Part B Insider (Multispecialty) Coding Alert

Part B Payment: 2 Historically Bad CCI Edits Will Soon Be History, CMS Says

Plus: Recoupments over incarcerated patients flummoxes practices nationwide.

If ophthalmological evaluations are a big part of your practice's revenue, you've probably been experiencing a level of stress beyond frustration thanks to CCI 19.2, which bundled 92012 and 92014 into scores of procedure codes. Fortunately, however, you will be able to recoup the money you lost from those troublesome CCI edits in October.

That's the word from an Aug. 27 CMS Open Door Forum, in which CMS's **Chris Ritter** acknowledged that edits bundling 92012 (Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient) and 92014 (Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; comprehensive, established patient, 1 or more visits) have caused challenges for coders.

"NCCI will be suspending edits beginning Oct. 1, and claims that been denied after July 1 because of the lack of a 25 modifier on either of those two codes can go ahead and be resubmitted after that time," Ritter said. CMS plans to work on making edits more appropriate for these two E/M codes, she added.

In black and white: You can read an Aug. 20 letter from CCI's **Niles Rosen, MD** to the American Academy of Ophthalmology's **Michael Repka, MD** confirming the upcoming edit reversal, which the AAO posted on its website at www.aao.org/aao/outofcs/wre/CMS_NCCI_letter.pdf. In the letter, CMS admits that even modifier 25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) was not allowing legitimate claims to bypass the edit as it should have, which is what led CMS to decide that deleting the edits was the best idea going forward.

Even if your doctor billed correctly in the first place for these services, MACs will not automatically reprocess claims, Ritter stressed. Instead, you will have to resubmit the bill to your MAC after Oct. 1. You should resubmit the claim at that point as if you're sending the bill for the first time, Ritter clarified you do not need to send in an appeal.

Transitional Care Management Answers Elucidated

CMS also acknowledged on the call that transitional care management claims have not been processed as smoothly as they could have been recently. "We know some practitioners have been having challenges billing for transitional care management, which was a new service that went into effect on Jan. 1, and we have been looking closely at our editing and made some revisions and also made some materials available as to how the services should be billed," said Ritter, who referred listeners to a new transitional care management (TCM) FAQ on the CMS web site.

One common reason for TCM denials, CMS notes, is that practices have submitted claims for TCM services that started prior to Jan. 1, 2013. However, CMS did not start reimbursing for TCM until after that date, so if your date of service spans any period before Jan. 1, 2013, those claims will be denied, CMS stresses in the FAQs, which are available at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/FAQ-TCMS.pdf.

Because you should bill for TCM services using the discharge dates, "The first payable date of service for TCM services is Jan. 30, 2013," CMS stresses.

CMS Attempting to Rectify Incarcerated Patient Denials

In addition, CMS representatives stressed the fact that although the agency plans to readjust claims that were incorrectly denied due to incorrect reports that the patient was incarcerated on the service date, those adjustments won't take place until October, so you are free to appeal before that time if you choose to.

Background: As we noted in the Insider Vol. 14 Issue 26, CMS admitted last month that it misidentified "a large number" of services that it had classified as involving incarcerated beneficiaries, mainly in June and July of this year. In some of these cases, CMS had requested a refund from you, and in others, MACs had initiated automatic recoupment for the funds. Then practices had to fight back and were asked to advise beneficiaries to contact their Social Security offices to clear up the issue.

Once CMS admitted that many of these patients were not, in fact, incarcerated at the time of service, the agency started "actively reviewing" data to correct inappropriate overpayment recoveries, and to change its process of identifying incarcerated patients.

A caller to the Aug. 27 forum noted that her practice has had thousands of dollars incorrectly recouped due to the error, but added that appealing each claim individually would take up too many practice resources. Therefore, the CMS representatives noted, those claims will be readjusted automatically starting in October.

Another caller pointed out that she's still getting demand letters regarding the incarcerated patient issue, and the CMS representatives advised her to either repay the demand amount or appeal as she normally would have, since the issue has not been completely straightened out yet, and that adjustments will take place accordingly in October.