Critical News from the California Academy of Eye Physicians and Surgeons

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Issue 9, 2008

Regulation makes Balance Billing "Unfair" practice for certain Emergency Services; Lawsuit pending

A regulation adopted by the Department of Managed Health Care (DMHC) has made it an "unfair billing practice" to balance bill a patient **covered by a Knox-Keene plan** for ***emergency*** services (as defined by state law), which might occur in the situation where a non-contracted physician provides such services and his or her usual, reasonable, and customary fee is higher than what is paid by the plan. Details of the new regulation (effective October 15, 2008) can be found at *http://www.dmhc.ca.gov/aboutthedmhc/gen/ann/gen_ann_bbe.aspx*

CAEPS is supporting a lawsuit brought by the California Medical Association and other medical societies to overturn this regulation in large part on the grounds that the DMHC has no statutory authority to regulate physicians, only health plans. Furthermore, such a restriction completely removes all incentive for a plan to pay a fair amount for emergency services such that the plan can actually contract with adequate numbers of physicians to provide care for their patients as required by law. Nevertheless, until the suit is heard, likely in November, physicians are strongly cautioned to adhere to the regulation. They may also wish to consider holding off on billing for co-payments and other items not covered by the regulation to avoid the awkwardness of having to bill twice should the regulation be invalidated.

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Note that services provided after a patient has been "stablilized" are no longer "emergency" services. Under California law, a patient is "stabilized" when "in the opinion of the treating provider, the patient's medical condition is such that, within reasonable medical probability, no material deterioration of the patient's condition is likely to result from, or occur during, a transfer...." [Health & Safety (H&S) Code §1317.1(j)]. The treatment obligation includes providing specialty consultation as medically appropriate by telephone and, "when determined to be medically necessary jointly by the emergency and specialty physicians," through personal examination and treatment by the specialist. [H&S Code §§1317.1(i), 1317.2(a)]

Based on information received from the CMA (which has been communicating with the DMHC), it appears that it is not necessary to refund payments received for bills sent prior to the effective date of the regulation. It remains unclear, however whether the regulation applies only to dates of service on or after October 15th or to bills sent after that date, so it is likely best to err on the side of sending no further balance billings for emergency services (which, again, are the ***ONLY*** services covered by this policy) unless the DMHC indicates otherwise or unless and until the courts invalidate the regulation. ***CMA has prepared a "toolkit" to help physicians navigate this process which they have agreed to allow CAEPS to share with its members and contains far more complete information than can be included here.*** Download at *www.californiaeyemds.org/associations/7660/files/BalanceBillingToolkit.pdf* (this link will be periodically updated with revisions, so please check this link frequently).

Palmetto continues to have major Customer Service issues

Despite implementing changes in its phone system to help alleviate waits of up to one hour or more. many continue to experience difficulty in trying to reach customer service personnel. Members are reminded that they can help minimize demand on this system by holding off making calls for all but the most urgent issues, and ***notifying the CAEPS office instead*** for what appear to be "systemic" issues. Members are

Continued on Page 2

Continued from Page 1

also strongly encouraged to consult the Palmetto Jurisdiction 1 website at *www.PalmettoGBA.com/J1B* ***prior to contacting Palmetto by phone.*** [Note: The "Claims Issues Log" mentioned in last month's *Insights* has been disabled, likely because it has been difficult to maintain; however it may reappear under under "Self-Service Tools and Top Links" in the near future.]

Reminder: Different Local Coverage Determinations now effective under Medicare

With the consolidation of California, Hawaii, and Nevada under "Jurisdiction 1," California physicians who are Medicare providers are now subject to Local Coverage Determinations (LCDs) covering a wider array of issues, reflecting, in principle, the "least restrictive" policy that was in effect in any part of the geographic area.

Members are strongly urged to become familiar with the requirements of the "active" California LCDs ***for services provided after September 2, 2008***, which can be viewed at *www.palmettogba.com/j1b/lcd*

Again, those with likely interest for ophthalmologists (but *not necessarily an exhaustive list*) are: Actinic Keratoses; Blepharoplasty, Blepharoptosis, and Brow Lift; Botulinum Toxin Types A and B Policy; Category III CPT Codes; Fundus Photography; Magnetic Resonance Angiography (MRA) of the Head and Neck, Chest, Abdomen & Pelvis, Lower Extremities; Monitored Anesthesia Care (MAC); MRI and CT Scans of Thorax/Chest (except Heart); Nervous System Studies - Autonomic Function, Nerve Conduction and Electromyography; Plastic Surgery; and Skin Lesion (Non-Melanoma) Removal (formerly Non-malignant Skin Lesion Removal).

