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Derm Coding Consult

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HHS to adopt ICD-10 code sets by October 2011

On Aug. 15, the Department of Health and Human Services (HHS) proposed a rule to adopt the ICD-10 series of diagnosis and procedure codes to replace the ICD-9-CM codes that the U.S. currently uses. CMS proposes an implementation schedule that would have the new coding system in place by Oct. 1, 2011.

The ICD-10 code set includes 155,000 codes, and can describe far more diagnoses and procedures than the ICD-9-CM code set of 17,000 codes. ICD-10 is the updated version of the ICD-9 code set currently used for coding diagnoses on all health care standard administrative transactions, and for coding procedures on standard inpatient hospital transactions. The ICD-9 code set was developed by the World Health Organization (WHO) and modified for US use in 1977. It has been in widespread use since 1988, and mandated for use under HIPAA since 2002.

The American Academy of Dermatology will join not only the American Medical Association but most medical specialty societies in commenting that the CMS proposed schedule for ICD-10 is unworkable. The costs for the average dermatology practice to undertake a project of this size will include a complete overhaul of current claims systems, software and superbills, as well as require a considerable amount of training for clinical and administrative staff.

In 1992, WHO produced an updated version, ICD-10. Modifications of the code set for US use have been developed by the National Center for Health Statistics (NCHS) for diagnoses (ICD-10-CM) and by the Centers for Medicare and Medicaid Services (CMS) for inpatient hospital procedures (ICD-10-PCS). In recent years, there has been increasing pressure to replace ICD-9 with ICD-10 as the standard code set for administrative transactions.

There are key differences between the current US version of ICD-9-CM and proposed US version of the ICD-10-CM code set that are critical for physicians and health care providers.

- There are significantly more codes in ICD-10 than ICD-9, by a factor of 10.
- The ICD-10 codes are significantly more detailed and granular level for reporting and statistical data, requiring more documentation to support.
- The ICD-10 codes are alphanumeric, as opposed to the primarily numeric ICD-9 codes.
- The ICD-10 codes contain up to 7 characters, as opposed to the 5 characters in ICD-9.

- The ICD-10 codes are organized differently than the ICD-9 codes.
 - Sense organs have been separated from nervous system disorders.
 - Injuries are grouped by anatomical site rather than injury category.
 - Postoperative complications are moved to procedure-specific body system chapters.

While NCHS has created “general equivalence mappings” between ICD-9 codes and ICD-10 codes which attempt to find corresponding diagnosis codes between the two code sets, there is not a consistent relationship between ICD-9 codes and ICD-10 codes. This is due to the differences in terminology and specificity between the code sets.

The differences in the code sets will pose a challenge for all providers as they transition from using ICD-9 to ICD-10. Diagnosis codes, currently represented by the ICD-9-CM code set, are used in virtually every aspect of a physician or health plan’s operations, both clinical and administrative. The impact of this change will affect business processes and the systems

— see **ICD-10 Code Sets** on page 3

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IMPORTANT Please Route to:

Dermatologist Office Mgr Coding Staff Billing Staff

Letter from the Editor

Dear *Derm Coding Consult* Reader:

The American Academy of Dermatology is proud to announce the **AAD Coding & Practice Management Webinars**. In response to AAD member interest, this new learning opportunity will provide AAD members and their practice management staff a live online coding educational event. Starting in 2009, these will also be available in a webcast format in order to provide individual learning opportunities on these topics.

The content for each of the Coding Webinars is developed by Practice, Policy and Management staff under the supervision and guidance of the dermatologists who serve on the Webinar Development Work Group. I want to thank Program Director: Scott Dinehart, MD, Chair/Coding & Reimbursement Task Force and our Program Content Advisors: Ben M. Treen, MD, Brent Moody, MD, and Sima Torabian, MD. Their guidance and participation has been invaluable.

