Indiana Medicare Part B HIGLAS Transition Effect on Claims Payments – HIGLAS Transition Activities

On March 7, 2012, National Government Services (NGS) will begin a transition to Healthcare Integrated General Ledger Accounting System (HIGLAS) that will affect claims payment for Part B claims. This transition means:

- Waiver of the payment floor will result in claim payments (checks and EFTs) being issued earlier than normal
- Providers are encouraged to continue submitting claims as normal
- Following the transition to HIGLAS, National Government Services will resume normal scheduled payments
- HIGLAS has no effect on Medicare Replacement plans
- Providers will need to monitor and manage their cash flow during this time period
- Questions about the HIGLAS transition can be directed to NGS Provider Contact Center at (866)276-8129 or for more information go to www.ngsmedicare.com

National Government Services HIGLAS Transition Timeline

<table>
<thead>
<tr>
<th>2012</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 7</td>
<td>Last Non-HIGLAS payment cycle (payment floor reduced to zero; all claims in an approved to pay location are released)</td>
</tr>
<tr>
<td>March 12</td>
<td>HIGLAS transition completed and the first HIGLAS cycle will be run</td>
</tr>
<tr>
<td>March 9 - 21</td>
<td>Electronic Claims Submission providers will experience a significant reduction in payments due to the early claim payments issued immediately prior to the transition. Providers need to monitor and manage their cash flows during this time period. <strong>No payments on electronically submitted claims will be made.</strong></td>
</tr>
<tr>
<td>March 9-April 5</td>
<td>Paper Claims Submission providers may experience a significant reduction in payments due to the early claim payments issued immediately prior to the transition. Providers need to monitor and manage their cash flows during this time period. <strong>No payments on paper submitted claims will be made.</strong></td>
</tr>
<tr>
<td>March 8</td>
<td>Electronic Claims Submission Payment Floor (14 days) is restored. Paper Claims Submission Payment Floor (29 days) is restored.</td>
</tr>
</tbody>
</table>
What You Need to Do Now to Avoid the 2013 eRx Payment Reduction

Although we just started 2012, it’s time to start thinking about the 2013 e-prescribing payment reduction or adjustment! For 2013, the penalty for failing to be a successful e-prescriber will increase to 1.5%. In other words, an unsuccessful e-prescriber in 2012 will only receive 98.5% of the Medicare Physician Fee Schedule amount for Part B covered professional services in 2013. So keep reading to see how an individual eligible professional can avoid the 2013 eRx payment reduction.

1. EPs (eligible professionals) who e-prescribed and reported 25 unique eRx events between January 1, 2011 and December 31, 2011 via claims, registry, or electronic health record are automatically exempt from the 2013 adjustment.

2. EPs who e-prescribe at least 10 times between January 1, 2012 and June 30, 2012 and report HCPCS code G8553 on their claims will also be exempt from the 2013 adjustment. For 2012, G8553 can be reported with any code for purposes of the payment adjustment. (NOTE: For the eRx incentive, G8553 must still be reported with one of the measure denominator codes.)

3. EPs who qualify for and submit a hardship exemption that is subsequently approved by CMS will also be exempt from the 2013 adjustment. The hardship exemption must be submitted by June 30, 2012 via the Communication Support Page which will be available this spring. The four hardship exemptions include:
   - EP practices in a rural area with limited high-speed internet access OR
   - EP practices in an area with limited available pharmacies that can receive electronic prescriptions OR
   - EP cannot e-prescribe due to local, state, or federal laws or regulations (i.e. narcotics or other controlled substances) OR
   - EP prescribed fewer than 100 prescriptions between January 1, 2012 and June 30, 2012

4. Some miscellaneous exceptions are also available:
   - EP is not an MD, DO, podiatrist, nurse practitioner, or physician assistant as of June 30, 2012
   - EP does not have prescribing privileges. Code G8644 must be reported at least one time on an eligible claim prior to June 30, 2012
   - Less than 100 patient services contain an encounter code in the measure denominator between January 1, 2012 and June 30, 2012
   - Less than 10% of the EP’s allowed Medicare charges for the January 1, 2012 – June 30, 2012 reporting period consist of codes in the measure denominator

Don’t forget that an individual eligible professional who reports at least 25 unique e-prescribing events between January 1, 2012 and December 31, 2012 via claims, registry, or EHR will also be eligible for a 1% incentive. So, start reporting today to earn the incentive and avoid future penalties!

