Frequently Asked Questions
Decoding the 2013 Medicare Physician Fee Schedule

For a detailed FAQ regarding the new CPT codes for nerve conduction studies, click here:
For a detailed FAQ on 2013 coding for IONM, click here:

Coding Questions – Intraoperative Neurophysiologic Monitoring (IONM)

Can the IONM add-on codes be used for monitoring during carotid endartarectomy (CEA)?

Yes, if you perform continuous monitoring. Use 95822 as a base code. If a senior technologist performs the IONM without a physician supervisor on-line, and a physician reads the record the next day, code with 95955 instead.

What are the RVU values for 95940, 95941, and G0453?
The AAN has posted a table with the national Medicare values of common neurology codes—including the new IONM codes—here: [http://www.aan.com/globals/axon/assets/10346.pdf](http://www.aan.com/globals/axon/assets/10346.pdf)

Is the G0453 a stand-alone code or do you use it with an E/ M code?

Code G0453 is an add-on code to be used in conjunction with the appropriate baseline procedure(s) performed. The code describes each additional 15 minutes of IONM from outside of the operating room after the baseline studies have been acquired.

Can a physician bill for monitoring outside of the OR while seeing patients at the same time in the office?

No. The monitoring professional is solely dedicated to performing intraoperative neurophysiologic monitoring and must be available to intervene at all times during the service as necessary, for the reported period. For any given time spent providing these services, the service takes full attention and, therefore, other clinical activities beyond providing and interpreting of monitoring cannot be provided during the same period.

For SSEP, the new G code is supplemental to the original codes? Do we bill the 95941 first?

No. The g-code was created by CMS to essentially replace 95941 for Medicare. CMS considers 95941 an “invalid” code in the MPFS. In this case, CMS disagreed with the language of 95941 and therefore created their own code they want used for Medicare patients. It’s important to note however that many private plans will in fact accept 95941 as written in the CPT code book.
I perform IOM activities and rarely have concurrent IOM procedures. In the event that this occurs, would you recommend billing for one procedure and then billing for the remaining time on the second procedure, assuming that one procedure finishes first?

Yes, and it depends on the carrier/payer. For Medicare, any time spent monitoring one Medicare beneficiary at a time should be billed. As mentioned previously, other payers may accept 95941 and you could bill for the total time of the second procedure (not just the “run out” time).

For the intraoperative monitoring, who has to be present? Must the physician be present, or is a technologist considered the monitoring professional?

A technologist must be present in the room. The supervising physician is either also in the OR with the technologist, or available for real-time communication with the technologist if not present in the OR.

Medicare Physician Fee Schedule (MPFS)

Where can I find the downloadable MPFS on the CMS website?
The final Medicare Physician Fee Schedule is currently available at this link:
http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1590-FC.html then click on "addenda" and select "addendum B"

What is the 2013 Medicare conversion factor?

$34.0230.

We have seen a decrease in our reimbursement for new patient office visits and follow up patient visits, but your numbers indicate that reimbursement has increased. Any idea why that may be the case?

The fee schedule we link to represents the national RVUs. Regional variances may account for the differences.

Coding Questions – EEG

Which CPT code would you recommend for continuous inpatient EEG monitoring (both overnight as well as prolonged ICU monitoring)?

If this is video monitoring use Code 95951 (Video and 16 channel recording). If the monitoring is not with video, use 95950 (8 channel recording) or 95956 (16 channel attended) or 95953 (16 channel unattended). All of these codes are billed in 24 hour increments. For these codes, if you do less than 12 hours, use a -52 modifier. If you do more than 12 hours, bill the code without this modifier. Please refer to the CPT manual to determine which of these codes are best suited to your situation.

Are there new codes in 2013 for routine EEG and ambulatory EEG?

There are no new codes for EEG in 2013.
Is the EEG increase related to the technical or professional component or both?

The increase in values is due to an increase in the technical component.

**Durable Medical Equipment (DME)**

Effective July 1, 2013 can I bill if I write a prescription for DME's other than wheelchairs, example: CPaps & BiPaps?

Yes, you may write a prescription for DME other than wheelchairs. For a complete list of covered items, please check Table 89 from the 2013 Final MPFS rule.

**Coding Questions – Chemodenervation**

Can the new 64615 be used only for a diagnosis of chronic migraine or can it be used for any type of headache?

The code descriptor follows the FDA-approved schedule of injections for chronic migraine.