For the majority of webinars (dependent on topic) each will qualify for AAD Category 1 CME Credit that may then be used toward the American Academy of Dermatology's Continuing Medical Education Award. Each of the webinars will also qualify for Continuing Education units (CEUs) recognized by the American Association of Professional Coders (AAPC). Each session includes fifty minutes of focused information and ten minutes of participant question and answer interaction. All questions submitted during the session will be answered during the session or participants will receive the follow-up Q&As via e-mail.

The registration fee for each webinar event allows access and participation for any number of practice management staff at one computer location. Detailed information on access and participation is provided the day prior to each live Webinar event. For more information on the upcoming webinars or to register for a webinar session on line, go to <http://www.aad.org/pm/index.html> or — Contact AAD Member Resources at (866) 503-SKIN. We look forward to having you join us!!

Best regards,



Norma L. Border, Editor

Coding Update

CHANGES TO DESTRUCTION CODE CCI EDITS

Recently, there have been numerous inquiries from dermatology practices regarding the CCI edits and CPT code 17000. In reviewing the CCI edits, one will discover that some of the previous edits pertaining to this code have been deleted and new ones became effective. For example:

Mutually Exclusive Col 1	Mutually Exclusive Col 2	Effective date	Deletion date	Modifier
17000	17111	19990101	20070630	1
17111	17000	20070701	☆	

Without noticing the deletion date, the modifier might be placed on the wrong code of the pair. At this time, CMS has no mechanism in place to eliminate from their files any code edits that have been deleted, thus, those edits remain in the spreadsheets.

The Correct Coding Initiative edits may be accessed on the Centers for Medicare & Medicaid Services (CMS) website. For each category, there are two sets of edits, the Column 1 / Column 2 edits and the Mutually Exclusive edits. When checking for applicable edits, both sets must be reviewed.

In looking at the edits, it is important to note all columns, which are:

- Column 1
- Column 2
- ☆ = edit in existence prior to 1996
- Effective date of edit — 19990101 = January 1, 1999
- Deletion date of edit — 20070630 = June 30, 2007
- Modifier use
 - 0= not allowed
 - 1= allowed
 - 9= not applicable

The column 2 receives the modifier. The complete instructions for the NCCI edits are found in the NCCI Policy Manual for Medicare Services. The link to that download is on the NCCI Overview page. See [CHAP1final-gencodingprinciples083108.pdf](#). There is also an article on proper use of modifier -59 that may be downloaded.

— see **Coding Update** on page 3

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Editor's Notes:

The material presented herein is, to the best of our knowledge accurate and factual to date. The information and suggestions are provided as guidelines for coding and reimbursement and should not be construed as organizational policy. The American Academy of Dermatology/Association disclaims any responsibility for the consequences of actions taken, based on the information presented in this newsletter.

Mission Statement:

Derm Coding Consult is published quarterly (March, June, September and December) to provide up-to-date information on coding and reimbursement issues pertinent to dermatology practice.

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Coding Update

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EXAMPLES OF CORRECT USE OF MODIFIER -59

- A) 17000 -59
17111

Rationale: Mutually Exclusive edit for code pair, 17000 is located in Column 2.

- B) 17004
17110 -59

Rationale: Mutually Exclusive edit for code pair, 17110 is located in Column 2.

- C) 17000
11100 -59
11301 -59

Rationale: Mutually Exclusive edits for the codes, code pair 17000 and 11100, 11100 is located in Column 2; code pair 17000 and 11301, 11301 is located in Column 2.

Note: Per the Column 1 / Column 2 edits for code pair 11100 and 11301, 11100 is located in Column 2. Thus, if only 11100 and 11301 were reported, only 11100 would need modifier -59.

EXAMPLE OF CCI INVALID CODE PAIR

- 17000 } not a valid code pair
17004 }

Rationale: Per the Column 1 / Column 2 edits for code pair this combination of codes is not allowable due to the descriptor of these codes. Thus, 0 is listed in the modifier field indicating that both codes are not reportable together.

It is important to use modifier -59 correctly to avoid claim denials. The only way to be certain of the correct placement of modifier -59 is to review the CCI edits. These edits are updated by CMS quarterly.

