Part B Insider (Multispecialty) Coding Alert

TRANSMITTALS: Upcoming CCI Edits Will Hit All Providers Billing Part B

Smaller overpayments will lead to demand letters from carriers

Soon other providers will have a taste of the coding maze that you have to navigate.

The infamous Correct Coding Initiative edits will apply to all providers who bill Part B starting in January, including physical therapists, skilled nursing facilities, comprehensive outpatient rehab facilities, home health agencies and speech-language pathology providers, according to Medlearn Matters article SE0545.

Also in recent Medicare transmittals:

1. Starting Sept. 6, if you don't respond to a demand letter for an overpayment greater than $10, you'll receive a second demand letter after 30 days and a third demand letter after 60 days, according to Transmittal 73 (Change Request 3932). Previously, Medicare only sent second and third letters for overpayments over $50, but since the threshold to refer debts to the Treasury Dept. was $25, it made sense to lower the limit for letters.

2. When carriers are recouping funds from providers for claims that they've already paid, the carriers should include a Financial Control Number on their demand letters, according to Transmittal 618 (Change Request 3772). If the carriers are only seeking partial repayment, they still should cancel the previous payment and enter a partial payment in the system, the **Centers for Medicare & Medicaid Services** says.

3. Comprehensive Error Rate Testing contractors should keep the proper contact info for providers in their database, but they shouldn't refer providers that don't respond to information requests to the **HHS Office of Inspector General**, according to Transmittal 115 (Change Request 3786).

4. Medicare gave contractors a heads-up on the launch of its new Chronic Care Demonstration Project, which will last three years and include 180,000 chronically ill beneficiaries. The program will test whether disease management can reduce costs including hospitalizations, according to Transmittal 26 (Change Request 3953).

5. Physicians can **bill code V2632** for inserting either an intra-ocular lens (IOL) or a presbyopia-correcting IOL in the office setting, according to Transmittal 636 (Change Request 3927). But Medicare will no longer pay an extra $50 for insertion of new-technology IOLs in the Ambulatory Surgery Center setting, according to Transmittal 639 (Change Request 3901).

6. You won't have to list special diagnoses to get Medicare to pay for low osmolar contrast material in the non-hospital setting. You can bill for LOCM for all medically necessary imaging procedures using new codes Q9945-9951, according to Transmittal 627 (Change Request 3902).

7. You should be able to bill the HCPCS codes for radiopharmaceutical agents (tracers) along with PET scans, for claims after Jan. 28, according to Transmittal 628 (Change Request 3945).

8. CMS is suspending its Health Insurance Portability and Accountability Act contingency program. Starting October 1, noncompliant claims will bounce back from carriers, CMS warns.