

Carrier Advisory Committee Notes – January 27, 2010

Comprehensive Error Rate Testing (Cert) Program

Insufficient documentation is mostly tied to signature requirements to determine who the supplying physician is. It is extremely important that each physician have a signature card on file to identify his/her signature and/or mark of initial.* Document all procedures including VA's (that only pay \$1.50) and E/M that prompted it. Legibility is required and determined by the OIG.

Elimination of consultation codes does not change the requirements for consultation. The admitting physician uses a modifier for his initial visit. The consulting physician(s) do not. The OP consultation no longer requires a written report. This is reported as 99215.

PQRI checks are in the mail if you qualified. Advantage patients do not qualify you for bonus checks. Visit www.cms.hhs.gov/efx incentive for more information.

The CMS quarterly communiqués policies are also on email.

WPS Changes

E/M RVV's increased – mentioned 6%. The policies as outlined in the agenda were discussed and there were no new changes relevant to family practice. It was brought out that even though medical specialties and specialists were discussed concerning some procedures (i.e. MOH's Surgery), CMS does not require this for payment.

The non-physician provider has no requirements to report a procedure and scope of practice is determined by the state. Example, PA's can report and interpret EKG's.

- The signature sheet should be sent with requested documents to be audited.
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