The link to the CCI page is: <http://www.cms.hhs.gov/NationalCorrectCodInitEd/>. On the left side of the page, click on NCCI Edits — Physicians. Then click on the appropriate Service Type, i.e., Integumentary System. *

ICD-10 Code Sets

— continued from page 1

supporting these operations as well as the relationships between providers and health care payers. There is no way to know the extent of the impact of this change, but it is thought to be far greater than that of the implementation of HIPAA standard transactions or the National Provider Identifier (NPI).

For dermatology practices these proposed coding changes will impact their documentation procedures, their record keeping procedures, their fee schedules, the medical review edits that health plans will apply, and the quality measures which will be used in assessing performance. While the impact of the HIPAA transactions and NPI enrollment and activation were generally limited to transactions with external partners, they did not require the significant level of change to many clinical and business workflow processes as ICD-10 will require. *

CMS Softens Signed Order Requirement

The Centers for Medicare and Medicaid Services has issued revised instructions to the Medicare Benefit Policy Manual (Pub 100-02) that eliminate the requirement that all orders for diagnostic tests must be signed by the treating or ordering physician. CMS has added the following note to the definition of an Order:

NOTE: No signature is required on orders for clinical diagnostic tests paid on the basis of the clinical laboratory fee schedule, the physician fee schedule, or for physician pathology services.... While a physician order is not required to be signed, the physician must clearly document in the medical record, his or her intent that the test be performed.

Diagnostic test orders may be faxed, phoned, e-mailed or hand delivered to the testing facility. If phoned in, both the treating physician and the testing facility must document the phone request in their respective copy of the beneficiary's medical record. *

CMS Pushes Back ABN Implementation Deadline

The Centers for Medicare and Medicaid Services (CMS) has advised Medicare contractors that it is extending the implementation period for the revised Advance Beneficiary Notice of Noncoverage (ABN) (CMS-R-131). The deadline for using the revised ABN has been extended until March 1, 2009. CMS released the revised ABN in March, 2008.

Derm Coding Consult published the full ABN form and the revised instructions for its use in the Spring, 2008 issue. Medicare Part B physicians and providers are authorized to begin using the notice as soon as they are able. However, use of the revised form will be required as of March 1, 2009. The revised ABN and form instructions can be accessed at www.cms.hhs.gov/bni on the CMS web site. You can also download the form and the instructions in *Derm Coding Consult*, Spring 08 from the AAD web site at <http://www.aad.org/members/publications/consult.html> *

Pre-order your 2009 Coding and Documentation Manual Today!

This manual is the only dermatology-specific book on the market and includes the newly updated AMA CPT, HCPCS, and ICD-9-CM coding, and E/M documentation requirements for 2009!



For more information or to place an order contact the Member Resource Center at 866-503-SKIN (7546).

08_197a

Billing for “Incident to” services furnished by Non-Physician providers

When evaluation and management (E/M) services are furnished “incident to” a physician’s service to Medicare beneficiaries by a non-physician practitioner, the physician may bill the CPT code that describes the E/M service furnished.

“Incident to” as related to physician’s professional services, includes services that are integral to the treatment of the patient. Services provided and billed as “incident to” require direct supervision by the physician. This requirement means that the physician must be immediately available should a situation arise that would require his or her assistance. Being “immediately available” means the physician must be present in the same office suite during the treatment and not necessarily in the treatment room with the non-physician provider. Without the physician’s presence in the same office suite while the professional services are being provided by the non-physician assistant, does not qualify to be billed as “incident to” to a Medicare contractor.

A physician is not precluded from billing under the “incident to” provision for services provided by employees whose services cannot be paid for directly under the Medicare program. Employees of the physician may provide services “incident to” the physician’s service, but the physician alone is permitted to bill Medicare.

APPROPRIATE BILLING “INCIDENT TO” SERVICE

Assuming dermatologist A evaluates a Medicare patient and recommends PUVA therapy. Plan of treatment states patient is to receive 3 treatments per week to be provided by a specially trained technician in the dermatologists’ office. The first three treatments are billed to Medicare under dermatologist A’s NPI number.