Billing Photos and Scanning Computerized Ophthalmic Diagnostic Imaging

CAEPS has received many reports of denials for billing for Fundus (92250) and External Ophthalmic (92285) Photos and Scanning Computerized Ophthalmic Diagnostic Imaging (SCODI, Posterior Segment, 92135), despite the fact that the coding they used was previously accepted by NHIC, Inc., the former Medicare carrier here in California. Although it is difficult to be certain since NHIC officials are no longer available to consult (and they considered their processes "proprietary,") ***indeed NHIC may indeed have paid on claims despite strictly "proper" coding.***

For example, because they were performing photos in both eyes, some ophthalmologists were billing NHIC 92250 with a -50 modifier to indicate bilaterality and getting paid, but report Palmetto is denying these. In addition, some report adding a -50 modifier to 92135 and were getting paid properly by NHIC, but now receive only half the correct payment from Palmetto. Still others are getting fundus photos denied by Palmetto when submitted with the same claim as 92135 when previously NHIC paid.

Rather than try to explain what happened under NHIC, it is simpler to understand what Palmetto apparently ***now expects***. For the record, NHIC likely should have expected the same things, but, again, may have developed a certain level of tolerance for what were technically coding errors if indeed it felt comfortable it was making proper payments. Palmetto appears more strict.

The codes for both fundus photos and external photos are ***inherently bilateral***, meaning payment is provided for both eyes. Therefore, using -50, -RT, or -LT is ***not appropriate***. Unless you are only performing the procedure unilaterally for a specific reason simply bill 99250 or 92285 without modifiers.

Doing fundus or external photos on one eye implies *reduced work*, and therefore requires Modifier -52 (again, ***without*** -RT or -LT). It also requires placing a concise statement in the documentation record (electronic claim) or Item 19 (paper claim) why the service is reduced (e.g. "92250 - right eye only")

Of course it bears repeating that there is an LCD (see above article) on Fundus Photography and its requirements must be adhered to regardless of coding issues.

In contradistinction, the code for SCODI, which is commonly used for both optic nerve fiber analysis and optical coherence tomography (OCT) of the retina is ***inherently unilateral*** (and this is indicated in its description). It therefore requires -RT or -LT. If done in both eyes, you have two choices:

Continued on Page 3

Continued from Page 2

92135-RT
92135-LT

OR

92135-50 AND Quantity = 2

Note that the "Quantity = 2" part is very important, since it explains why those using the -50 without increasing the Quantity were getting paid only half of the correct amount. [Given this subtlety, however, it may just be simpler to use the -RT and -LT and code on two separate lines.]

With regard to performing both Fundus photos and SCODI on the same day there is a Correct Coding Initiative (CCI) edit dating back to around 2004 that prevents payment for the Fundus Photos on the same day SCODI is performed. This appears related to the fact that at the time the edit was developed, 92135 was used almost exclusively for optic nerve fiber analysis, and it was felt by some that optic nerve head photos did not provide additional (medically necessary) information. ***However, since this code is now used for, among other things, OCT, there may indeed be medically necessary reasons why photos should be taken concurrently*** (e.g., treatment of wet ARMD with intraocular Avastin or Lucentis and even in combination with optic nerve fiber analysis in appropriate circumstances).

Because 92250 has a "CCI modifier indicator" of "1" (based on CCI tables), you can use Modifier -59 to bypass the CCI edits that would disallow the combination ***if you feel it is medically necessary for both services to be separately payable on the same day***. This modifier should not be used indiscriminately (and is currently the subject of ongoing investigation by the Office of the Inspector General). However, in appropriate circumstances document your reasoning in the chart supporting medical necessity and append the -59 to the Column II code (again, based on the CCI tables), which in the case under discussion is 92250.

Using the example of treatment of wet macular degeneration, since only one eye may be under treatment, it might also be necessary to use -52 (as described above). Therefore, as an example, if both OCT and Fundus Photos are done only in the right eye this would be coded:

91235-RT
92250-59-52
[with "99250 - right eye only" in the documentation field or Item 19]

Articles or processes from Palmetto's website are helpful in providing additional detail are:
Modifier Lookup
CCI Edit Changes: Column I and Column II Codes
Bilateral Surgeries and Modifier -50
Fundus Photography: Coding Reminder

More on NPIs and Medi-Cal

A reminder that rendering Medi-Cal providers ***must*** register their National Provider Identifier (NPI) using their individual Medi-Cal provider numbers. Each member of a provider group must register their individual NPI separately from the group's NPI. A provider group may register an individual provider's NPI on their behalf, but the group must ensure that it uses the correct NPI and Medi-Cal provider number.

NPIs can be registered by using the NPIC tool at *http://files.medi-cal.ca.gov/pubsdoco/npi/npi_reginfo.asp* or by submiting the *National Provider Identifier Registration Form* (DHCS 6218). After completing the required information, return the form with the National Plan and Provider Enumeration System (NPPES) verification document [available at *https://nppes.cms.hhs.gov/NPPES/Welcome.do*] to the address shown at the bottom of the form. Note that if a rendering provider's NPI is already registered, then a *Medi-Cal Supplemental Changes* (DHCS 6209) form must be completed and submitted to Provider Enrollment Division (PED) for any NPI-related updates. Providers can call the Telephone Service Center (TSC) at 1-800-541-5555 by choosing option 16 and then option 18 to obtain forms, ask questions about NPI registration or verify a rendering provider's registration status.

