

MD AAHAM

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Presented by:
HIGHMARK MEDICARE SERVICES

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Agenda

- Contractor Updates
- Comprehensive Error Rate Testing (CERT)
- Medicare Updates
- Self Service Options
- Questions

Highmark Medicare Services

- **Laura Minter**
 - J12 Project Manager
 - 717-302-4120
 - Laura.minter@highmarkmedicareservices.com
- **David Vaughan**
 - Vice President of Operations
 - 717-302-3709
 - David.vaughan@highmarkmedicareservices.com
- **Dr. Robert Muscalus**
 - Vice President and Contractor Medical Director
 - 717-302-3030
 - Robert.muscalus@highmarkmedicareservices.com

Contractor Updates

LAURA MINTER
J12 PROJECT MANAGER

PHONE: (717) 302-4120

FAX: (717) 302-4165

LAURA.MINTER@HIGHMARKMEDICARESERVICES.COM

Recovery Audit Contractor (RAC) Part A Activity

- Averaging 2,750 Part A RAC adjustments/month
 - Appeals – 28%
 - Reversals – 11%
- RAC/MAC Collaboration – bi-weekly meetings, share results, education, etc.

Affordable Care Act Provisions Requiring Reprocessing of Medicare FFS Claims

- Adjustment processing began in March 2011
 - Current Status:
 - ✦ Delaware A – completed May 20, 2011
 - ✦ WPS Providers A – completed April 27, 2011
 - ✦ PA/NJ/MD/DC A – Section 508 processing completed July 6, 2011, other adjustments completed August 2011
 - ✦ Part B All J12 States – projected completion is December 2011

5010 Transition

- All vendors, clearinghouses, billing services, and providers must transition to version 5010 prior to January 1, 2012
- Failure to transition timely will result in the inability to conduct electronic transactions
- All 837I (Part A) and 837P (Part B) electronic claim files submitted in version 4010.A1 after December 31, 2011 will be rejected
- Highmark Medicare Services began accepting 5010 production files for Medicare Part A on July 25, 2011
- Highmark Medicare Services began accepting 5010 production files for Medicare Part B on April 29, 2011
- Migration to version 5010 Electronic Remittance Advice (ERA) (835) must be completed by January 1, 2012

5010 Transition (cont'd)

- Migration to production 5010 ERA (835) for Part A will not occur at this time due to a known national issue with the Part A Shared System
- Trading partners using their own software are required to test
- Providers and billing services using an approved vendor or clearinghouse are not required to test
- Testing is encouraged to be completed using Mpower Provider Portal, an Internet-based testing portal (information on next slide)
- Visit Highmark Medicare Services 5010 Information Website for important information on the 5010 transition at <https://www.highmarkmedicareservices.com/edi/5010/index/html>

Mpower Provider Portal

- Mpower Provider Portal is the preferred method for all Highmark Medicare Services 5010 testing because it offer the following benefits:
 - Avoid dial-up costs and connection issues by submitting 837I (Part A) and 837P (Part B) electronic claim test files and viewing response reports through the Internet.
 - Receive testing response reports immediately.
 - Receive approval status without viewing the detailed response reports and manually calculating the acceptance rate. Mpower Provider Portal will verify the 837 test files, meet all mandated testing requirements and update your status automatically.
 - Migrate to production 5010 837I and 837P electronic claim submission automatically. This will allow you to submit production 5010 claims in three business days of being approved.
- Step-by-step instructions are available on our Website's Mpower Provider Portal section to walk you through the use of this new product and the successful completion of your version 5010 testing at:
<https://www.highmarkmedicareservices.com/edi/mpower/index.html>