Then dermatologist A goes on vacation and is not available for the second week of treatment. These treatments cannot be billed as “incident to” dermatologist A as it does not meet the criteria and rules for billing “incident to” service. Unless there is another provider available in the office suite filling in for dermatologist A, these services are not a billable service to Medicare. However, provider B can bill Medicare under his/her NPI number and report the service as “incident to” service as long as provider B is in the office and immediately available.

When services to be billed as “incident to” meet Medicare guidelines they can be billed at 100% of the physician fee schedule. Services that do not meet the Medicare “incident to” guidelines must be billed by the non-physician provider at 85% of the physician fee schedule. The services must be provided in accordance with the applicable state laws and billed under the non-physician providers own NPI.

“INCIDENT TO” IN GROUP SETTINGS

Services furnished “incident to” a physician’s service by dermatologists in the same group practice that are in the same specialty must bill and will be reimbursed as though they were a single physician. If more than one E/M service is provided on the same day to the same patient by the same

physician or more than one physician in the same specialty in the same group, only one E/M service may be reported unless the E/M services are for unrelated problems. Instead of billing separately, the physicians should select a level of service representative of the combined visits and submit the appropriate code for that level.

Physicians in the same group practice but who are in different specialties may bill and be paid without regard to their membership in the same group.

More information on non-physician billing can be viewed at the American Academy of Physician Assistants’ (AAPA) website www.aapa.org and American Academy of Nurse Practitioners (AANP) website at www.aanp.org.

It is always advisable to review your Medicare carrier website for information on “Incident to” billing, and in the Medicare Claims Processing Manual, Chapter 12 - Section 30.6.4 at <http://www.cms.hhs.gov/manuals/downloads/clm104c12.pdf>. It is also important to check with the State regulations for rules and guidelines you must be aware of regarding non-physician providers.

NOTE

“Incident to” guidelines referred to in this article only apply to Medicare services and do not apply to other commercial carriers. Please check with your participating commercial carriers to find out what their requirements are for billing “incident to”.

CMS-1500 – Claims Rejected if Item 11 MSP Information Incomplete

Medicare announced that it will reject claims with a new message. CO16/MA83 – “Did not indicate whether we are the primary or secondary payer” when Item 11 of the CMS-1500 claim form, a required field, is not properly completed. You may download the CMS Medicare Secondary Payer Manual at: www.cms.hhs.gov/manuals/downloads/msp105c06.pdf 2007-10-27

By completing Item 11, the physician/supplier acknowledges having made a good faith effort to determine whether Medicare is the primary or secondary payer. If there is insurance primary to Medicare (Medicare is the secondary payer), the practice should enter the insured’s policy or group number and proceed to Items 11a–11c. Items 4, 6 and 7 must also be completed. If there is no insurance primary to Medicare, enter the word “None” and proceed to Item 12. Claims submitted without the appropriate information will be rejected.

For additional information about determining when Medicare is the secondary payer and for links to manuals, job aids and other important information, please refer to the Medicare Secondary Payer (MSP) information on your Medicare Carrier or Medicare Administrative Contractor web site. ✚

Waiving Beneficiary Cost-sharing Without Trouble from OIG

Physicians and health care providers affected by recent retroactive increases in Medicare payment rates can avoid OIG sanctions for not collecting retroactive cost-sharing amounts from their patients under certain circumstances. The Department of Health and Human Services' (DHHS) Office of Inspector General (OIG) said in a recent statement that providers will not be subject to sanctions if they waive Retroactive Beneficiary Liability related to the payment rate increases for Medicare providers that Congress approved July 15, 2008, overriding President Bush's veto.

As part of the deal to secure passage, Congress required Medicare and Medicaid recipients to shoulder out-of-pocket more of the cost of their treatment. Because the previous fee schedule expired July 1, certain Medicare or Medicaid patients who obtained medical treatment, were transported by ambulance or received other covered services in the interim will be responsible for paying about 20 percent of the payment rate increase for those services.

