



VEI

Indianapolis Medical Management

7330 Shadeland Station, Ste 200
Indianapolis, IN 46256

IMM

Insight

The IMM Newsletter

IMM INSIGHT

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SPECIAL MEDICARE PAYMENT UPDATE: PRESIDENT SIGNS EXTENSION OF PHYSICIAN PAYMENT FREEZE

On March 2, 2010, the president signed [H.R. 4691](#), the Temporary Extension Act of 2010 into law. This legislation includes a provision that freezes Medicare physician payments at their current level until March 31, 2010. The legislation also extends the therapy cap exception process through until March 31, 2010. The bill passed the Senate by a vote of 78 – 19. The House of Representatives had unanimously approved a companion bill by voice vote on Feb. 25.



MEDICARE CLAIMS CROSSOVER TO SUPPLEMENTAL PAYER PROBLEM

The Centers for Medicare & Medicaid Services (CMS) has identified a problem where claims were not automatically crossing over to supplemental payers even though the provider remittance advice indicated otherwise. This problem began January 5, 2010. Part A institutional claims and Part B professional claims, with the exception of supplier claims processed by durable medical equipment Medicare administrative contractors (DME MACs), were impacted by this problem. Claims processed by DME MACs were not impacted.

Part A Institutional Claims

No action is required by Part A institutional providers. As of February 2, 2010, CMS successfully implemented a systems fix to ensure that all Part A institutional claims are now crossing over to supplemental payers as indicated on the remittance advice received by providers. As part of the fix, CMS Medicare contractors were able to identify claims processed between 01/05/2010–02/01/2010, where the provider remittance advice indicated that the affected claims were crossed over to various supplemental payers but were not. On February 2, 2010, the affected Medicare contractors began to send the affected claims to the Coordination of Benefits Contractor (COBC) to be crossed over to supplemental payers. This effort is now largely completed. Please allow until March 1, 2010, for supplemental payers to receive and process these claims before attempting to balance bill them for any remaining balances after Medicare.

Part B Professional Claims

Action is required on behalf of Part B professional providers where a remittance advice with an issue date between 01/05/2010–02/12/2010, has two or more service lines for a beneficiary where both of the *following* apply:

- One service line is 100 percent reimbursable (i.e., the approved amount and amount to be paid are equal,) **and**



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T**MEDICARE CLAIMS CROSSOVER...(CONTINUED)**

- One service line where part of or the entire Medicare approved amount is applied to the Part B deductible and/or carries coinsurance amounts.

The Centers for Medicare & Medicaid Services is not able to forward these beneficiary claims to supplemental payers even though the remittance advice may indicate otherwise. Providers will need to identify these claims by reviewing their remittance advice with an issue date between 01/05/2010–02/12/2010 that contains the criteria noted above. Once identified, providers will need to take action to balance bill the beneficiary's supplemental payer. As of February 12, 2010, this system problem was fixed and all claims are crossing over to supplemental payers as indicated on the provider remittance advice.

**CMS UPDATE ON CLAIMS PROCESSING FOR ORDERING / REFERRING PROVIDERS**

The Centers for Medicare & Medicaid Services (CMS) will delay until January 3, 2011, the implementation of Phase 2 of Change Request (CR) 6417 (Expansion of the Current Scope of Editing for Ordering/Referring Providers for Claims Processed by Medicare Carriers and Part B Medicare Administrative Contractors (MACs)) and CR 6421 (Expansion of the Current Scope of Editing for Ordering/Referring Providers for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Supplier Claims Processed by Durable Medical Equipment Medicare Administrative Contractors (DME MACs)).

This delay will give physicians and non-physician practitioners who order items or services for Medicare beneficiaries or who refer Medicare beneficiaries to other Medicare providers or suppliers sufficient time to enroll in Medicare or take the action necessary to establish a current enrollment record in Medicare prior to Phase 2 implementation.

Although enrolled in Medicare, many physicians and non-physician practitioners who are eligible to order items or services or refer Medicare beneficiaries to other Medicare providers or suppliers for services do not have current enrollment records in Medicare.

