2011 Annual Meeting
California Orthopaedic Association
May 20, 2011
Laguna Niguel, CA

Palmetto GBA J1 A/B MAC
Provider Outreach and Education

Agenda

- 2011 Updates and Changes
- Comprehensive Error Rate Testing (CERT)
- RAC Audits-Common Errors
- Provider Enrollment Update: Are you in PECOS?
- ICD-10-and HIPAA 5010
- Provider Outreach
- Resources

2011 Updates and Changes

2011 Fee Schedule

- Medicare and Medicaid Extender Act of 2010 (MMEA)
  - President Obama signed into law
  - Prevented a scheduled payment cut from taking effect
  - CMS revised the fee schedule to implement the zero percent update
  - Relative Value Units must be budget neutral
  - Conversion factor adjusted
  - 2011 claims processed timely

Incentive Payment for Primary Care Services CR 7060

- Effective 2011
  - Incentive payment of 10% of provider's payment amount in addition to HPSA bonus
  - For primary care services
  - Furnished by primary care practitioners
    - Family Medicine
    - Internal Medicine
    - Geriatric Medicine
    - Pediatric Medicine

Incentive Payment for Primary Care Services

- Other Primary Care Practitioners
  - Nurse Practitioners
  - Clinical Nurse Specialists
  - Physician Assistants *****
- Primary care services
  - Accounted for at least 60% of practitioner's allowed charges under Part B

2011 Outpatient Therapy Cap Values for CY 2011(CR 7107)

- $1,870- physical therapy and speech language pathology
- $1,870- occupational therapy
- Therapy cap extended through 2011
  - Continue to submit claims with KX modifier when appropriate

Multiple Procedure Payment Reduction for Therapy Services (MPPR) CR 7050

- Full payment for procedure/unit with highest Practice Expense (PE)
- Subsequent outpatient therapy services
  - Office and other non institutional settings
    - 100% for work and malpractice components
    - 80% for PE component
  - Institutional settings
    - 75 % for PE component
    - 100 %for work and malpractice component

Reducing the Paid Claims Error Rate (CERT)

Claim Review Programs

Prepayment Claim Review Programs	Postpayment Claim Review Programs
National Correct Coding Initiative (NCCI) Edits	Comprehensive Error Rate Testing (CERT) Program
Medically Unlikely Edits (MUE)	Recovery Audit Contractor (RAC)
MAC Medical Review (MR)	

National Paid Claims Error Rate

- What is a claims error?
  - A claim error is defined as an ‘improper payment’
  - Improper payments are payments that should not have been made or payments made in an incorrect amount (including overpayments and underpayments)

National Paid Claims Error Rate

- November 2010

Type of Contractor	National Part B Error Rate	J1 Part B Error Rate
Part B	12.9%	22.4%

National Paid Claims Error Rate

- Top CERT errors
  - No documentation
  - **Insufficient documentation**
  - Medically unnecessary

National Paid Claims Error Rate

- No documentation
  - No response to CERT documentation request
  - Documentation submitted was for the wrong date of service (DOS)
  - No medical records to support the services
  - Provider did not provide a service to the beneficiary on the date indicated on the claim
  - Provider indicates they have the medical record, but refuses to send it

National Paid Claims Error Rate

- Insufficient documentation
  - Medical documentation submitted does not include pertinent patient facts
    - E.g., the patient's overall condition, diagnosis and extent of services performed

National Paid Claims Error Rate

- Medically unnecessary service errors
  - Medically unnecessary errors includes situations where enough documentation is identified in the medical record to make an informed decision that the services billed to Medicare were not medically necessary

National Paid Claims Error Rate

- CERT Additional Documentation Request (ADR)
  - Respond with the requested information within 45 days, including information from a third party, if necessary
  - Providers will receive additional letters, for example: Second Request, Third Request or OIG Final Request
  - If the requested information is not received within the specified timeframe, the claim will be reviewed based on the information on hand, which could lead to a claim denial or reduction in payment