The OIG said that physicians and other providers may waive the retroactive portion of the beneficiaries' increased payment once that portion becomes known without being subject to sanctions for violating federal anti-kickback or other medical fraud and abuse regulations. **Physicians are not required** to waive the retroactive portion that Medicare or Medicaid patients are supposed to pay under the provisions of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA).

Ordinarily, routine waivers of Medicare cost-sharing amounts potentially implicate the federal anti-kickback statute, the civil monetary penalty and exclusion laws related to kickbacks, and the civil monetary penalty law prohibiting inducements to beneficiaries. However, according to OIG, in these limited circumstances, physicians and health care providers will not be subject to OIG administrative sanctions if they waive Retroactive Beneficiary Liability, subject to the following conditions:

CONDITIONS FOR WAIVING BENEFICIARY LIABILITY:

- The waivers of Retroactive Beneficiary Liability are only for the period from July 1, 2008, until the date on which the Center for Medicare and Medicaid Services (CMS) or the relevant carrier or intermediary implements the applicable increased payment rates. "Once new payment rates are implemented," OIG said, "Providers **are expected** to calculate cost-sharing amounts based on the new payment rates."
- The waivers cannot be for Retroactive Beneficiary Liability conditioned in any manner on the provision of future items, supplies, or services."
- The policy does not apply to waivers of beneficiary cost-sharing amounts that were calculated using the lower payment rates temporarily in effect since July 1, 2008.

OIG noted that although MIPPA became law on July 15, "as a practical matter, the revised payment rates took some time to be implemented by CMS (or the relevant contractors and intermediaries. The exact implementation dates may vary by benefit, contractor, and intermediary. Until such time as the new

payment rates are implemented, some Providers may continue to calculate beneficiary cost-sharing obligations based on the prior, temporary payment rates, and the beneficiaries may pay, or be billed for, a lower amount than they actually owe under MIPPA.

Because it may be several months before the new fee schedule is implemented for some benefits, and because beneficiaries generally will be responsible for 20 percent of the increased costs, some Medicare and Medicaid patients may not be able to afford the accumulated retroactive cost, and therefore the OIG is giving providers the option to waive these costs for their patients without being subject to OIG sanctions.

The OIG statement stressed that providers may still waive any cost-sharing amounts "on the basis of a good-faith, individualized determination of a beneficiary's financial need." **However, providers may not advertise nor solicit business on the basis of an offer to waive cost-sharing amounts, nor may they routinely waive cost-sharing amounts without regard to individual circumstances.** Federal law provides that a good-faith determination be made to see the beneficiary is in financial need or that reasonable collection efforts have failed before waiving any costs.

For more information, please visit http://www.oig.hhs.gov/fraud/docs/alertsandbulletins/2008/MIPPA_Policy_Statement.PDF *

Medicare Publishes Billing Edits to Reduce Payment Errors

The Centers for Medicare & Medicaid Services on October 1, 2008, published most of the edits utilized in its Medically Unlikely Edit (MUE) program. The MUE edits were established to improve the accuracy of claims payments. They were developed by CMS and national health care organizations representing physicians, hospitals, and other groups.

Claims processing contractors utilize these edits to assure that providers and suppliers do not report excessive services. The edits are applied during the electronic processing of all claims. These edits check the number of times a service is reported by a provider or supplier for the same patient on the same date of service. Providers and suppliers report services on claims using HCPCS/CPT codes along with the number of times (i.e., units of service) that the service is provided. There have been data entry errors of a misplaced modifier 25 in the CMS 1500 claim unit field which paid a service 25 times the allowable.

CMS is not able to publish all active MUEs because some are primarily designed to detect and deter questionable payments rather than billing errors. Publishing those MUEs would diminish their effectiveness. Therefore, some of the highly used CPT codes are missing from the published list.

The MUE edits are published on the CMS Web site at http://www.cms.hhs.gov/NationalCorrectCodInitEd/08_MUE.asp#TopOfPage.

Coding Q & A's

Is pregnancy test separately billable with Acne visit?