A current enrollment record is one that is in the Medicare Provider Enrollment, Chain and Ownership System (PECOS) and contains the NPI. Under Phase 2 of the above referenced CRs, a physician or non-physician practitioner who orders or refers and who does not have a current enrollment record that contains the NPI will cause the claim submitted by the Part B provider/supplier who furnished the ordered or referred item or service to be rejected.

CMS continues to urge physicians and non-physician practitioners who are enrolled in Medicare but who have not updated their Medicare enrollment record since November 2003 to update their enrollment record now. If these physicians and non-physician practitioners have no changes to their enrollment data, they need to submit an initial enrollment application which will establish a current enrollment record in PECOS.

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TOP 10 COMMON ELECTRONIC DATA INTERCHANGE EDITS FOR JANUARY 2010

National Government Services Common Electronic Data Interchange (CEDI) has identified the following edits as the top ten edits that were received on the CEDI GenResponse Report (GENRPT) during the month of January. The edit, its description and tips to resolve the error are provided below.

For more information regarding the CEDI front-end edits, please review the *CEDI Front End Report Manual* located on the CEDI Web site at the following link http://www.ngscedi.com/outreach_materials/outreachindex.htm.

For questions regarding the edits, please contact the CEDI Help Desk at 866-311-9184 or by e-mail at ngs.cedihelpdesk@wellpoint.com.

1. C202 Ordering Provider Not Authorized

The edit C202 is a warning edit. It will not reject the claims until it becomes a rejection in January 2011. The edit indicates that the ordering provider submitted in the claim is not found on the Centers for Medicare & Medicaid Services (CMS) supplied Provider Enrollment Chain & Ownership System (PECOS) file of providers/suppliers who are authorized to order durable medical equipment (DME) supplies. Contact the ordering provider identified in the edit to verify their information, including their National Provider Identifier (NPI), and eligibility with PECOS.

2. C200 Referring Provider Not Authorized

The edit C200 is a warning edit. It will not reject the claims until it becomes a rejection in January 2011. The edit indicates that the referring provider submitted in the claim is not found on the CMS supplied PECOS file of providers/suppliers who are authorized to refer DME supplies. Contact the referring provider identified in the edit to verify their information, including their NPI, and eligibility with PECOS. The referring provider does not need to be sent on DME claims. The referring provider may be removed from the submitted claim. However, if the information is sent, it will be checked as part of the CEDI front-end edits.

3. C201 Referring Provider Not Authorized

The edit C201 is a warning edit. It will not reject the claims until it becomes a rejection in January 2011. The edit indicates that the referring provider submitted in the claim is not found on the CMS supplied PECOS file of providers/suppliers who are authorized to refer DME supplies. Contact the referring provider identified in the edit to verify their information, including their NPI, and eligibility with PECOS. The referring provider does not need to be sent on DME claims. The referring provider may be removed from the submitted claim. However, if the information is sent, it will be checked as part of the CEDI Front-end edits.

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T**TOP 10 COMMON ELECTRONIC DATA INTERCHANGE EDITS... (CONTINUED)****4. C172 Invalid Procedure Code and/or Modifier**

The procedure code, modifier, or procedure code and modifier combination is invalid. To resolve this error, verify the Healthcare Common Procedure Coding System (HCPCS) and modifier combination is valid.

If the procedure code, modifier, or combination is valid, verify the first position does not contain a space.

Helpful Tips to verify a Procedure Code/HCPCS and modifier combination:

- Check the validity of the procedure code/modifier combination by using the Pricing, Data Analysis and Coding (PDAC) Web site www.dmepdac.com.
- Check the local coverage determination (LCD) at the DME Medicare administrative contractors (MACs) for guidelines on procedure codes and modifier usage for that LCD.
- Reference the supplier manual at the DME MAC Jurisdiction(s).
- Contact the Customer Care department at the appropriate Jurisdiction:

Jurisdiction A: 1-866-590-6731

Jurisdiction B: 1-866-590-6727

Jurisdiction C: 1-866-270-4909

Jurisdiction D: 1-866-243-7272

5. C008 EIN/SSN Not on File with NPI

When C008 fires on its own, it can indicate the Tax ID (Employer Identification Number/Social Security Number) submitted on the claim does not match what is on file with National Plan and Provider Enumeration System (NPPES) or the National Supplier Clearinghouse (NSC).