National Paid Claims Error Rate

- CERT Additional Documentation Request (ADR)
  - Submit any and all documentation to establish medical necessity
  - Include documentation prior to and/or following the dates of service under review; progress notes, lab results, op reports, physician orders for diagnostic tests, treatment plans
  - Documentation must be LEGIBLE and there must be a LEGIBLE physician signature or the claim will be denied

Signature Requirements

Medical Records Signature Requirements

- Individual's Who Ordered or Provided Services:
  - First and Last Name
  - Credential
  - Dated

- CMS Change Request (CR) 6698
  - www.cms.gov/MLNMattersArticles/downloads/MM6698.pdf

Signature Findings

- Illegible, unrecognizable handwritten signatures or initials
- Unsigned typewritten progress notes with a typed name only
- Unverified or unauthorized electronic signatures
- No indication of the rendering physician
- ‘Stamps’ alone in the records

Valid Signatures

- Signatures must be handwritten or electronic
- Signature must be legible
- Services provided/ordered must be authenticated by author
- Not acceptable:
  - Stamped signatures

Key Points for CERT

Key Points for CERT

- How long do we have to respond?
  - Within 75 days from the date of the initial letter request
- CERT will send repeat letters and may contact provider by phone

Key Points for CERT

- Billed services covered by an NCD or LCD must meet all aspects of coverage
- Linking a billed service to a covered ICD-9 code does not guarantee payment on post payment review
- Medical records from the ordering physician are critical to medical necessity
- Physician order must be present
- Physician signature must meet all requirements

CERT Appeals
Providing Documentation

CERT Appeals- Providing Documentation

- Prior to filing an appeal
  - Check your Remittance Advice (RA) to identify the denial reason
  - Verify what records were supplied to CERT
  - Compare the records sent to the CERT contractor, the claim and denied services
    - Ensure the corresponding entries support documentation and coverage requirements
  - For electronic records, make sure a ‘final’ signed report/note is provided

CERT Appeals

- Requests must be made in writing and must be filed within 120 days
- Submit all supporting documentation
  - Ensure patient's name is on every page
- Redetermination Form on Web site
  - www.palmettogba.com/J1b
- Send or fax request to Palmetto GBA
  - Fax (803) 462-3914

Recovery Audit Contractor (RAC)

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- Region D RAC
  - HealthDataInsights
- https://racinfo.healthdatainsights.com
  - New Issues

New Issues Approved by CMS

New Issues Approved by CMS

All new issues that are identified by HDI must first be approved by CMS.

Name	Description	Number	Claim Type	Date Approved	Region D States	Region D MACS	Dates of Service	Additional Information
Newborn Pediatric CPT Codes Billed for Pts Exceeding Age Limit	Certain service codes are specific to patients of a specific age and should not be applied/billed for patients which exceed the age limit defined by the CPT Code.	D000312009	PART A OP PART B	06/17/2009	All	AB MACs FIs Carriers	Applies to claims paid on or after October 1, 2007	American Medical Association (AMA), Current Procedural Terminology 2007, 2008, 2009
Once in a Lifetime	Certain procedures are only performed once in a persons lifetime. Query identifies claims paid for those procedures for more than one service date.	D000322009	PART A OP PART B	06/11/2009	All	AB MACs FIs Carriers	Applies to claims paid on or after October 1, 2007	CMS Pub 100-08, Ch. 3, § 3.6.
Excessive Units-Untimed Codes	When reporting service units for untimed codes (excluding Modifiers -KX, and -59) where the procedure is not defined by a specific timeframe, the provider should enter a 1 in the units bill column per date of service.	D000332009	PART A OP PART B	06/26/2009	All	AB MACs FIs Carriers	Applies to claims paid on or after October 1, 2007	CMS Pub 100-04, Transmittal 1019, dated 8.3.06, pages 7-11 CMS Pub 100-04, Ch. 5, § 20.2
Excessive Units-Blood Transfusions	Blood Transfusions should be billed with a maximum of (1) unit per patient per date of service.	D000342009	PART A OP PART B	06/24/2009	All	AB MACs FIs Carriers	Applies to claims paid on or after October 1, 2007	Federal Register, Volume 67, No.212, page 2. Program Memorandum Intermediaries, Transmittal A-01-50, April 12, 2001, page 1 CMS Pub 100-04, Ch. 4, § 231.8