Q. A female patient currently on accutane therapy is seen for acne follow-up in a dermatology practice. As part of patient care patient is constantly monitored for blood level counts and confirmation of negative pregnancy test by way of urine dip stick test. Is the pregnancy test separately billable?

A. Yes, the pregnancy dip stick test is a separately billable procedure as it is not included in the E/M service code. Therefore, the visit will be coded as

706.1 – Acne

V58.69 – long-term (current) use of other medications

9921X -25 – Evaluation and Management (when appropriate)

81025 – urine pregnancy test, by visual color comparison methods.

In the event of blood draw during the same encounter, you may report the blood draw with 36415 – venous blood draw

Q. Can I charge for a new-patient visit at a new practice if I saw the patient at my previous practice?

A. AMA CPT defines a new patient as one who within the past three years has not received any face-to-face professional service rendered by a physician and reported with a CPT code.

Thus, if the patient was seen at the previous practice during the past three years and a face-to-face professional service was rendered by the physician and reported with a CPT code, it would not be appropriate to report a new patient service at the new location. Having a new location with a different tax ID number doesn't matter in this instance.

Q. Must our office submit a Part B claim to Medicare for all Medicare patients?

A. The Social Security Act (Section 2848(g)(4)(A)) requires that all participating and non-participating physicians submit Medicare Part B claims for covered services to Medicare patients. This also includes claims submission when the patient has Medicare as the Secondary Payer. But services that are considered statutorily excluded from coverage such as a cosmetic/non-covered claims does not need to be submitted unless requested by the patient.

The exception to the mandatory claims submission is applicable only to those providers who have opted out of the Medicare program. Non-participating providers may choose to submit the claim without accepting assignment. In this instance, the patient would pay the provider and any Medicare reimbursement for the services would be paid directly to the patient.

Medicare Update

MEDICARE ADMINISTRATIVE CONTRACTOR (MAC) UPDATE

As Medicare transitions the administration of the Medicare Part A and Part B claims functions to 15 new Medicare Administrative Contractors (MACs), it is important for dermatologists to watch for any changes to current coverage policies. In some cases, MACs may discontinue, change, or adopt new local coverage decisions (LCDs), impacting coverage for dermatology procedures and the medical necessity. The LCDs are published on the MAC contractor websites and through provider correspondence such as bulletins and newsletters.

There have been many complaints of denied claims for benign lesions treatments. Numerous Benign Lesion Policies LCDs have been changed requiring a second diagnosis, that proves medical necessity. This secondary diagnosis is not specifically linked to the procedure on the claim, it simply justifies the procedure. J1 (California, Nevada, Hawaii) and J13 (New York, Connecticut) are experiencing these LCD changes.

OTHER MAC ISSUES:

J1 A/B MAC/California, Nevada, Hawaii – new email address

Due to the completion of the J1 MAC transition, the J1 Transitional e-mail address, J1MAC@PalmettoGBA.com, is no longer active. The new address is: J1PCC.Contact@PalmettoGBA.com. For all inquires or concerns, the Part B Provider Contact Center is (866) 931-3901.

J4 PART B MAC TRAILBLAZER OKLAHOMA – 07 PQRI BONUS DELAYS

The Enterprise Data Center (EDC) experienced a file error which resulted in a delay of the 2007 Physician Quality Reporting Initiative (PQRI) Bonus incentive payments. The file showed the checks had been mailed erroneously. The issue has been resolved and Oklahoma providers should begin to receive their 07 PQRI incentive checks immediately.