Verify the information entered on the NPPES Web site matches what you are submitting.

Note: This edit can fire with the C003 Billing NPI Not on Crosswalk. If this occurs, the Tax ID (Employer Identification Number/Social Security Number) may have been **TOP 10** entered correctly in the claim; however, with the NPI not on the crosswalk, the Tax ID could not be verified. Please refer to edit C003 for more information for resolving this error.

6. C003 Billing NPI Not on Crosswalk

The edit C003 indicates there is no link between the NPI that was submitted and a PTAN/NSC. Verify the PTAN/NSC has been entered on the NPPES Web site as Medicare NSC and/or the supplier's information at NPPES and the NSC has the same information to create a match. The following information needs to be verified:

For Individuals:

The Social Security number (SSN) and PTAN/NSC number entered with NPPES must match the SSN and PTAN/NSC number on file with the National Supplier Clearinghouse (NSC).

- If a match cannot be found, the SSN and Practice Address ZIP Code at NPPES must match the SSN and Practice Address ZIP Code at the NSC.

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T**COMMON ELECTRONIC DATA INTERCHANGE EDITS... (CONTINUED)**

- If the second match cannot be found, an active crosswalk record will not be created.

For Organizations:

- The Tax ID number (EIN), PTAN/NSC and Practice Address ZIP Code at NPES must match the EIN, PTAN/NSC and Practice Address ZIP Code at the NSC.
- If the match cannot be found, an active crosswalk record will not be created.

7. C095 Diagnosis Code Invalid – Pointer 1

The diagnosis code pointed to as the first relevant diagnosis on the claim was not valid for the date of service. This is usually, but not always, the first diagnosis code on the claim. Contact the DME MAC Jurisdiction where the claim would be processed based on the beneficiary state code for assistance with the diagnosis code entered.

8. 1001 Required Loop Not Found

This edit indicates a required loop was not found in the file received by CEDI. This typically occurs when loop 2420E (ordering provider info) is omitted as it is required on every charge line for Medicare DME. Contact your software vendor for assistance in resolving this edit.

9. 3001 Duplicate File Found – File Not Processed

This edit is received when a duplicate file has been submitted to CEDI. A duplicate file is determined by the following:

- Claim count
- Service line count
- Record count
- Total charge amount
- First and last patients listed in the claim file

To work around this edit, submitters should verify the following information with their vendors:

- If a single ST to SE envelope is being created per claim

OR

- If one ST to SE segment envelope is being created for the entire claim file.

If the first scenario outlined above is being created, please contact the CEDI Help Desk to ask if the record of the duplicate claims can be deleted. The original claims file itself will not be removed, only the data stored to compare future claim files for a duplicate submission. A resubmission of those claims can then be prepared and submitted.

If the second scenario outlined above is being created, either add or delete a claim from the claims file. A resubmission of the claims can then be prepared and submitted.

10. C044 Subscriber Primary ID Invalid

The patient's Medicare ID (HICN) is invalid. Verify the number on the patient's red, white, and blue Medicare card.

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http://www.ngscedi.com/outreach_materials/outreachindex.htm.

For questions regarding the edits, please contact the CEDI Help Desk at 866-311-9184 or by e-mail at ngs.cedihelpdesk@wellpoint.com.

For more information, visit the CMS Web site at:
http://www.cms.hhs.gov/MedicareProviderSupEnroll/04_InternetbasedPECOS.asp.

The NPPEs Web site can be accessed at
<https://npes.cms.hhs.gov/NPES/StaticForward.do?forward=static.npistart>.

**AETNA – REIMBURSEMENT CHANGE FOR MID-LEVEL PRACTITIONERS**

Beginning with services rendered on or after June 1, 2010 Aetna will pay 85% of the contracted rates for covered professional services that are rendered by mid-level practitioners.

This policy change **will apply** to:

- Nurse practitioners
- Physician assistants
- Certified nurse midwives
- Registered nurses

As of June 1, you will need to list the mid-level practitioner's name in the servicing provider field when you submit claims for services rendered by a mid-level practitioner.

