

Bilateral Procedures

The way to bill payers for bilateral services depends on the payer's preference. CPT Assistant indicates that the use of modifier -50 (Bilateral procedure) is not appropriate for bilateral radiology procedures.

Any one of the following may be appropriate:

- List the appropriate code twice on the claim, append modifier -LT (Left side) and RT (Right side)
- Report a single-line item and report 2 units ■

Anthem/Blue Cross Radiology Precertification Transitioning to AIM

The pre-certification process will change for the radiology management program offered by Anthem. Effective March 15, 2010, radiology precertification for imaging modalities will transition to American Imaging Management® (AIM). For details on the

changes in process, visit anthem.com > provider (enter state) > Rapid Updates.

Note: Radiology management is administered by American Imaging Management, a separate company. ■

CMS Manual Update on Signatures

Medicare claim review contractors (carriers, fiscal intermediaries (called affiliated contractors, or ACs), Medicare administrative contractors, the comprehensive error rate testing contractor, and recovery audit contractors) are tasked with measuring, detecting and correcting improper payments in the fee for service Medicare program. These contractors review claims and medical documentation submitted by providers.

The previous language of the Program Integrity Manual required a legible identifier in the form of a handwritten or electronic signature for every service provided or ordered. This CR updates these requirements and adds e-prescribing language.

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WPS Medicare Guidance on Provider Signature Requirements for Medical Documentation

The issue of illegible and missing/invalid signatures is currently a hot topic with CMS and various other Medicare contractors. With only a few exceptions, Medicare regulations require that the individual practitioner who ordered or provided services be **clearly** identified and validated through a signature in the medical record documentation. The Internet-Only Manual (IOM), Publication 100-08, Program

Integrity Manual, Chapter 3, Section 3.4.1.1, states:

Medicare requires a legible identifier for services provided/ordered. The method used shall be hand written or an electronic signature (stamp signatures are not acceptable) to sign an order or other medical record documentation for medical review purposes. ■

Changes in Medicare Timely Filing Requirements

On March 23, 2010, President Obama signed into law the *Patient Protection and Affordable Care Act* (PPACA) which amended the time period for filing Medicare fee-for-service (FFS) claims as one of many provisions aimed at curbing fraud, waste and abuse in the Medicare Program.

PPACA amended the timely filing requirements to reduce the maximum time period for submission of all Medicare FFS claims to one calendar year after the date of service.

Under the new law, claims for services furnished on or after January 1, 2010, must be filed within one calendar year after the date of service. In addition,

section 6404 of the law, mandates that claims for services furnished before January 1, 2010, must be filed no later than December 31, 2010.

The following rules apply to claims with dates of service prior to January 1, 2010. Claims with dates of service before October 1, 2009, must follow the pre-PPACA timely filing rules. Claims with dates of service October 1, 2009, through December 31, 2009 must be submitted by December 31, 2010.

Proposals for exceptions will be specified in future proposed rulemaking. ■