind and long as the medical record reflects the fact that a prescription drug was considered for the plan of care of a patient. A list of medications alone would not satisfy the medical record reflecting that a prescription drug was assessed for use in the plan of care for that particular date of service. The record should state something like: "continue XYZ at the same dose for (diagnosis)".

Question 9. Can I use a questionnaire when completing the ROS and PFSH and if so, what documentation is required?

Answer 9. ROS is an inventory of body systems obtained through a series of questions seeking to identify signs and/or symptoms that the patient may be experiencing or has experienced. Ancillary staff may record the ROS or it may be a form completed by the patient; however, there must be documentation by the physician confirming the information recorded by others.

Question 10. Do your auditors use a point system to quantify the MDM and, if so, can you provide me with the rules and your auditing form so I can incorporate the rules correctly into my compliance plan?

Answer 10. Yes, our medical review team uses a point system. See the following link for the auditing tool.
http://www.medicarenhic.com/providers/articles/E_M_complete.pdf.

Ambulance

Question 11. Do all ambulance suppliers – municipal, private, hospital based, etc, use the same fee schedule? Some ambulance suppliers are still billing for oxygen, IV therapy, cardiac monitoring even though they have been removed from the fee schedule.
Answer 11. All ambulance suppliers in the same locality are paid the same fee schedule. Medicare will deny oxygen, IV therapy, and cardiac monitoring as these services are no longer paid separately.

Question 12. How can we avoid duplicate claim denials on ambulance transports that have the same modifiers on the same day?

Answer 12. Unfortunately, there is no easy resolution to this issue. We have system edits in place to deny a claim as a duplicate when the majority of the claim information is the same. We suggest entering in the narrative field " Second trip, same day" or similar verbiage.

Question 13. What modifier do you use for ambulance billing if your pick up location is a ferry and you transport ALS non-emergency to a hospital ER?
Answer 13. The origin modifier is S (scene of acute event) and the destination modifier is H (hospital).

Question 14. If a patient is transported round trip by ambulance and they are covered under Part A benefits from a SNF to an appointment other than the excluded services in the Medicare billing guide, do you bill the SNF?
Answer 14. You would bill the SNF as the SNF is reimbursed by Medicare Part A. NHIC suggests that you have a billing arrangement with the SNF.

Provider Enrollment

Question 15. Why do so many of my physicians have to file an 855R?
Answer 15. Prior to the implementation of NPI, our system did not verify if a physician belonged to the group that was billing. When NPI went into place, the system looks for a match to be sure the individual physician is part of that group practice. If a match is not found, the physician must complete the 855R

Question 16. How can a group practice find out the individual physicians that are linked to the group?
Answer 16. The authorized official of the group practice should access the CMS internet-based Provider Enrollment, Chain, and Ownership System (PECOS). Internet-based PECOS will allow physicians, non-physician practitioners, and provider and supplier organizations the option of enrolling, making a change in their Medicare enrollment information, *viewing Medicare enrollment information*, or tracking the status of their Medicare enrollment applications throughout the Internet submission process. The PECOS Web-site is http://www.cms.hhs.gov/MedicareProviderSupEnroll/04_InternetbasedPECOS.asp#TopOfPage.

General

Question 17. A patient has a primary care physician (PCP). Do we need referrals from the PCP for patients in a skilled nursing facility (SNF)?
Answer 17. No, the Part B program does not require referrals for SNF patients.

Question 18. Can a provider update the patient's Coordination of Benefits (COB) file?
Answer 18. No, the patient must call the toll free line at 1-800-999-1118 to update their file.

Question 19. Will NHIC professional fee claims ever be on-line like FISS?
Answer 19. We have been experimenting with a pilot program, but have no plans to date to implement the program live.

Question 20. Other states release the name of the SNF or hospice the patient is involved with through the Interactive Voice Response (IVR). Is this service offered thru the NHIC IVR system?
Answer 20. This information is not on the IVR system; however, the customer service representatives can give providers the name of the SNF or hospice.

Question 21. A patient has a Medicare HMO and has chosen a hospice plan. I bill with the appropriate GV or GW modifier, but the physician service denies.
Answer 21. The service should be allowed. Item 19 of the CMS-1500 claim form or electronic equivalent must contain the statement "This patient enrolled in an HMO, but has elected hospice." If you have denials, contact the reopening line at 1-877-757-7781, give the representative the comment, and ask that the claim be reopened.