Codify
BY AAPC

Part B Insider (Multispecialty) Coding Alert

CMS Clarifies 3 Hot Issues

From bilateral billing to ICD-10 regs, CMS was busy working on May policy adjustments.

Typically, the spring is a quiet time for Medicare regulations, but this week the government issued several clarifications that tightened up CMS policy on a few different issues. We've got the scoop on exactly what you need to know as you wade through the stack of transmittals and articles.

1. Rubber stamp signatures are okay if you're physically unable to sign. Most Part B practices know that a practitioner must either submit a handwritten or electronic signature for services that they order or provide, and that stamped signatures aren't acceptable. However, CMS made a new exception to that policy this week with MLN Matters article MM8219.

"CMS will permit the use of a rubber stamp for signature in accordance with the Rehabilitation Act of 1973 in the case of an author with a physical disability that can provide proof to a CMS contractor of his/her inability to sign their signature due to their disability," CMS says in the document, which is effective June 18. "By affixing the rubber stamp, the provider is certifying that they have reviewed the document."

2. You can now bill venous infusion and contact lens fitting bilaterally. Although the bilateral indicator for the following codes was "0" in the past, meaning that bilateral payment did not apply, CMS changes that thanks to new MLN Matters article MM8291:

- 37211 – Transcatheter therapy, arterial infusion for thrombolysis other than coronary, any method, including radiological supervision and interpretation, initial treatment day
- 37212 – Transcatheter therapy, venous infusion for thrombolysis, any method, including radiological supervision and interpretation, initial treatment day

The new bilateral indicator for these codes is "1," which means that the 150 percent payment adjustment applies if you report it with modifier 50 (Bilateral procedure).

In addition, CMS changes the bilateral indicator for 92071 (Fitting of contact lens for treatment of ocular surface disease) from "3" (which meant that the endoscopic billing criteria applied) to "1" as well. This means that modifier 50 will be your friend when you perform these contact lens fittings on both eyes during the same visit.

These bilateral changes are all effective retroactive to Jan. 1, which means you can institute the change immediately, according to the MLN Matters article.

3. Emergency room observation services that span the ICD-10 date should not be split into two charges. CMS previously clarified how to report services that span the ICD-10 date of Oct. 1, 2014, but this week the agency clarified how to report those claims when an emergency room visit or observation stay is involved. "Single item services whose time-frames cross over midnight on Sept. 30, 2014 (e.g., emergency room visits and observation) are not split into two separate charges," the agency writes in Transmittal SE1325. "Rather, the single item service should be placed in the claim based on the line item date of service."

For emergency room encounters, that is the date the patient enters the emergency room, and for observation care, it

refers to the date the observation care begins.

Resource: CMS provides examples of how these claim forms should look in the transmittal, which you can read at www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1325.pdf.