ICD-10 Medical Coding

- Compliance Deadline: October 1, 2013
- Suggestions:
 - Identify current systems using ICD-9 codes
 - ✦ Clinical Documentation
 - ✦ Encounter Forms/Superbills
 - ✦ Practice Management System
 - ✦ Electronic Health Record System
 - ✦ Contracts
 - ✦ Public Health and Quality Reporting Protocols
 - Talk with practice management system vendor about version 5010 and ICD-10 codes
 - Discuss implementation plans with your clearinghouses, billing services, and payers to ensure a smooth transition
 - Assess staff training needs
 - Conduct test transactions using version 5010/ICD-10 codes with payers and clearinghouses
 - Keep Up To Date: Visit the CMS website at www.CMS.gov/ICD10 to receive timely information about the upcoming version 5010 and ICD-10 transitions

Provider Enrollment Services – Revalidation Effort

- Affordable Care Act requires revalidation – Section 6401 (a)
- All providers/suppliers enrolled with Medicare prior to March 25, 2011 must revalidate their enrollment information when notified by their Medicare Administrative Contractor (MAC)
- **Once notification is received from Highmark Medicare Services:**
 - Update enrollment through Internet-based Provider Enrollment Chain and Ownership System (PECOS) at <https://pecos.cms.hhs.gov> or complete the 855 form;
 - Sign the certification statement on the application;
 - If applicable, pay fee through pay.gov; and
 - Mail supporting documents and certification statement to Highmark Medicare Services
- Reference MLN Matters Article: SE1126 Revised

Comprehensive Error Rate Testing (CERT) Program

Comprehensive Error Rate Testing (CERT)

- National Claim Paid Error Rate:
 - 7.8% = \$24.1 Billion
- Impacts all providers submitting Fee for Service claims
- Limited random claim sample
- Record requests must be received within 30 days from the initial CERT letter
- Right to Appeal? Yes

Part A Concerns

- One Day Stays
- Documentation does not support admission
 - Did the order clearly indicate intent for observation or inpatient admission?

Part B Concerns

- Evaluation and Management Services
- Insufficient Documentation
 - No orders and missing records
 - Documentation did not contain a valid physician's signature
- Incorrect Coding
 - Documentation did not support code billed
 - One or more of the key components failed to meet or exceed

Comprehensive Error Rate Testing (CERT) Center

- Medical Record Requests
- Common Errors
- Articles and Frequently Asked Questions
- References and Contact Information
- Visit:
 - <https://www.highmarkmedicareservices.com/cert/index.html>

Medicare Updates

Part B

Clarification of Evaluation and Management Payment Policy

- Elimination of consultation codes
 - CMS clarifies coding for initial hospital care when key components are not met allowing providers to bill subsequent hospital care codes
 - Policy also applies to initial visits provided in skilled nursing facilities, and nursing facilities
- CMS recognized the newly created CPT subsequent observation care codes (99224 – 99226)
- Change Request, CR7405: Effective January 1, 2011; Implementation November 28, 2011
 - <https://www.cms.gov/transmittals/downloads/R2282CP.pdf>

Reminders for Billing Correctly for Ordered/Referred Services

- Three basic requirements for ordering and referring:
 - physician or non-physician practitioner must be enrolled in Medicare or in an opt-out status.
 - National Provider Identifier (NPI) used for ordering/referring must be for an individual physician or non-physician practitioner (cannot be an organizational NPI).
 - physician or non-physician practitioner must be of a specialist type that is eligible to order and refer.
- Only Medicare-enrolled individual physicians and non-physician providers of a certain specialist type are eligible to order/refer for Part B and DMEPOS Medicare beneficiary services.
 - Only Medicare-enrolled individual physicians of a certain specialist type are eligible to order/refer for Part A when a plan of treatment is needed and submitted from an HHA for beneficiary services
- In order to order/refer, the provider must have an enrollment record in PECOS