For more information go to www.cms.gov/ERxIncentive.
Coding Corner

Q: What codes would be used when a Vaginal Wet Mount and KOH prep are performed? We have been using CPT codes 87210 and 87220.

A: Per the American Congress of Obstetricians and Gynecologists (ACOG), use CPT code 87210 (Smear, primary source with interpretation; wet mount for infectious agents (eg, saline, India ink, KOH preps)) for wet mount and KOH preps.

Do not use CPT code 87220 (Tissue examination by KOH slide of samples from skin, hair or nails for fungi or ectoparasite ova or mites) since this code does not include vaginal specimens.

Typically one specimen and one slide is used, however if for any reason the test requires 2 specimens/2 slides, CPT code 87210 should be billed twice with a -59 modifier on the second one. Documentation must CLEARLY indicate that 2 specimens/2 slides were used to perform the test in order to bill for both.

Q: We’ve recently been seeing denials for wet preps billed to Medicare using CPT 87210. Is there something wrong with this code?

A: For Medicare, the HCPCS code for wet mounts is Q0111 (Wet mounts, including preparations of vaginal, cervical or skin specimens) and for KOH preparations, report HCPCS code Q0112 (All potassium hydroxide (KOH) preparations), unless otherwise instructed by your carrier.

A certificate for provider-performed microscopy procedures (PPMP) is required for both tests.

AAPC Webinars

The AAPC offers weekly specialty webinars. IMM has purchased the series and invites you to attend at no cost to you or your practice. The events are scheduled on site at VEI, 7330 Shadeland Station. There is no remote access. Please see the webinar topics for February below. Register by email to tschuster@ecommunity.com.

- Wednesday, February 1 1:00 – 2:00pm
  “Orthopaedic Case Studies: Upper and Lower Extremities”

- Wednesday, February 8 1:00 – 2:00pm
  “Chargemaster and Outpatient Facility Coding”

- Wednesday, February 15 1:00 – 2:00pm
  “Defending an Adverse E/M Audit”

- Wednesday, February 29 1:00 – 2:00pm
  “Cardiovascular – Pacers, Defibrillators and Electrophysiology in 2012”

Not Otherwise Classified PQRS G-codes Problem

The Centers for Medicare and Medicaid Services (CMS) has indicated that certain Physician Quality Reporting System (PQRS) G-codes were inadvertently rejected by Carrier/MACS during the 2011 and 2012 program years. This only impacted Part B claims that were submitted utilizing the 5010 format. The problem has since been resolved and the codes have been reactivated. However, if your 2011 5010 claim was rejected, please be sure to resubmit your claim by February 24, 2012. The PQRS measures affected by this error can be found in the attachment that accompanied this newsletter.

It should be noted that the G-codes affected are predominantly the ones used to indicate that the provider did not perform the quality action and no reason was specified (performance failures).

If you have questions, please contact the QualityNet Help Desk at 1-866-288-8912 or Qnetsupport@sdps.org.

https://www.cms.gov/PQRS/15_MeasuresCodes.asp#TopOfPage
Flagging Patient Medical Records

Does your practice flag patient charts as a method to high-light a patient’s medical condition such as “AIDS”? Sometimes this sticker may be on the inside cover of the chart so that staff members who do not “need to know” would not be able to read the sticker. Although this process does address the privacy rights of the patient, it does not address the original reason for flagging the chart.

Employers want to protect their employees from exposure to blood borne pathogens. However, flagging a patient chart is not a reliable method to protect staff. All healthcare workers should use universal precautions. This means treating ALL human blood and other bodily fluids as potentially infectious. Healthcare workers should use the appropriate personal protective equipment when handling bodily fluids. Practicing universal precautions is the only means of ensuring consistent protection.

Not every patient is tested for blood borne pathogens; therefore, flagging a patient’s chart as a means to indicate the need for personal protective equipment is contrary to the requirements of the Bloodborne Pathogens Standard. Whenever a staff member could be potentially exposed to infectious materials, they must utilize their personal protective equipment to reduce the possibility of exposure.