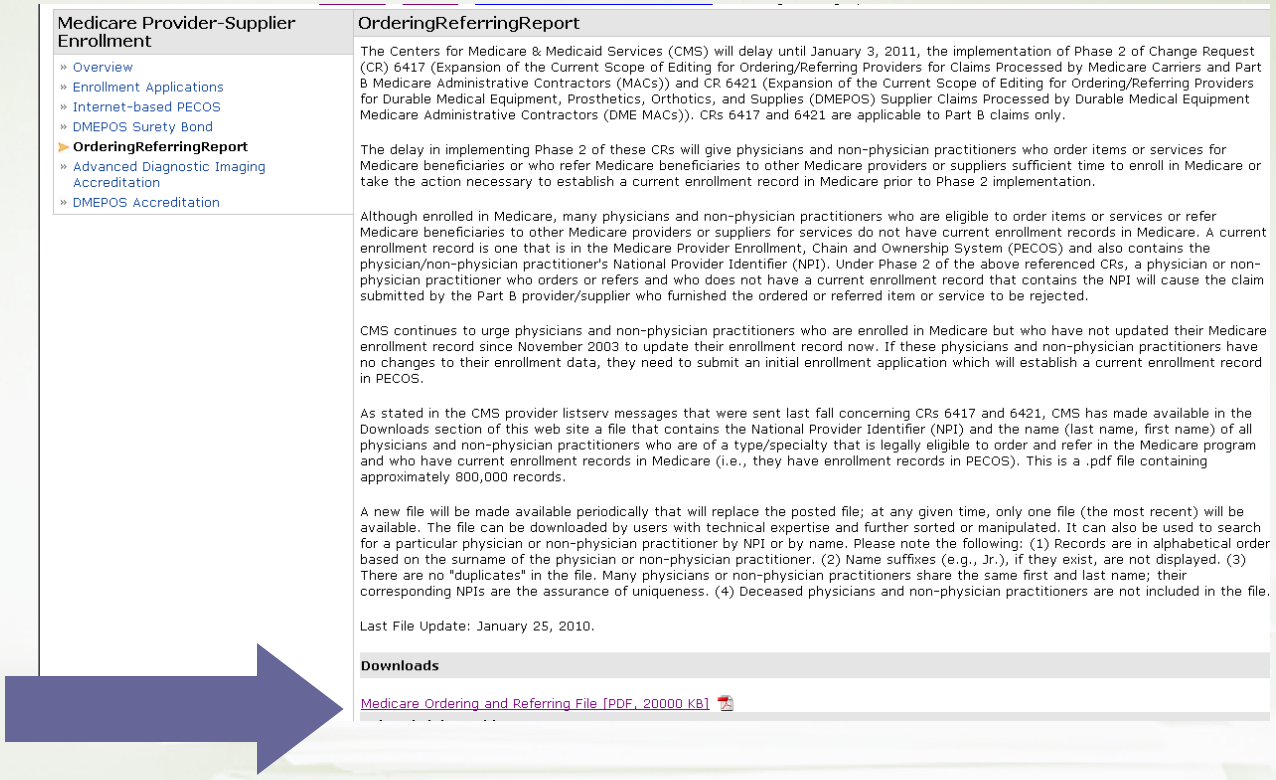
Provider Enrollment
Are you in PECOS?

CR 6417 / CR 6421

- Verifies the provider is enrolled in Medicare and eligible to order or refer services
  - Phase 1 (10/5/09-12/31/10)
    - Warning messages N264/N265 on RA
- Phase 2 (Deadline pending)
  - Automated edit delayed
  - Extended the deadline to revalidate enrollment
  - PTAN must cross-match NPI in PECOS
  - Claims rejects if ordering/referring physician is not in PECOS

Are You In PECOS?