Will any of the chemodenervation codes be deleted?

None of the chemodenervation codes were deleted for 2013.

Can the new chemodenervation code be billed with EMG guidance?

Yes, use the existing add-on EMG guidance code (+95874).

If I have two different diagnoses being treated can I report a 64612 and 64613?

Yes, though payer policies will differ in how to report (modifier use) and in whether they will reimburse separately for both procedures on the same date of service.

When and why would I use the new 64615 instead of code 64612 with a -50 modifier for injections for migraine?

Previously, there was not an accurate CPT code to report for chemodenervation for chronic migraine, so providers were using different combinations of existing CPT codes. The issue was first identified by American Medical Association (AMA) CPT staff through correct coding initiatives. The AMA CPT staff therefore requested one code to describe the work directly related to this service, which the AAN did develop.

Can I still bill modifier -50 (bilateral) in conjunction with code 64614?

This is not clear. New parenthetical instructions in the CPT book specify that 64614 can now only be billed once per session, but no parenthetical language restricts use of the bilateral modifier on this code. Individual payer policies will likely differ in their acceptance/non-acceptance of the modifier. Check your local payer coverage policies.
Can 64614 be billed with multiple units if more than one limb is injected (such as a stroke patient with spastic hemiparesis requiring denervation of an arm and a leg)?

No. New parenthetical instructions in the CPT book specify that 64614 can now only be billed once per session.

**Coding Questions – Transitional Care Management (TCM)**

**Can you present a scenario for when I would use the transitional care codes?**

TCM services are a combination of at least one face-to-face visit provided by a physician or qualified health care professional and non–face-to-face services by the physician or qualified health care professional and licensed clinical staff under his or her direction. These services include activities to manage the transition from an inpatient hospital setting, partial hospitalization, observation status, or skilled nursing facility to the patient's community setting (i.e., home, domiciliary, rest home, or assisted living facility) and address any needed coordination of care performed by multiple disciplines and community service agencies.

Codes for TCM are based on the level of medical decision-making and date of the first face-to-face visit.

**Are the transitional care codes billed in addition to the face-to-face visit?**

TCM requires a face-to-face visit, initial patient contact, and medication reconciliation within specified time frames. The first face-to-face visit is part of the TCM and not separately reported. Additional face-to-face visits within the 30-day period may be reported separately.

**When do I submit the 99495 code? Do I submit it the day you talk to the patient/caregiver, or on the 7th or 14th day when I see the patient for the face-to-face encounter?**

The date of service for TCM codes is not the date of the face-to-face visit. The time is still running until day 29 for TCM services. The TCM charges should be submitted 30 days following discharge.

**If you submit the 99495 code prior to the 7th or 14th day, what happens if the patient does not show up for follow-up?**

Do not submit the code until the follow up visit physically occurs. Medicare will deny the charges if they are submitted sooner than 30 days from the date of discharge. If you are unable to have a face-to-face follow-up within 7 to 14 days from discharge you would be unable to bill either of the TCM codes.

**Post discharge encounter: does this include phone calls with the patient after discharge?**

TCM begins on the date of discharge and continues for the next 29 days. These services require an initial interactive patient contact, a patient visit, and medication reconciliation within specified time frames.

**What documentation is needed to report a transitional care code?**

- Within 2 business days of discharge, an interactive contact with the patient or caregiver must take place. This contact can be face-to-face, by telephone, or electronic means.
- A face-to-face visit must take place within 7 to 14 calendar days following discharge depending

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on the complexity of the patient and code reported.

- Medication reconciliation and management must take place no later than the date of the first face-to-face visit following discharge.

**Is it correct that the face to face visit is included in the TCM codes?**

The first face-to-face visit is part of the TCM and not separately reported. Additional face-to-face visits within the 30-day period may be reported separately. Subsequent face-to-face visits would be reported using the established patient visit codes (99211 to 99215).

**Do other health insurance carriers recognize TCM?**

Yes. Many private insurers are also recognizing and providing reimbursement for TCM services. Some of the private plans are also reimbursing for chronic care coordination services. It’s important to check with your payers to determine which are providing reimbursement for these services.

**Questions Regarding Programs with Incentives and/or Penalties to Physician Payments**

**If we had a physician join our practice in late 2012 will we face penalties from the Medicare EHR Incentive Program?** We plan to have the new physician certified for Meaningful Use in 2013.