Continued on Page 4

Continued from Page 3

Effective November 1, 2008, providers must enter their Medi-Cal registered National Provider Identifier (NPI) numbers on all *Treatment Authorization Requests* (TARs). TARs submitted with a legacy number after that date will not be processed. In addition, it is currently required that Medi-Cal providers must submit the following forms with an NPI:

- *Biller: Medi-Cal Hardcopy Biller Application Agreement*
- *CHDP Telecommunications Provider and Biller Application/Agreement (DHCS 4431)*
- *Electronic Health Care Claim Payment/Advice Receiver Agreement (DHCS 6246)*
- *Medi-Cal Eligibility Verification Enrollment Form*
- *Medi-Cal Point of Service (POS) Network/Internet Agreement*
- *Medi-Cal Telecommunications Provider and Biller Application/Agreement (DHCS 6153)*
- *Point of Service (POS) Device Usage Agreement*
- *Provider: Medi-Cal Hardcopy Biller Notification Form*

Nominating Committee proposes 2009 Slate

The CAEPS Nominating Committee is proposing the following slate for positions available in 2009. Other nominations can be made by written petition due Friday, November 21, 2008. Contact the CAEPS office for details of that process. Those in unconstested races will be elected by acclamation. Candidates are:

Officers (One-Year Terms)
President-Elect: Andrew F. Calman, MD, PhD
Vice President – Advocacy and Program: Kimberly P. Cockerham, MD
Vice President – Finance and Administration: Frank A. Scotti, MD

Representatives (Councilors: One-Year Term)
Region 1 [Amador, Butte, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Lake, Lassen. Mendocino, Modoc, Napa, Nevada, Placer, Plumas, Sacramento, Shasta, Sierra, Siskiyou., Solano, Sonoma, Sutter, Tehama, Trinity, Yolo, and Yuba Counties]
Councilor, Office 1: Bruce D. Gaynor, MD
Councilor, Office 2: Dan R. Lightfoot, MD
Councilor, Office 3: Eric J. Kahle, MD
Councilor, Office 4: Mary O'Hara, MD
Councilor, Office 5: Richard A. Jones, MD

Region 2 [Alameda, Contra Costa, Marin and San Francisco Counties]
Councilor, Office 1: Linda J. Margules, MD
Councilor, Office 2: Thomas McDonald, MD
Councilor, Office 3: Stuart R. Seiff, MD
Councilor, Office 4: Suketu S. Sanghvi, MD
Councilor, Office 5: Malena Amato, MD

Region 3 [Alpine, Caleveras, Fresno, Imperial, Inyo, Kern, Kings, Madera, Mariposa, Merced, Mono, Riverside, San Bernardino, San Joaquin, Stanislaus, Tulare, and Tuolumne Counties]
Councilor, Office 1: Jodi O. Smith, MD
Councilor, Office 2: Steven G. Fogg, MD
Councilor, Office 3: John Canzano, MD
Councilor, Office 4: Pending Nomination

Region 4 [Monterey, San Benito, San Luis Obispo, San Mateo, Santa Barbara, Santa Clara. Santa Cruz, and Ventura Counties]
Councilor, Office 1: Robert A. Kolarczyk, MD
Councilor, Office 2: Beverly L. Sarver, MD
Councilor, Office 3: Ma'an A. Nasir, MD
Councilor, Office 4: Leland H. Rosenblum, MD
Councilor, Office 5: W. Lee Wan, MD

Continued on Page 5

Continued from Page 4

Region 5 [Los Angeles County]
Councilor, Office 1: David S. Boyer, MD
Councilor, Office 2: Sherwin Isenberg, MD
Councilor, Office 3: Damien Goldberg, MD
Councilor, Office 4: Timothy V. Scott, MD
Councilor, Office 5: Kenneth R. Diddie, MD
Councilor, Office 6: Robert A. Goldberg, MD
Councilor, Office 7: Laura A. Fox, MD
Councilor, Office 8: Mario A. Meallet, MD
Councilor, Office 9: James J. Salz, MD
Councilor, Office 10: Lynn K. Gordon, MD, PhD
Councilor, Office 11: John Schofield, DO

Region 6 [Orange and San Diego Counties]
Councilor, Office 1: Floyd L. Wergeland, Jr., MD
Councilor, Office 2: Lorne Kapner, MD
Councilor, Office 3: Leah Levi, MD
Councilor, Office 4: John Maggiano, MD
Councilor, Office 5: Asa D. Morton, III, MD

Very Large Group
Councilor, Northern Office 1: Eddy Tamura, MD
Councilor, Northern Office 2: Harup Kaur, MD
Councilor, Southern Office 1: Savina Q. Low, MD
Councilor, Southern Office 2: Pending Nomination

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