CMS – MEDICARE BUSINESS ISSUES:

CMS has advised that the Internal Revenue Service (IRS), in conjunction with the Department of the Treasury, has given CMS the authority to collect overdue taxes from physicians through a levy on certain federal payments; such as Medicare Remittances. Effective: 10/01/08 CR 6125 ✱

2007 PQRI Bonus Payment Status

If you have not received the 2007 PRQI Bonus either by a paper check or electronic remittance with the description of “P4R” by now, check Centers for Medicare & Medicaid Services (CMS) website to understand what happened. Like every pilot program there is a learning curve. This one offered a variety of possible errors such as a new provider ID system – NPI, the reporting of a CPT code that included an alpha and numeric system without money attached which is foreign to most computer systems. Finally, there was the potential hurdle of getting all this new information as a clean claim through a clearinghouse system that may not have been ready! If your

– see PQRI on page 8

MAC Contract Updates

The following table provides the current status on the CMS transitioning of Medicare Part B Claims payment from the Medicare Carriers to the new Medicare Administrative Contractors. Dermatology practices are advised to keep close tabs on these transitions and to alert AAD Practice, Policy and Management staff of any unanticipated changes to claims processing and payment in their areas.

A/B MAC JURISDICTION #	CURRENT MAC CONTRACTOR	CURRENT/ FORMER FISCAL INTERMEDIARIES	EXPECTED IMPLEMENTATION DATE
1 Am Sa, CA, GU, HI, NV, North. Mar. Isl	PALMETTO GBA	*Mutual of Omaha Insurance Company *Noridian Mutual Insurance Company *United Government Services, LLC	10/01/08
2 AK, ID, OR, WA	NATIONAL HERITAGE INSURANCE CORP** On May 27, 2008, a protest against the award was filed with Govt. Account. Office (GAO). Final GAO decision was expected by 09/02/08. In accordance with the Competition in Contracting Act (CICA), this triggered an automatic stay on performance of the NHIC contract pending GAO's decision.	*Connecticut General Life Insurance Company *Mutual of Omaha Insurance Company *Noridian Mutual Insurance Company	
3 AZ, MT, ND, SD, UT, WY	NORIDIAN ADMINISTRATIVE SERVICES	*Blue Cross and Blue Shield of Alabama, doing business as Cahaba Government Benefit Administrators *Blue Cross and Blue Shield of Arizona *Blue Cross and Blue Shield of Montana, Inc. *Blue Cross and Blue Shield of Wyoming *Mutual of Omaha Insurance Company *Noridian Mutual Insurance Company	March-08
4 CO, NM, OK, TX	TRAILBLAZER HEALTH ENTERPRISES	*Pinnacle Business Solutions *Healthcare Services Corporation *Mutual of Omaha Insurance Company *Noridian Mutual Insurance Company *TrailBlazer Health Enterprises, LLC	Spring 2008
5 IA, KS, MO, NE	WISCONSIN PHYSICIAN SERVICES	*Arkansas Blue Cross and Blue Shield *Blue Cross and Blue Shield of Kansas, Inc. *Blue Cross and Blue Shield of Mississippi *Blue Cross and Blue Shield Nebraska *Mutual of Omaha Insurance Company *Noridian Mutual Insurance Company	09/09/08
6 IL, MN, WI	TO BE ADVISED	*Anthem Insurance Companies, Inc. *Mutual of Omaha Insurance Company *Noridian Mutual Insurance Company *United Government Services, LLC *Wisconsin Physicians Service Insurance Corporation	
7 AR, LA, MS	PINNACLE BUSINESS SOLUTIONS INC** On July 2, 2008, a protest against the award was filed with Govt. Account. Office (GAO). Final GAO decision is expected by 10/10/08. In accordance with the Competition in Contracting Act (CICA), this triggered an automatic stay on performance of the NHIC contract pending GAO's decision.	*Arkansas Blue Cross and Blue Shield *Blue Cross and Blue Shield of Alabama *Blue Cross and Blue Shield of Mississippi *Mutual of Omaha Insurance Company	
8 IN, MI	TO BE ADVISED	*AdminaStar Federal, Inc. *Anthem Insurance Companies, Inc. *Mutual of Omaha Insurance Company *United Government Services, LLC *Wisconsin Physicians Service Insurance Corporation	
9 FL, PR, VI	FIRST COAST SERVICE CORP	*Cooperativa de Seguros de Vida de Puerto Rico *First Coast Service Options, Inc. *Mutual of Omaha Insurance Company *Triple S, Inc.	03/01/09
10 AL, GA, TN	TO BE ADVISED	*Blue Cross and Blue Shield of Alabama *Blue Cross and Blue Shield of Georgia, Inc. *Blue Cross and Blue Shield of Tennessee *Connecticut General Life Insurance Company *Mutual of Omaha Insurance Company	
11 NC, SC, VA, WV	TO BE ADVISED	*Blue Cross and Blue Shield of South Carolina *Connecticut General Life Insurance Company *Mutual of Omaha Insurance Company *TrailBlazer Health Enterprises, LLC *United Government Services, LLC	
12 DE, DC, MD, NJ, PA	HIGHMARK MEDICARE SERVICES	*Blue Cross and Blue Shield of Tennessee *Empire HealthChoice Assurance, Inc. *Highmark, Inc. - HGSAdministrators *Highmark, Inc. *Mutual of Omaha Insurance Company *TrailBlazer Health Enterprises, LLC	end of 2008
13 CT, NY	NATIONAL GOVERNMENT SERVICES (NGS)	*Empire HealthChoice Assurance, Inc. *First Coast Service Options, Inc. *Group Health Inc. *HealthNow New York, Inc. *Mutual of Omaha	Nov-08
14 ME, MA, NH, RI, VT	TO BE ADVISED	*Anthem Health Plans of Maine, Inc. *Anthem Health Plans of New Hampshire, Inc. *Arkansas Blue Cross and Blue Shield *Mutual of Omaha Insurance Company *National Heritage Insurance Company	
15 KY, OH	TO BE ADVISED	*AdminaStar Federal, Inc. *Anthem Insurance Companies, Inc. *Blue Cross and Blue Shield of South Carolina *Mutual of Omaha Insurance Company	