Can you explain Indiana Medicaid’s 90 day rule?

When a third-party insurance company does not respond to a claim within 90 days of the provider’s billing date, the provider can submit the claim to the Indiana Health Coverage Program (IHCP) for payment consideration. Provider’s offices must substantiate their attempts to bill the third party. Attempts to collect from the third-party payor must be documented in the claim note segment of the 837P transaction.

Document:

- Date of the filing attempt
- The phrase “no response after 90 days”
- Member’s RID
- Provider’s IHCP provider number
- Name of primary insurance carrier billed

When submitting written notification, unpaid bills or statements, providers should include the third-party insurance carrier’s name. (IHCP Provider Manual Ch. 8.30)

2012 Indiana Medicaid Update Seminars

<table>
<thead>
<tr>
<th>Location</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bloomington, IN</td>
<td>Wednesday, March 14</td>
</tr>
<tr>
<td>Fort Wayne, IN</td>
<td>Tuesday, March 27</td>
</tr>
<tr>
<td>Indianapolis, IN</td>
<td>Wednesday, March 28</td>
</tr>
<tr>
<td>Merrillville, IN</td>
<td>Tuesday, April 3</td>
</tr>
<tr>
<td>South Bend, IN</td>
<td>Wednesday, April 4</td>
</tr>
<tr>
<td>Carmel, IN</td>
<td>Tuesday, April 24</td>
</tr>
<tr>
<td>Evansville, IN</td>
<td>Tuesday, May 22</td>
</tr>
</tbody>
</table>

This program has the prior approval of AAPC for 6 continuing education hours. (Granting of prior approval in no way constitutes endorsement by AAPC of the program content or the program sponsor.)

Upcoming Educational Opportunities

See attached flyers for more information and to register or visit [http://www.veicorp.com/imm/](http://www.veicorp.com/imm/)

Billing and Collections 101

Tuesdays, March 6 – May 15
8:30am – 11:30am (ET)
Making the Transition to ICD-10

On October 1, 2013 a key element of the data foundation of the United States health care system will undergo a major transformation. We will transition from the decades old Ninth Edition of the International Classification of Diseases (ICD-9) set of diagnosis and inpatient procedure codes to the far more contemporary, vastly larger, and much more detailed Tenth Edition of those code sets – or ICD-10 – used by most developed countries throughout the world.

This transition will have a major impact on anyone who uses health care information that contains a diagnosis and/or in-patient procedure code, including:

- Hospitals
- Health insurers and other third-party payers
- Hardware and software manufacturers and vendors
- Health care practitioners and institutions
- Electronic transaction clearinghouses
- Public and private health care research institutions

The Center for Medicare and Medicaid Services (CMS) has developed The ICD-10 Implementation Guide for Small and Medium Provider Practices. A small physician practice is defined as having one to five physicians and may provide single specialty or multispecialty services. Medium physician practices are standalone clinics not affiliated with a larger health care organization that have 6-20 physicians who provide single specialty or multispecialty, patient care services. They may also provide ancillary services (diagnostic, therapeutic, and custodial care). The ICD-10 Implementation Guide for Small and Medium Provider Practices groups the milestones and tasks into the following six phases:

1. **Planning**
   - Establish project management structure
   - Establish governance
   - Plan to communicate with external partners
   - Establish risk management

2. **Communication and awareness**
   - Create a communication plan
   - Assess training needs and develop a training plan
   - Meet with staff to discuss effect of ICD-10 and identify responsibilities

3. **Assessment**
   - Assess business and policy impacts
   - Assess technological impacts
   - Evaluate vendors

4. **Operational implementation**
   - Identify system migration strategies
   - Implement business and technical modifications
   - Prepare and deliver training

5. **Testing**
   - Complete level I internal testing
   - Complete level II external testing

6. **Transition**
   - Prepare and establish the production and go-live environments
   - Deliver ongoing support

ICD-10 Effects on Physician Reimbursements

The transition to ICD-10 will result in changes to physician reimbursements. The nature of these changes will vary based on each practice's individual contracting arrangements. Physicians should include ICD-10 in their payer contract negotiation discussions during the next two years to decrease the risk of compliance errors and claims denials. As the implications of the expanded, more detailed code sets become apparent, payers may also institute policies that involve greater payment for more complex cases and lower payment for less complex cases.

