Reprocessing Claims Affected by 2010 MPFS Changes

As part of the Affordable Care Act signed into law last year, corrections were made to the Medicare Physician Fee Schedule (MPFS) with an effective date retroactive to January 1, 2010. Due to this, a large volume of Medicare fee-for-service claims will be reprocessed over the next several weeks.

In the majority of cases, you will not have to request adjustments because your Medicare claims administration contractor will automatically reprocess your claims. Please do not resubmit claims because they will be denied as duplicates. However, any claim that contains services with submitted charges lower than the revised 2010 fee schedule amount cannot be automatically reprocessed at the higher rates. In such cases, you will need to request a manual reopening/adjustment from your Medicare contractor. While there is normally a one-year time limit to request the reopening of claims, CMS is extending the time period to request adjustment of these claims, as necessary.

Medicare claims administration contractors will follow the normal process for handling any applicable underpayments or overpayments that occur while reprocessing claims. Underpayments will be included in your next regularly scheduled remittance after the adjustment. When a claim adjustment results in an overpayment, the Medicare contractor will send a request for repayment. If this overpayment is less than $10, your contractor will not request repayment until the total amount owed accrues to at least $10.

Don’t Miss Out on Upcoming Seminars!

IMM is pleased to announce the following seminars:

- **Charge Entry** (March 17 and March 23)
- **Billing and Collections 101** (April 12 - June 7)
- **2011 Indiana Medicaid Update** (April 20) – Presented by Maureen Hoffmeyer from Association Management Plus+, LLC
- **PMCC** (July 7 – December 15)

See the flyers which accompanied this newsletter for further information and register today!
**IHCP Applying NCCI Code Edits**

The Indiana Health Coverage Programs (IHCP) on January 27, 2011, began applying the National Correct Coding Initiative (NCCI) edits to claims with dates of service (DOS) on or after October 1, 2010, as directed by the Centers for Medicare & Medicaid Services (CMS). A list of these Medicaid NCCI edits can now be found at:

http://www.cms.gov/MedicaidNCClcoding/

Beginning the week of March 14, 2011, the IHCP will initiate a mass adjustment on claims previously processed with a DOS of October 1, 2010 and forward. You may see recoupments as a result. If a provider believes a claim was coded correctly but processed incorrectly based on NCCI edits, he/she must file an appeal within **7 days** of notification of claim denial.

Send requests for administrative review to:

Written Correspondence  
PO Box 7263, Indianapolis, IN 46207-7263  
ATTN: Healthcare Administrative Review Specialist

Modifiers may be appended to CPT codes only when clinical circumstances justify the use of a modifier. **A modifier should not be appended to a CPT code solely to bypass NCCI edits.** Expect increased audits of modifiers 25, 57, and 59.

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**Connex Online Application Now Available!**

Connex is the all-new Medicare online application developed by National Government Services (NGS) just for you! Connex allows you to access a wide array of information, such as:

- Beneficiary eligibility and entitlement information  
- Claim status  
- Provider/supplier demographic information  
- Financial data  
- Ability to order remittances

Connex is available at [www.NGSConnex.com](http://www.NGSConnex.com) and offers you superior search capabilities that will help make it fast and easy for you to find the information you seek without having to place calls to the NGS Provider Contact Center. Best of all access is free!

Registering to use the Connex online application is simple and free. Get started today by logging onto [www.NGSConnex.com](http://www.NGSConnex.com).

**Note:** Registration for Community employed providers will be handled by the Cooperative Business Office (CBO). Be on the lookout for additional information from the CBO!

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**New Physician Compare Website**

On January 1, 2011, CMS launched a new web-based Physician Directory tool called Physician Compare as mandated by the Affordable Care Act. This new tool can be accessed at [www.medicare.gov/find-a-doctor/provider-search.aspx](http://www.medicare.gov/find-a-doctor/provider-search.aspx). CMS is using its existing Healthcare Provider Directory, which is based on information in the Provider Enrollment, Chain and Ownership System (PECOS), as a foundation for the Physician Compare website.

Physician Compare includes information such as:

- Contact and address information  
- Medical specialty  
- Education and resident training  
- Foreign languages spoken  
- Gender  
- Whether or not a physician accepts Medicare.

Other information to be added at a future date includes:

- E-prescribe status  
- Information about quality of care and reporting of Physician Quality Reporting System (PQRS) measures

CMS is currently addressing problems with the site such as the inability to locate physicians and hopes to have the issues resolved by the end of March.
IHCP Covers Zoster (Shingles) Vaccine

The Indiana Health Coverage Programs (IHCP) now provides coverage for CPT code 90736 – Zoster (shingles) vaccine, for dates of service on or after May 1, 2006, for members 60 years and older.