Advanced Diagnostic Imaging Accreditation – Time is Running Out

- As a reminder, beginning January 1, 2012, Part B providers and suppliers who furnish the technical component of Advanced Diagnostic Imaging (ADI) must be accredited in order to bill Medicare for these services.
- ADI procedures include MRI, CT, nuclear medicine imaging, and positron emission tomography
 - Excludes x-ray, ultrasound, fluoroscopy
 - Accreditation requirements do not apply to ADI services furnished in hospital outpatient setting
- The technical component of ADI services includes the performance of the imaging procedures, not the physician interpretation.
- For dates of service on or after January 1st Medicare Administrative Contractors will begin denying claims for the technical component of ADI that are submitted under the Physician Fee Schedule by suppliers who have not yet been accredited.
- Once a provider becomes accredited, they can begin billing Medicare for these services again.
- For more information about ADI Accreditation, including a list of accrediting organizations and details of the accreditation process, please visit http://www.CMS.gov/MedicareProviderSupEnroll/03_AdvancedDiagnosticImagingAccreditation.asp
- An MLN Special Edition Article on this subject – “Important Reminders about Advanced Diagnostic Imaging Accreditation Requirements” (MLN SE1122) – is also available at <http://www.CMS.gov/MLNMattersArticles/Downloads/SE1122.pdf>

Medicare Updates

Part A and B

October Quarterly Updates

- End Stage Renal Disease Prospective Payment System
 - <https://www.cms.gov/MLN MattersArticles/downloads/MM7476.pdf>
- Average Sales Price Medicare Part B Drug Pricing Files
 - <https://www.cms.gov/MLN MattersArticles/downloads/MM7488.pdf>
- Laboratory National Coverage Determination Edit Software
 - <https://www.cms.gov/MLN MattersArticles/downloads/MM7507.pdf>
- Correct Coding Initiative Edits, Version 17.3
 - <https://www.cms.gov/MLN MattersArticles/downloads/MM7511.pdf>

October Quarterly Updates

- 2011 Medicare Physician Fee Schedule Database
 - <https://www.cms.gov/MLN MattersArticles/downloads/MM7528.pdf>
- Integrated Outpatient Code Editor (I/OCE) Specifications Version 12.3
 - <https://www.cms.gov/MLN MattersArticles/downloads/MM7541.pdf>
- Hospital Outpatient Prospective Payment System (OPPS)
 - <http://www.cms.gov/MLN MattersArticles/Downloads/MM7545.pdf>
- Ambulatory Surgery Center (ASC) Payment System
 - <https://www.cms.gov/MLN MattersArticles/downloads/MM7547.pdf>

October Annual Updates

- International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)
 - <https://www.cms.gov/MLN MattersArticles/Downloads/mm7454.pdf>
- Fiscal Year (FY) 2012 Inpatient Psychiatric Facility (IPF) PPS Changes
 - <https://www.cms.gov/transmittals/downloads/R2289CP.pdf>
- Fiscal Year (FY) 2012 Inpatient Prospective Payment System (IPPS), Long Term Care Hospital (LTCH) PPS, and Critical Access Hospital (CAH) Changes
 - <https://www.cms.gov/MLN MattersArticles/downloads/MM7508.pdf>
- Skilled Nursing Facility (SNF) Prospective Payment System (PPS) Pricer Update FY 2012
 - <https://www.cms.gov/MLN MattersArticles/downloads/MM7522.pdf>

Magnetic Resonance Imaging (MRI) in Medicare Beneficiaries with FDA-Approved Implanted Permanent Pacemakers (PMs) for use in an MRI Environment

- Effective for dates of service on or after July 7, 2011, CMS believes the evidence is adequate to conclude that magnetic resonance imaging (MRI) improves health outcomes for Medicare beneficiaries with implanted permanent pacemakers (PMs) when used according to the FDA-approved labeling for use in an MRI environment
- Other contraindications that may be present in any given beneficiary would continue to apply in patients with PMs
- Change Request, CR7441: Effective July 7, 2011; Implementation September 16, 2011
 - <https://www.cms.gov/transmittals/downloads/R134NCD.pdf>