(Continued on page 6)
Next Steps

Using the CMS ICD-10 Implementation handbook as a guide, your practice should now be ready to take the following steps:

1. Establish awareness among practice leadership involved in ICD-10 implementation.
2. Identify an ICD-10 coordination manager who will create an inventory of key tasks for ICD-10 implementation and be in charge of monitoring the daily activities associated with ICD-10 implementation.
3. Identify vendor support needs for the ICD-10 implementation from vendors and health associations.

The CMS *ICD-10 Implementation Guide for Small and Medium Provider Practices* is a great tool to begin your planning and implementation process. You can review the tool at the CMS website and start getting ready!

You can find the *ICD-10 Implementation Guide for Small and Medium Provider Practices* at:


Are you ready for ICD-10? The time to begin preparation for clinical documentation improvement is now. Do not waste the opportunity to improve on current diagnosis documentation in ICD-9-CM. Learning how to improve your documentation now will make the transition into ICD-10-CM much easier.

Certified ICD-10 instructors with ICDExpert.net are here to help with your transition to ICD-10! For additional information on ICD-10 implementation or an evaluation of your ICD-10 readiness as well as training for you and your staff, please visit our website at www.icdexpert.net or call us at 877-413-ICD-10.

Are You Ready for ICD-10? Our Experts Can Help Get You There!
PQRS Measures Affected by 5010 Processing Error

#20 Perioperative Care: Timing of Antibiotic Prophylaxis
#32 Stroke and Stroke Rehab: Discharged on Antiplatelet Therapy
#36 Stroke and Stroke Rehab: Consideration of Rehab Services
#40 Osteoporosis: Management Following Fracture of Hip, Spine, or Distal Radius Age 50 & Older
#55 Emergency Medicine: 12-Lead ECG Performed for Syncope
#79 End Stage Renal Disease (ESRD): Influenza Immunization in Patients with ESRD
#100 Colorectal Cancer Resection Pathology Reporting: pT Category (Primary Tumor) and pN Category (Regional Lymph Nodes) with Histologic Grade
#121 Chronic Kidney Disease (CKD): Laboratory Testing (Calcium, Phosphorus, Intact Parathyroid Hormone (iPTH) and Lipid Profile)
#123 Chronic Kidney Disease (CKD): Plan of Care – Elevated Hemoglobin for Patients Receiving Erythropoiesis-Stimulating Agents (ESA)
#135 Chronic Kidney Disease: Influenza Immunization
#202 Ischemic Vascular Disease (IVD): Complete Lipid Profile
#204 Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic
#231 Asthma: Tobacco Use: Screening - Ambulatory Care Setting
#236 Hypertension: Blood Pressure Control
#244 Hypertension: Blood Pressure Management
#263 Preoperative Diagnosis of Breast Cancer
#269 Inflammatory Bowel Disease: Type, Anatomic Location and Activity All Documented
#271 Inflammatory Bowel Disease: Preventive Care: Corticosteroid Related Iatrogenic Injury – Bone Loss Assessment
#273 Inflammatory Bowel Disease: Preventive Care: Pneumococcal Immunization
#276 Sleep Apnea: Assessment of Sleep Symptoms
#278 Sleep Apnea: Positive Airway Pressure Therapy Prescribed
#279 Sleep Apnea: Assessment of Adherence to Positive Airway Pressure Therapy
#295 Hypertension: Appropriate Use of Aspirin or Other Antiplatelet or Anticoagulant Therapy
#296 Hypertension: Complete Lipid Profile
#297 Hypertension: Urine Protein Test
#298 Hypertension: Annual Serum Creatinine Test
#299 Hypertension: Diabetes Mellitus Screening Test
#300 Hypertension: Blood Pressure Control
#302 Hypertension: Dietary and Physical Activity Modifications Appropriately Prescribed
#317 Preventive Care and Screening: Screening for High Blood Pressure

https://www.cms.gov/PQRS/15_MeasuresCodes.asp#TopOfPage