Claims that were previously submitted for payment will be reprocessed. The reprocessed claims will appear on the Remittance Advice (RA) dated February 22, 2011. Providers with claims for this procedure code that have not been submitted for processing should submit their claims for payment consideration. If the claim is past the one-year filing limit, submit a copy of banner BR201108 to waive the filing limit.

Anthem CPT Coding Compliance Program

In an effort to promote appropriate coding practices and to monitor and improve the accuracy of payments, Anthem is launching a CPT Coding Compliance Program, to be conducted by Healthcare Recoveries, Inc. to review use of modifiers 24, 25, 57, and 59 and evaluation and management claims. The objectives of this program include:

- To help ensure that Anthem understands provider billing practices and to verify that providers are billing in conjunction with CPT/HCPCS Coding Guidelines as well as Anthem policies and procedures.
- To educate providers on billing practices to promote compliance with the CPT/HCPCS Coding Guidelines and/or Anthem policies and procedures.
- To identify and correct any underpayments and overpayments that may be identified during the review.

Prior to review, a notification will be sent, in writing, to cover review guidelines. Findings will be provided in writing to you and your billing staff. Contact your local Provider Relations consultant or Provider Audit Department at (804)354-2300 if you have any questions.

Retroactive Eligibility

Utilize claim notes when billing a claim to Medicaid that is past the filing limit and the member was awarded retroactive eligibility. In the case of retroactive member eligibility, claims must be submitted within one year of the eligibility determination date. Complete the claim as you would normally using the Web interChange. Click on the Notes button. Enter information stating “Member has retroactive eligibility. Please waive timely filing.”

How do I bill the new vaccine administration codes?

Effective January 1, 2011, CPT 90465-90468 were deleted and replaced with two new vaccine administration codes. The new CPT codes are as follows:

90460: Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first vaccine/toxoid component

+90461: Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; each additional vaccine/toxoid component

For administration/counseling of the Tdap vaccine to a 7 year old child the following could be billed depending on payer policy:

90715 – Tetanus, diphtheria toxoids and acellular pertussis vaccine, for intramuscular use

90460 – Administration/counseling of 1st component (tetanus)

90461 – Administration/counseling of 2nd component (diphtheria)

90461 – Administration/counseling of 3rd component ( pertussis)

However, Medicaid does not recognize any vaccine administration codes including 90460 and 90461. For a vaccine administered as part of the Vaccines for Children (VFC) program, the provider should only bill for the vaccine product code with a fee of $8. So in the previous example, CPT 90715 would be billed to Medicaid with a fee of $8. For a vaccine that is not part of the VFC program, Medicaid allows the provider to bill for both the vaccine product and its administration with CPT 96372 (Therapeutic, prophylactic, or diagnostic injection; subcutaneous or intramuscular); however, CPT 96372 should not be reported if an Evaluation and Management service is provided on the same day as the immunization. In that case, only the vaccine product code should be billed.

Check with your payer for specific billing guidelines to see if they cover these new codes and if so, how to report them!
Have You Started External Testing of Version 5010?

All HIPAA-covered entities that submit transactions electronically are required to upgrade from Version 4010/4010A to Version 5010 transaction standards by January 1, 2012.

Testing should be conducted both internally and with external business partners in preparation for the January 1, 2012 compliance deadline. Internal testing should have been completed by December 31, 2010. Now is the time to begin external testing! Testing transactions using Version 5010 standards will assure that you are able to send and receive compliant transactions effectively and to continue to receive payment for claims. Stay ahead of the Version 5010 transition! Know the deadlines and mark your calendars:

- **April 5, 2011**: Medicare Administrator Contractors (MACs) begin accepting test claims and pay them if valid.
- **October 1, 2011**: All practices and clearinghouses, along with any organization that transmits HIPAA protected information electronically, have until this date to request testing with MACs.
- **December 31, 2011** - External testing of Version 5010 for electronic claims must be complete.
- **January 1, 2012** - All electronic claims must use Version 5010; Version 4010 claims are no longer accepted.

