



New Medicare Therapy Claims Requirements

Effective July 1, 2010, all claims for therapy services submitted to Medicare that are performed by persons other than licensed therapy professionals must contain additional information on the claim to include:

The name and therapy degree of the individual performing the service.
The name of the academic institution which conferred the therapy degree.
The date of graduation.
The name and degree of the supervising physician or mid-level provider.

This information is to be included in the comment field of electronic claims and should be included as an attachment on paper claims.

Accreditation for Advanced Imaging Services Slated for 2012

CMS is proposing that organizations providing advanced imaging services must be accredited by 2012 in order to bill Medicare for the technical component of MRI, CT and nuclear imaging services such as PET. Excluded from the list of services requiring this accreditation are x-ray, ultrasound, fluoroscopy, and diagnostic and screening mammography.

Three national accreditation organizations have been approved including the American College of Radiology, The Intersocietal Accreditation Commission, and The Joint Commission.

CMS has instructed contractors to begin informing enrolled physicians, non-physician practitioners, and independent diagnostic

testing facilities by letter on a quarterly basis beginning in July, 2010.

This accreditation applies only to the technical component of advanced imaging services and does not impact billing for the professional component.

CMS recommends that, due to the anticipated backlog, those entities affected by this requirement should initiate the accreditation process no later than March, 2011, in order to complete it by January 1, 2012, and avoid denials.

If you have questions, please contact your consultant or you can reach Bryan Burke at bburke@hci-ebs.com or 1-800-572-5275.

Medicare To Cover New Annual Wellness Visits in 2011

The recently released proposed rule for the 2011 Medicare Physician Fee Schedule included a provision for a covered annual wellness visit. This coverage allows for payment after Jan. 1, 2011 for a beneficiary beyond the first year of the effective date of their initial Part B coverage and has not received either an IPPE (the Welcome to Medicare visit) or an annual wellness visit in the past 12 months. The annual wellness visit must include the following services:

- Establishment of the individual's medical and family history, listing prescribed medications and supplements;
- Establishment of a list of current providers and suppliers regularly involved in providing medical care to the individual;
- Measurement of the individual's height, weight, body mass index (or waist circumference, if appropriate), blood pressure, and their routine measurements as deemed appropriate;
- Detection of any cognitive impairment that the individual may have;
- Review of the individual's potential (risk factors) for depression, including current or past experiences with depression or other mood disorders, based on the use of an appropriate screening instrument for persons without a current diagnosis of depression;
- Review of the individual's functional ability

and level of safety, based on direct observation or the use of appropriate screening questions or a screening questionnaire;

Establishment of the following:

- A written screening schedule, such as a checklist, for the next 5 to 10 years as appropriate, based on recommendations of the USPSTF and the Advisory Committee on Immunization Practices, and the individual's health status, screening history, and age-appropriate preventive services covered by Medicare; and
- A list of risk factors and conditions for which primary, secondary or tertiary interventions are recommended or are underway, including any mental health conditions or any such risk factors or conditions that have been identified through an initial preventive physical examination, and a list of treatment options and their associated risks and benefits;
- Furnishing of personalized health advice and a referral, as appropriate, to health education or preventive counseling services or programs aimed at reducing identified risk factors and improving self management, or community-based lifestyle interventions to reduce health risks and promote self-management and wellness, including weight loss, physical activity, smoking cessation, fall prevention, and nutrition; and

Any other element determined appropriate by the Secretary through the National Coverage Determination process.

Subsequent visits would include the above with the exception of the depression screening and the functional status assessment. Two new G codes will be established to accommodate these new covered services for which coinsurance and deductibles are waived. The proposal intends for these services to have the same work RVUs as 99204 and 99214 with anticipated allowances of approximately \$173.30 for the initial exam and \$115.04 for the subsequent exam.

*If you have any questions or want additional information, please contact your consultant: Barry Brooks at bbrooks@ihmsmo.com
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