- To Locate File of Providers In PECOS



  - http://www.cms.gov/MedicareProviderSupEnroll/06_MedicareOrderingandReferring.asp

Internet-based PECOS Limitations

- PECOS cannot be used to:
  - Make changes to the Name, Tax ID or Social Security Number
  - Change an existing business structure
  - Change an NPP specialty type
  - Reassignment of benefits if the other supplier does not have a current Medicare enrollment record in PECOS (since 2003)

Steps to Take Before Using PECOS

- What information do I need?…
  - Active NPI
  - Legal business name & Taxpayer ID
  - Bank account information
  - Practice location address
  - Business license(s)
  - Information about any final adverse actions

PECOS Certification Statements

- Submit a signed/dated certification statement within 15 calendar days of the date it was submitted or the application may be rejected.
- The 15-day rule applies to all CMS-855 PECOS Internet applications, regardless of the transaction involved.
- If the provider submits: (1) an undated certification statement, or (2) a certification statement on which the Web Tracking ID does not match that in PECOS, the contractor shall treat it as a non-submission.

Minimizing Risks

- Ensure EFT and EDI information is current
  - CMS 588 form is required and must be accurate
  - EDI enrollment/submitter linkage is completed through EDI team and not Provider Enrollment
- Protect your privacy!

Internet-based PECOS

- Contact External User Services (EUS) Help Desk at
  - (866) 484-8049 for technical support
- 'How To' questions are to be directed to the Provider Enrollment Support Line
  - (866) 895-1520
- Frequently Asked Questions

Provider Reporting Responsibilities

- Report the following enrollment changes within 30 days of the event:
  - Change in Ownership or Managing Control
  - Change in Practice Location
  - Change in final Adverse Action

Provider Reporting Responsibilities

- Report the following enrollment changes within 90 days of the event:
  - Change in Organization Legal Business Name/Tax Identification Number
  - Change in Authorized or Delegated Officials
  - Change in Banking Arrangements
  - Change in Reassignment of Benefits
  - Change in Business Structure

Version 5010

5010 Implementation

- Health Insurance Portability and Accountability Act (HIPAA)-required electronic standards adoption
  - Health care administrative transactions
- Current Versions
  - Accredited Standards Committee (ASC) X12 Version 4010/4010A1

5010 Implementation

- Effective January 1, 2012
  - Preparing for the International Statistical Classification of Diseases and Related Health Problems, 10th Revision (ICD-10) implementation
- Implement ASC X12 Version 5010
- Accommodate ICD-10 codes
- Failure may result in claim delays

Who Needs To Transition

- HIPAA-covered entities
  - Providers
  - Health plans
  - Clearinghouses and vendors
  - Billing and service agents

What 5010 Does

- Increases ICD code field from 5 to 7 bytes
- Adds one-digit version indicator
  - Indicates Version 9 versus Version 10
- Increases number of diagnosis codes on claim
  - 12 for Part B
  - 24 for Part A
- Includes additional data modification adopted by Medicare FFS

HIPAA Compliance Timelines

- April 1, 2011
  - Providers begin external testing 5010
  - CMS accepting Version 5010 claims
- December 31, 2011
  - External testing of Version 5010 must be completed
- January 1, 2012
  - Level III-All electronic claims must use Version 5010
  - Version 4010 no longer accepted
- October 1, 2013
  - All claims submitted using ICD-10 for medical diagnosis and inpatient procedures
  - CPT codes for will continue to be used for outpatient services