In addition, you need to find out the following:

1. **Vendor’s Software Plans**: You need to know how your practice management, claims processing, and Electronic Health Record (EHR) software will be updated for 5010. Will you have to pay fees? How long will the change take?
2. **Is the updated software dual standard compatible?** This means that the software can perform HIPAA transactions in 4010A and 5010. This is crucial since not all payers will be 5010 ready at the same time.
3. **Ask your clearinghouse about their 5010 testing plans.**
4. **Check with your Medicare Carrier/MAC.**

CMS has resources that can help you with the Version 5010 transition at [http://www.cms.gov/Versions5010andD0/](http://www.cms.gov/Versions5010andD0/)

Compressed Gas Safety

One of the safety plans required by OSHA is to ensure the safety of healthcare workers in the storage and handling of compressed gas cylinders. Storage guidelines must be followed to eliminate the fire and explosion hazards that compressed gases present. Storage policies should consider chemical incompatibilities, temperatures, and access to the area. In addition, special precautions must be observed when working with oxygen, due to its ability to support combustion. All cylinders should be stored 20 feet away from combustible materials. Smoking is prohibited within 50 feet of compressed gas cylinder storage. Cylinders need to be stored and protected from external heat sources, falling objects, and electrical sparks. Title 29 CFR 1926.350(a)(9) requires that compressed gas cylinders regardless of whether they are completely filled, partially filled, or empty to be stored upright at all times. In addition, they need to be secured by a chain or other appropriate means. The standard only permits compressed gas cylinders to be horizontal for short periods of time when they are being hoisted or carried. When transporting the compressed gas cylinder, never lift it by the valve or cap and never drag the cylinder. The proper way to move the cylinder is by tilting it sideways and rolling it along its bottom edge or by placing it in a cart.

Safe use of medical equipment includes routine assessments through inspection, testing and maintenance to prevent injury to patients, visitors and staff. Check your gas cylinders monthly to make sure they are labeled correctly, haven’t expired, and are stored upright in a secured, ventilated area. Also, check monthly for availability of the wrench/regulator and complete a crack test and verify that the valve is tight after the test. Also include the signature of the individual performing the checks. A record of the checks should be documented on a monthly log sheet. If you need a log sheet, please contact your clinical /regulatory consultant.
E-Prescribe Now to Avoid Payment Adjustments in 2012!

Beginning in 2012, eligible professionals who are not successful electronic prescribers will be subject to a payment adjustment on their Medicare Part B covered professional services. Specific requirements must be met in order to qualify for an incentive payment and to avoid future decreases in payment.

- **A decrease** in reimbursement from Medicare will occur if the following is not met:

<table>
<thead>
<tr>
<th>No of e-prescriptions completed</th>
<th>By Date</th>
<th>If not met</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 (claims-based reporting)</td>
<td>June 30, 2011</td>
<td>Decrease 1% in 2012</td>
</tr>
<tr>
<td>25</td>
<td>December 31, 2011</td>
<td>Decrease 1.5% in 2013</td>
</tr>
</tbody>
</table>

- The 1% payment adjustment in 2012 can be avoided if the eligible professional meets one of the following exceptions:
  - Is not a physician (MD, DO, or podiatrist), nurse practitioner, or physician assistant as of June 30, 2011 based on primary taxonomy code in NPPES;
  - Does not have prescribing privileges. Code G8644 must be reported at least one time on an eligible claim prior to June 30, 2011;
  - Does not provide at least 100 Medicare office visits, nursing facility visits, or psychotherapy services between January 1, 2011 and June 30, 2011.
  - < 10% of eligible provider's allowed Medicare charges for the January 1, 2011 – June 30, 2011 reporting period are comprised of office visits, nursing facility visits, or psychotherapy services.
  - Qualifies for a hardship exemption:
    - The eligible professional practices in a rural area with limited high-speed internet access. Code G8642 must be reported at least one time on an eligible claim prior to June 30, 2011; OR
    - The eligible professional practices in an area with limited available pharmacies that can receive electronic prescriptions. Code G8643 must be reported at least one time on an eligible claim prior to June 30, 2011.

- If the 25 e-prescriptions are completed by December 31, 2011, an **incentive** equal to 1% of the eligible provider's total allowed charges for all covered services during 2011 will be received. Note: If a provider participates in the Medicare Electronic Health Record (EHR) Incentive Program in 2011, he/she is not eligible for the 1% e-prescribing incentive in 2011.

- To ensure documentation of an e-prescription, **code G8553** must be billed along with the covered service. Report G8553 with a line-item charge of zero dollars ($0.00). If a system does not allow a $0.00 line-item charge, a nominal amount ($0.01) can be substituted. Check the Remittance Advice for standard remark code N365 which indicates the e-prescribing measure was successfully reported.

- For additional information, visit [http://www.cms.gov/erxincentive](http://www.cms.gov/erxincentive)