Newly practicing EPs who would not have had time to become meaningful users can apply for a 2-year limited exception to payment adjustments. Thus EPs who begin practice in calendar year 2015 would receive an exception to the penalties in 2015 and 2016, but would have to begin demonstrating meaningful use in calendar year 2016 to avoid payment adjustments in 2017.

The 2015 payment adjustment for the Medicare EHR Incentive Program will be based on successful reporting during the 2013 calendar year. For eligible professionals who begin reporting in 2014, they must begin their 90-day reporting period no later than July 1, 2014 and attest no later than October 1, 2014.


**To participate in the Physician Quality Reporting System (PQRS) and the Medicare Electronic Prescribing (eRx) Incentive Program do I have to apply to request participation or just use the appropriate codes when billing as done in previous years?**

The process for participation in the Medicare eRx Incentive Program has not changed between 2012 and 2013. Participants do not need to contact Medicare or register to begin participation.


The process for participating in PQRS has not changed, self nomination is only required for those wishing...
to participate in the Group Practice Reporting Option (GPRO).

Information for reporting on measures through the Physician Quality Reporting System (PQRS) can be found on the CMS website,


**Can you participate in the EHR Incentive Program, PQRS, and the Medicare eRx Incentive Program?**

The PQRS, Medicare eRx Incentive Program, and EHR Incentive Program are three distinctly separate CMS programs. The PQRS incentive can be received regardless of an eligible professional’s participation in the other programs. There are three ways to participate in the EHR Incentive Program: through Medicare, Medicare Advantage, or Medicaid.

If participating in the EHR Incentive Program through the Medicaid option, eligible professionals are also able to receive the Medicare eRx incentive and PQRS incentive.

If participating in the Medicare or Medicare Advantage options for the EHR Incentive Program, eligible professionals must still report the eRx measure to avoid the penalty but are only eligible to receive one incentive payment. Eligible professionals successfully participating in both programs will receive the EHR incentive payment. They can also earn the PQRS incentive.

Eligible professionals should continue to report the eRx measure in 2013 even if their practice is also participating in the Medicare or Medicare Advantage EHR Incentive Program because claims data for the first six months of 2013 will be analyzed to determine if a 2014 eRx Payment Adjustment will apply to the eligible professional. If an eligible professional successfully generates and reports electronically prescribing 25 times (at least 10 of which are in the first 6 months of 2013 and submitted via claims to CMS) for eRx measure denominator eligible services, (s)he would also be exempt from the 2014 eRx payment adjustment.

The Physician Quality Reporting System is a separate reporting program; eligible providers can choose to report on measures through this program in via qualified registry, claims, or through EHR PQRS pilot program. Eligible Providers who do not successfully report on measures through the PQRS program in 2013 will be subject to a -1.5% payment adjustment in 2015; providers may choose to report on 1 measure in order to avoid the payment adjustment.

**Can you explain the Meaningful Use incentives?**

The Medicare EHR Incentive Program payment schedule is as follows:

Last Updated: April 10, 2013
<table>
<thead>
<tr>
<th></th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>Total</th>
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<tr>
<td>Start in 2011</td>
<td>$18,000</td>
<td>$12,000</td>
<td>$8,000</td>
<td>$4,000</td>
<td>$2,000</td>
<td>0</td>
<td>$44,000</td>
</tr>
<tr>
<td>Start in 2012</td>
<td>$18,000</td>
<td>$12,000</td>
<td>$8,000</td>
<td>$4,000</td>
<td>$2,000</td>
<td>0</td>
<td>$44,000</td>
</tr>
<tr>
<td>Start in 2013</td>
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<td>$12,000</td>
<td>$8,000</td>
<td>$4,000</td>
<td>0</td>
<td>0</td>
<td>$39,000</td>
</tr>
<tr>
<td>Start in 2014</td>
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<td>$4,000</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>$24,000</td>
</tr>
<tr>
<td>Start in 2015</td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

To receive the maximum incentive payment, Medicare eligible professionals would have needed to begin participation in 2011 or 2012. For eligible professionals who begin participating in the Medicare EHR Incentive Program in 2013, they can earn up to $39,000 over four continuous years.

Incentive payments are based on the calendar year. The reporting period for the first year of participation in the program is any continuous 90-days during the calendar year. Also, regardless of what participation year an eligible professional is in, the 2014 reporting year will be a 90-day reporting period only.

The last year to begin participation in the Medicare EHR Incentive Program is 2014.