Local Coverage Determination (LCD)/Billing & Coding Article

- The following LCDs will become effective October 27, 2011:
 - [Intraoperative Neurophysiological Testing \(L27499\)](#)
 - [Magnetic Resonance Angiography \(MRA\) \(L31399\)](#)
 - [Qualitative Drug Testing \(L32050\)](#)
 - [Serotypes A and B Botulinum Toxin Products \(L27476\)](#)
 - [Services That Are Not Reasonable and Necessary \(L31686\) \(formerly titled Non-Covered Services\)](#)
 - [Stereotactic Radiosurgery \(SRS\) \(L32057\)](#)
- The following Draft LCD is on hold until we have completed our review of comments received
 - [Transcranial Magnetic Stimulation \(TMS\) for the Treatment of Depression \(DL32055\)](#)

Local Coverage Determination (LCD)/Billing & Coding Article

- The following article has been posted for notice and will be effective September 13, 2011:
 - A47773, Self-Administered Drug Exclusion List

Preventive Services Month

- National Breast Cancer Awareness Month



- For More Information

- The Guide to Medicare Preventive Services for Healthcare Professionals (see Chapter 8)
- Medicare Preventive Services Quick Reference Information Chart
- Cancer Screenings Brochure for Physicians, Providers, Suppliers, and Other Healthcare Professionals
- Department of Health and Human Services
- National Breast Cancer Awareness Month official website
- The Centers for Disease Control (CDC) Breast Cancer Awareness website
- The CDC's National Breast and Cervical Cancer Early Detection Program

Flu Vaccine Reimbursement and Administration Fees

- 2011 - 2012 Flu Vaccine Reimbursement and Administration fees posted
 - <https://www.highmarkmedicareservices.com/partb/reimbursement/flu-pnu-hep-11.html>
- Get the Flu Vaccination – NOT the Flu

Medicare Updates

Part A

Exclusion from Skilled Nursing Facility (SNF) Consolidated Billing

- A policy decision has been made by CMS that Dacogen, (J0894) meets the clinical parameters for exclusion from SNF consolidated billing as a high-intensity chemotherapy drug
 - Effective October 3, 2011, for claims with dates of service on or after January 1, 2011 claims processing edits will be revised to allow separate payment of J0894

Reason Codes 51MUE & 52MUE

- Claims billed with Healthcare Common Procedure Code (HCPC) 90853 and several other HCPC codes were denying incorrectly for Medically Unlikely Edits (MUE) limits.
- The problem has been corrected and claims are now processing correctly.
- The Centers for Medicare and Medicaid Services(CMS) is still working with the Contractors to determine how these claims can be adjusted. We will keep you updated as we receive direction from CMS.

October 2011 Update of the Hospital Outpatient Prospective Payment System (OPPS)

**Change Request (CR) 7545
Effective 10/1/2011**

<https://www.cms.gov/transmittals/downloads/r2296cp.pdf>

Changes to Device Edits for October 2011

- Procedure code 64569 (Revision or replacement of cranial nerve, (eg, vagus nerve) neurostimulator electrode array, including connection to existing pulse generator) is being added as an appropriate procedure for device code C1778 (Lead, neurostimulator)
 - Added to file effective January 1, 2011 for services furnished on and after January 1, 2011
 - ✦ Claim submitted prior to this update and returned to providers may be resubmitted

New Device Pass-Through Categories

HCPCS	Effective Date	SI	APC	Short Descriptor	Long Descriptor	Device Offset from Payment
C1830	10-01-11	H	1830	Power bone marrow bx needle	Powered bone marrow biopsy needle	\$0
C1840	10-01-11	H	1840	Telescopic intraocular lens	Lens, intraocular (telescopic)	\$221.71

Drugs and Biologicals with OPPS Pass-Through Status

HCPCS	Long Descriptor	APC	SI
C9286*	Injection, belatacept, 1mg	9286	G
J0638	Injection, canakinumab, 1mg	1311	G