5010 Improvements

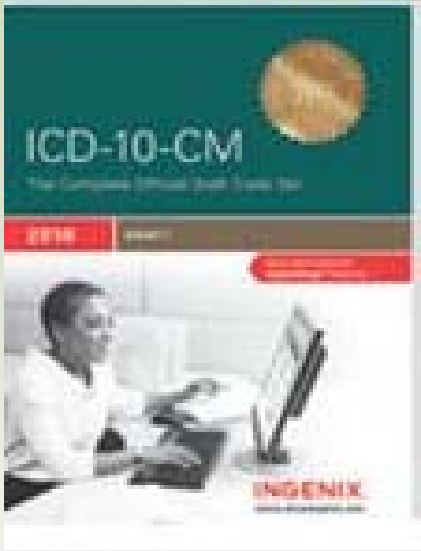
- Support monitoring of:
  - Certain illness mortality rates
  - Outcomes for specific treatment options
  - Some hospital length of stays
  - Clinical reasons for care
- Includes ‘present on admission’ indicator

Format Comparison

- Side-by-side comparison available
  - CMS Web site
  - www.cms.gov/ElectronicBillingEDITrans/18_5010D0.asp#TopOfPage

ICD-10-CM/PCS

ICD-10-CM/PCS



- Two parts
  - ICD-10-CM for diagnosis coding
    - All U.S. health care setting
    - Three to seven-digit alphanumeric codes
  - ICD-10-PCS for inpatient procedure coding
    - All U.S. inpatient hospital settings only
    - Seven alphanumeric digits
    - More specific
    - Substantially different

Provider Claims Compliance

- No delays
- No grace period
- ICD-9-CM for dates of service < October 1, 2013
- ICD-10 for dates of service ≥ October 1, 2013
- Still use CPT and Healthcare Common Procedure Coding System (HCPCS)

Structure Differences

- Number of codes
  - 14,025 ICD-9-CM vs. 68,069 ICD-10-CM
  - 3,824 ICD-9-CM procedure codes vs. 72,589 ICD-10-PCS codes
- Codes are longer
- Greater clinical detail and specificity
- Updated terminology and classifications

Staff Training Needs

- CMS MLN Matters SE1019 recommends:
  - 16 hours of ICD-10 training for coders
  - Staff training on structure, organization and features of ICD-10-CM/PCS
  - Medical terminology and medical record document
    - Knowledge Assessment
    - Review and refresh knowledge

Resources

- American Medical Association
- www.ama-assn.org/go/5010
  - Fact Sheets
  - 5010 Checklist
  - Project Plan Template – Helping Practices Prepare for the New HIPAA Standards
  - Seven steps

Resources

- The Centers for Medicare & Medicaid Services (CMS) Web site
  - www.cms.gov/ICD10
- CMS-sponsored calls
  - www.cms.gov/ICD10/02c_CMS_Sponsored_Calls.asp#TopOfPage
- American Health Information Management Association (AHIMA)
  - www.ahima.org/ICD10/

Provider Outreach and Education

Educational Offerings

- POE Educational Opportunities include:
  - Workshops
    - Classes
    - Seminars/Conferences
    - Open policy meetings
    - Register through the Workshops Database on Web
  - Webinars
    - On-line sessions presented in WebEx
  - Ask the Contractor Teleconferences (ACTs)
    - One hour sessions designed to notify the provider community about hot topics and the latest Medicare Part B changes
    - Allows the provider community to ask topic related questions

Social Media

Palmetto GBA now offers even more ways for you to stay connected with us!

- TWITTER
- FACEBOOK
- YOUTUBE
- LINKEDIN
- BLOGGING
- LOCATION APPS
- OTHER

Provider Contact Center

Provider Contact Center (PCC)

- Handles provider issues related to claims, billing, eligibility, payment and provider education that cannot be resolved using Provider Self Service options
- Includes the provider telephone inquiries staff, general written inquiries unit and walk-in inquiries staff
- Phone number: (866) 931-3901
- Hours of operation:
  - Monday through Friday
  - 7 a.m. – 5 p.m. PST

Provider Contact Center Reminder

- Questions concerning information on the Remittance Advice (RA)
  - Need to have the RA on hand when calling
  - Education will be provided on how to read or get information from the RA

Any Questions?

The information provided in this presentation was current as of April 15, 2011. Any changes or new information superseding the information in this presentation are provided in articles with publication dates after April 15, 2011, posted on our Web site at www.PalmettoGBA.com/J1B.