This policy change **will not apply** to:

- Certified registered nurse anesthetists, registered nurse first assistants or behavioral health practitioners
- Claims billed with an assistant to surgery modifier
- Covered DME, orthotics, prosthetics, supplies, drugs, laboratory, radiology services and immunizations billed by a mid-level practitioner
- Medicare Private Fee-for-Service (non-network)
- Providers contracted through a third party or vendor

For more information, contact your network representative or visit www.aetna.com.



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QUALITY HEALTH FIRST PROGRAM (QHF)

Quality Health First Program (QHF) is a service of the Indiana Health Information Exchange. It is a non-profit corporation that combines clinical, claims and point-of care data to provide physicians with reports and alerts/reminders based on nationally endorsed quality measures. The measures include asthma treatment, children's health, diabetes care, heart health, mental health and women's health.

There are no costs to the physicians. Funding comes from participating health plans. In fact, participating health plans have agreed to provide compensation to physicians to participate and utilize QHF to improve care. The plans currently enrolled are Medicare, Medicaid, United Healthcare, Unified Group Services, Anthem and soon Cigna.

Currently, QHF is serving physicians in all of Indiana, including Primary Care, Internal Medicine, Pediatrics and OB/GYN. QHF has not expanded to include specialists, yet. They do have future plans to serve Cardiology (12/10), Endocrinology, and Oncology.

Quality Health First will train your staff on site. To register call (317) 644-1752 Toll free (800) 435-7343 or on the web at www.qualityhealthfirst.org



SEVERE WEATHER PREPAREDNESS WEEK IN INDIANA

Springtime in Indiana means the possibility of severe weather. Each year Governor Mitch Daniels proclaims a week in March as Severe Weather Preparedness Week. Typically one day in March is designated for a statewide test of communications systems and this will be conducted through two tornado drills, one in the morning and one in the evening. (As of printing this article, the specific day had not yet been identified.) Schools and businesses are encouraged to participate in the morning drill. Citizens are asked to review their plans and procedures at home if a tornado occurs by participating in the evening drill.

Severe weather occurs most often from April to July, but can occur at any time of the day or year. There is typically very little time to react in an actual tornado, so it is important to have a plan in mind. Be sure staff members know what to do if they are at work when a tornado hits.

**Please take this opportunity to review with staff your facility action plan for tornados which can be found in your Safety Manual under:
EOP: 5 RESPONSE: TORNADO – CODE GRAY.**





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Jan Hooker	621-1644
Kathy Mills	621-1889
Judy Odom	621-1645
Ann Silvia	621-9783
Michelle Trandel	621-9743

TPPECC

(Third Party Payer Enrollment
Credentialing Committee)

Darlene Gebhart	621-9312
Michelle Hayes	621-1647
Pat Schmitter	621-7187
Richard Tornes	621-9002
Kara Welch	621-1886

Regulatory Compliance

Brenda Chapelle	621-9782
Joanne Komari	621-9797
Beth Wilhelm	621-9751

IMPORTANT IMM SEMINARS AVAILABLE

Just a reminder:

- **BILLING AND COLLECTIONS 101 April 13 - June 15**

A series of 10 classes catered to your individual needs.
Attend the whole series or choose from any of the ten sessions.
\$650 for entire 10 weeks or choose any 10 @ \$75 per class
8:30am – 11:30 a.m.

- Contact Sue Gabriel for more information:
317-621-7197 or email sgabriel@ecomunity.com

ALSO AVAILABLE:

- **MEDICAID UPDATE**
2010 INDIANA HEALTH COVERAGE PROGRAMS UPDATE - April 6th

Presented by Maureen Hoffmeyer

9:00am – 4:30pm

\$125 per person

- Contact Sue Gabriel for more information:
317-621-7197 or email sgabriel@ecomunity.com



Do you have questions IMM can help with?

Please submit questions to be answered in a future IMM Insight Newsletter at:
<http://imm.ecomunity.com/>.



SOME HEALTHCARE RECOGNITION DATES FOR MARCH

National Colorectal Cancer Awareness Month

National Nutrition Month®

Save Your Vision Month

National Patient Safety Awareness Week 7th - 13th

National Poison Prevention Week 14th – 20th

Brain Awareness Week 15th – 21st

World Tuberculosis Day 24th

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