* New code effective 10/1/2011

Updated Payment Rate for HCPCS Code J9185 Effective 7/1/2011 Through 9/30/2011:

HCPCS	SI	APC	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
J9185	K	0842	Fludarabine phosphate inj	\$104.52	\$20.90

Clarifications to Condition Code 44 Policy (When a Patient's Status may be Changed from Inpatient to Outpatient)

- To bill with Condition Code 44, all of the following must be met:
 - The change in patient status from inpatient to outpatient is made prior to discharge or release, while the beneficiary is still a patient of the hospital;
 - The hospital has not submitted a claim to Medicare for the inpatient admission;
 - The practitioner responsible for the care of the patient and the UR committee concur with the decision; and
 - The concurrence of the practitioner responsible for the care of the patient and the UR committee is documented in the patient's medical record.

Self Service Options

Medicare Insights Weekly Podcast

- Weekly podcast covering important Medicare news and events
- Automatically delivered
- Easy to subscribe, just copy the link to your podcast software.
- Visit:
 - <https://www.highmarkmedicareservices.com/podcasts/>

Mailing List

- Subscribe to our E-Mail Lists
 - <https://www.highmarkmedicareservices.com/maillinglists.html>
- Available mailing lists
 - Part A General Education
 - Receives All Updates, except Electronic Data Interchange (EDI)
 - Part A Electronic Billers (EDI)
 - Part B General Education (Receives All Updates, except EDI)
 - Part B Electronic Billers (EDI)
 - Part A & B PC-ACE Pro32 Users (EDI)

Highmark Medicare Services Website

www.highmarkmedicareservices.com

- Our website offers a wide variety of valuable resources including, but not limited to:
 - A/B Reference Manual
 - Appeals
 - Electronic Billing (EDI)
 - Frequently Asked Questions
 - News and Bulletins
 - Self-Service Tools
- For additional resources visit:
 - <https://www.highmarkmedicareservices.com/parta/index.html>
 - <https://www.highmarkmedicareservices.com/partb/index.html>

Calendar of Events

- Our Training and Events Center offers a wide variety of education
- Join us for Workshops, Teleconferences, and Webinars
- To view the most current calendar of events, visit:
 - <https://www.highmarkmedicareservices.com/training/index.html>

Centers for Medicare & Medicaid Services (CMS)

- The CMS website offers valuable resources such as:
 - CMS Internet Only Manuals (IOMs)
 - Medicare Learning Network (MLN) Matters Articles
 - Open Door Forum
- For additional resources visit:
 - <http://www.cms.gov/>

Contact Information

- Part A Provider Customer Contact Center and Interactive Voice Response (IVR)
 - 1-877-235-8048
 - <https://www.highmarkmedicareservices.com/selfservice/index.html>
- Part B Provider Customer Contact Center and Interactive Voice Response (IVR)
 - 1-877- 235-8073
 - <https://www.highmarkmedicareservices.com/selfservice/index.html>
- Patient / Medicare Beneficiary
 - 1-800-MEDICARE (1-800-633-4227)
 - <http://www.medicare.gov/>

Provider Telephone Consolidation Project

- One toll free telephone number for all Highmark Medicare Services' (HMS) telephone inquiries
 - 1.877.235.8073
- Consolidate the following toll free telephone lines
 - General inquiries
 - Provider Enrollment (PE)
 - Electronic Data Interchange (EDI)
 - Telephone Reopenings
- Telephone consolidation becomes effective on December 1, 2011
- Prior toll free telephone numbers will become inactive on May 1, 2012

Provider Telephone Consolidation Project Benefits

- Prompts will route providers to either:
 - Part A or B Interactive Voice Response (IVR)
 - Part A or B Electronic Data Interchange (EDI)
 - Part A or B Provider Enrollment (PE)
 - Part B Claims Correction
- Benefits of telephone consolidation
 - Fewer numbers
 - Decrease wait times
 - Reduce busy signals

Thank You