NOTE: Medicare eligible professionals who predominantly furnish services in an area designated as a Health Professional Shortage Area (HPSA) will receive a 10% increase in their annual EHR incentive payments. (The additional 10% HPSA incentive is not available for eligible professionals who participate in the Medicaid EHR Incentive Program.)

For the Medicare eRx Incentive Program, can I continue to report as an individual provider, or will I be required to report as a group?

Eligible professionals can continue reporting as an individual in the Medicare eRx Incentive Program in 2013.

For eligible professional eligibility requirements, visit [http://cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ERxIncentive/Eligible-Professionals.html](http://cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ERxIncentive/Eligible-Professionals.html).

As a stroke physician, I see a lot of Medicare patients but the medications involved in their care (e.g. aspirin, blood pressure medications) are managed by their primary care provider (PCP). I therefore do not electronically prescribe since the medications are already being managed. Will I be penalized for not electronically prescribing?

This depends on if you are eligible for the program.

Eligible physicians can participate in the Medicare eRx Incentive Program (and are subject to the

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payment adjustment) if the encounter codes they bill to Medicare fall within the encounter codes listed below. Eligible Professionals must have at least 10% of their Medicare Part B charges comprised of the codes in the denominator of the measure to be incentive eligible (and subsequently, be eligible for the payment adjustment).

An eligible professional's analysis is performed at the Tax Identification Number/National Provider Number (TIN/NPI) level. Eligible professionals practicing under multiple TINs must report the eRx measure under each of their TINs.

**Denominator Criteria (Eligible Cases):**

Any patient visit for which one (or more) of the following denominator codes applies and is included on the claim

**Patient visit during the reporting period (CPT or HCPCS):** 90791, 90792, 90832, 90834, 90837, 90839, 92002, 92004, 92012, 92014, 96150, 96151, 96152, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0101, G0108, G0109

For more information on the e-prescribing measure, visit [http://cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ERxIncentive/Electronic_Prescribing_Measure.html](http://cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ERxIncentive/Electronic_Prescribing_Measure.html)

If a provider does not meet the minimum eligibility requirements, no further action is required and the provider does not need to alert CMS. CMS will make the determination after the reporting period is over, based on claims data.

**Can a solo practice physician participate in PQRS, or does the group have to be at least 2?**

Solo practitioners are able to participate in PQRS, in order take part in the Group Practice Reporting Option (GPRO) a practice must contain at least two eligible providers. The GPRO reporting option requires reporting of specific measures which generally do not apply to a single specialty neurologic practice.

**Does the PQRS penalty apply to single physicians?**

The 2015 payment adjustment applies to all eligible providers who fail to successfully report on at least one quality measure in 2015. Eligible providers may still earn incentive in 2013 by successfully reporting 3 or more individual measures or one or more measures group.

**How many electronic prescriptions are required for a single physician practice?**

*To earn the 2013 Incentive:*

For successful reporting under the 2013 Medicare eRx Incentive Program (and be eligible for the 2013 incentive amount of 0.5%), eligible professionals must generate at least one eRx associated with a patient visit on 25 or more unique events during the reporting period of January 1, 2013 and December 31, 2013.

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To avoid the 2014 payment adjustment:

The 2014 eRx payment adjustment is a 2.0% reduction to the physician fee schedule amount for covered professional services furnished by the eligible professional who is not a successful e−prescriber. There are two options for the 2014 payment adjustment reporting period, both a 12−month option (1/1/2012–12/31/2012) and a 6-month claims−based only option (1/1/2013–6/30/2013). An eligible professional who successfully e−prescribed in the 2012 eRx Incentive Program will be considered exempt from the 2014 payment adjustment.

Can you explain how funds are dispersed for the Medicare EHR Incentive Program?

The incentive payments for the Medicare EHR Incentive Program will be made approximately four to eight weeks after an eligible professional (EP) successfully attests that they have demonstrated meaningful use of certified EHR technology. However, EPs will not receive incentive payments within that timeframe if they have not yet met the threshold for allowed charges for covered professional services furnished by the EP during the year. Payments will be held until the EP meets the threshold in allowed charges for the calendar year in order to maximize the amount of the EHR incentive payment they receive. Medicare EHR incentive payments are based on 75% of the estimated allowed charges for covered professional services furnished by the EP during the entire calendar year. If the EP has not met the threshold in allowed charges by the end of calendar year, CMS expects to issue an incentive payment for the EP in March of the following year (allowing two months after the end of the calendar year for all pending claims to be processed).