2007 PQRI Bonus Payment Status

— continued from page 6

dermatology practice participated in the 2007 PQRI program but didn't receive a bonus, it's important to find out why. Any of these discrepancies would lower or eliminate the bonus. There are more measures in the future and now is the time to understand how the system works.

Due to the hardship for physicians to acquire the 2007 PQRI Feedback Reports, CMS recently announced that a new self service look-up tool for the Medicare Physician Quality Reporting Initiative (PQRI) is available on the QualityNet site. This tool allows an eligible professional to see if their 2007 PQRI Feedback Report is available at this website: <https://www.qualitynet.org/portal/server.pt>

Once on the QualityNet site, go to the "Verify TIN Report Portal" (that is located at the bottom of the page) and enter the appropriate Tax Identification Number. The tool will produce a message regarding whether 07 Feedback is available.

To view your 2007 PQRI Feedback Report, you must first register on the IACS website at <https://applications.cms.hhs.gov/category.html?name=acctmngmt>. For assistance with registering on this website, please call 866-484-8049. After you have obtained an IACS username and password, log into the PQRI Quality Net website with this information to view your 2007 Feedback Report.

The QualityNet does have a Help Desk telephone number to check if a 2007 PQRI Feedback Report is available. They are only allowed to disclose if there is a report. The QualityNet Help Desk can be reached via telephone at 1-866-288-8912 from the hours of 7am-7pm CST or via email at Qnetsupport@ifmc.sdps.org. *

IN THE KNOW...

Legible Provider Identification a Requirement on medical record documentation

Did you know that Medicare requires a legible identifier for services provided or ordered? The acceptable method is a handwritten or an electronic signature to sign an order or other medical record documentation for medical review purposes, per CMS. Stamp signatures are not acceptable.

An exception applies to originally written or electronic signatures on all documents: when faxing certification of terminal illness for patients being admitted to hospice, the fax copy is acceptable. Fascimile and hard copies of a physician's electronic signature must be in the patient's medical record for the certification of terminal illness for hospice.

For more information, visit MLN at www.cms.hhs.gov/MLNMattersArticles/downloads/SE0829.pdf

or

www.cms.hhs.gov/Transmittals/downloads/R248PI.pdf

You are in the Know!



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