Payments to Medicare EPs will be made to the taxpayer identification number (TIN) selected at the time of registration, through the same channels their claims payments are made. The form of payment (electronic funds transfer or check) will be the same as claims payments.

Is there a benefit to group reporting over individual reporting on PQRS?

There is no benefit to choosing one reporting option over another; the incentive payment is the same no matter what, as well as the payment adjustment.

Does a solo practitioner have to participate in PQRS?

In order to avoid the payment adjustment in 2015 all eligible providers must report on at least one quality measure.

For participation in PQRS, do we need to participate in all measures for the full year?

It depends on the reporting method an eligible provider chooses to utilize. If an EP chooses to report via claims they must report on quality measures for the 12 month reporting period. If an EP chooses to report via a qualified registry there is more than one way to do so; an EP can choose individual measures and report on them for 80% of eligible patients for the 12 month reporting period, choose a measures group and report on that group either for 80% of eligible patients for the 12 month reporting period, or report on the measures group for 20 unique patients.
With a group with two physicians billing under one tax identification number (TIN). Are they eligible for group PQRS?

Yes, a group of two physicians can report using the Group Practice Reporting Option (GPRO). It may not be feasible for a single specialty clinic to participate using this option as most measures apply to family practice.

Is the Medicare eRx incentive based upon how many electronic prescriptions were written by the group as an aggregate or assigned to individual members of the group?

This depends on if the group has elected to participate in the Medicare eRx Incentive Program’s Group Practice Reporting Option (GPRO). If reporting in the GPRO, the group must meet the minimum requirements to be successful in the program.

If the practice is not participating in the GPRO, each member of the group will be reporting as an individual and must meet the requirements to be successful in the program.

For more information on the eRx GPRO, visit http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ERxIncentive/Downloads/2013_eRxGPROMadeSimple_PMBR_F01162013.pdf

I am a single neurologist in a group with six Family Practitioners. Should I be reporting PQRS separately, as an individual provider?

The number of eligible professionals is not specialty specific for the group reporting option. If your practice is reporting using the GPRO, you must report through the GPRO as it goes by tax identification number (TIN). If your practice is not reporting using a GPRO, you should be reporting as an individual provider.

Do you have any information about how satisfying criteria for the Medicare EHR Incentive Program will satisfy the PQRS requirements?

CMS has developed the Physician Quality Reporting System (PQRS)-Medicare EHR Incentive Pilot Program. This voluntary program requires participants to report clinical quality measures (CQMs) for a full 12-month calendar year (regardless of the eligible professional's year of participation in the Medicare EHR Incentive Program).

Those who wish to participate in this pilot program will be able to indicate within the EHR Incentive Program attestation module their intent to fulfill the Meaningful Use (MU) objective of reporting CQMs by participating in the pilot. It will allow those who are participating in both MU and PQRS to report their clinical quality measures once. Eligible professionals wishing to utilize this reporting option must report on the three core measures (or alternate core measures) as well as any of the remaining 38 measures to participate. Eligible professionals who are unable to report on any of these measures (report any zeroes for the denominator for the EHR Incentive Program) are not permitted to participate in the PQRS-Medicare EHR Incentive Pilot.

Those who do not participate will continue to report their Meaningful Use CQMs through attestation. The purpose of this pilot is to move towards integration of reporting on quality measures under the PQRS with the reporting requirements of the Medicare EHR Incentive Program.

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Can you suggest any good resources or information on how a solo practitioner can set up PQRS in their office?

There are several good resources available to assist members in participating in PQRS. The first big step is to decide which reporting method you would like to utilize, keeping in mind that registry reporting may have different requirements than claims reporting. After deciding on the reporting method review the available measures for that option and choose either an applicable measures group or at least three individual measures. There are measures specifications available for measures groups and individual measures. The AMA has also developed worksheets for measures reportable via claims to assist with the documentation and coding requirements.


http://www.aan.com/go/practice/pay/resources

https://aan.pqriwizard.com/

Do I need to apply to use PQRS measures?

The only official election that must be made for PQRS is for the Group Practice Reporting Option, those using this option must submit a nomination letter to CMS. Those choosing to report via claims do not need to sign up you simply begin reporting on your eligible claims. Those reporting via a qualified registry do not need to elect to do so however each registry may have some type registration they require.