Indiana State Medical Association – Coalition Meeting
May 23, 2014

Coalition Topics

1. Due to the increased number of billing errors with new patients, please provide a reminder of when a patient is a new patient versus an established patient. CMS has released Medicare Learning Network (MLN) Matters article (MM8165) regarding the changes to the Common Working File (CWF).

WPS Medicare response: The "CMS Medicare Claims Processing Manual," Chapter 12, Section 30.6.7 provides that "Medicare interpret the phrase "new patient" to mean a patient who has not received any professional services, i.e., Evaluation and Management (E/M) service or other face-to-face service (e.g., surgical procedure) from the physician or physician group practice (same physician specialty) within the previous 3 years. For example, if a professional component of a previous procedure is billed in a 3 year time period, e.g., a lab interpretation is billed and no E/M service or other face-to-face service with the patient is performed, then this patient remains a new patient for the initial visit."

CMS has implemented changes to the CWF to prompt CMS contractors to validate there are not two new patient CPTs being paid within a three year period of time. If Medicare discovers that a new patient code has been paid more than one time in a 3-year period to the same physician, then Medicare contractors will consider this an overpayment and will take steps to recoup the payment. If the situation is detected prior to payment of a second claim, the second claim will be rejected. We have posted an article on our website, "New Patient Visits and Overpayments," regarding the national edits implemented by CMS and what providers can do if receiving one of these denials. The provider need not contact Medicare. The article identifies the steps providers can take to review records and evaluate whether the same physician or another physician for the same specialty in the same group (same tax ID) had previously billed a professional service for the patient. If a previous service is found, then the provider can resubmit the claim (within the one year filing limit) identifying the service as a subsequent E/M procedure code.

2. Recovery Auditor (RA) Program – what's happening?

WPS Medicare response: CMS is in the procurement process for the next round of Recovery Audit Program contracts. It is important that CMS transition down the current contracts so that the RAs can complete all outstanding claim reviews and other processes by the end date of the current contracts. In addition, a pause in operations will allow CMS to continue to refine and improve the Medicare Recovery Audit Program. Several years ago, CMS made substantial changes to improve the Medicare Recovery Audit program. CMS will continue to review and refine the process as necessary. For example, CMS is reviewing the Additional Documentation Request (ADR) limits, timeframes for review and communications between RAs and providers. CMS has proven it is committed to constantly improving the program and listening to feedback from providers and other stakeholders.

- 02/21/14 was the last day a Recovery Auditor could send a post payment Additional Documentation Request (ADR)
- 02/28/14 was the last day a Medicare Administrative Contractor (MAC) could send prepayment ADRs for the Recovery Auditory Prepayment Review Demonstration

- 06/01/14 is the last day a RA may send improper payment files to the MACs for adjustment.

Additional information is posted on CMS' RA Program Recent Updates web page. CMS will continue to update their website with more information on the procurement and awards as information is available. Providers should contact RAC@cms.hhs.gov for additional questions.

3. ICD-10 Update

WPS Medicare response: On April 1, 2014, the Protecting Access to Medicare Act of 2014 (PAMA) (Pub. L. No. 113-93) was enacted, which said that the Secretary may not adopt ICD-10 prior to October 1, 2015. Accordingly, the U.S. Department of Health and Human Services expects to release an interim final rule in the near future that will include a new compliance date that would require the use of ICD-10 beginning October 1, 2015. The rule will also require HIPAA covered entities to continue to use ICD-9-CM through September 30, 2015.

July ICD-10 End-to-End Testing Canceled: Additional Testing Planned for 2015 - CMS planned to conduct ICD-10 testing during the week of July 21 through 25, 2014, to give a sample group of providers the opportunity to participate in end-to-end testing with Medicare Administrative Contractors (MACs) and the Common Electronic Data Interchange (CEDI) contractor. The July testing has been canceled due to the ICD-10 implementation delay. Additional opportunities for end-to-end testing will be available in 2015.

4. Transitional Care Management (TCM)– Readmit During the 30 Day Period – How to Bill

WPS Medicare response: If the provider has provided some of the non-face-to-face and the face-to-face service, and the patient is then readmitted, providers have a choice in how to bill. They can include all services provided within the 30 days from the original discharge, including the time after the second discharge, into one TCM service. They would then bill on the 30th day from the original discharge. The second choice is to simply start again from the date of the second discharge. In this case, an E/M provided prior to the second hospitalization would be billed as an E/M and all the requirements for TCM would follow the second discharge (interactive contact within 2 days of the discharge and the face-to-face service within 7 or 14 days of the 30 days following discharge).

The WPS Medicare TCM on Demand Training web page includes links to an audio recording of a WPS Medicare teleconference, CMS MLN publications, CMS Frequently Asked Questions, and WPS Medicare prepared Questions and Answers.

5. Appeals – Amount in Controversy

WPS Medicare response: CMS Publication 100-04, Chapter 29, includes instructions for Appeals of Claims Decisions, including principles for determining amount in controversy. CMS has also published a flowchart that shows, for 2014, the 5 levels of appeal, the time limits for requesting appeals, and the minimum amount in controversy, when applicable.

Excerpted from Publication 100-04, Chapter 29:

250.2 - Principles for Determining Amount in Controversy

(Rev. 2729, Issued: 06-21-13, Effective: 07-23-13, Implementation: 07-23-13)

As part of the requirements for a hearing before an ALJ, a party to a proceeding must meet the AIC provisions at 42 CFR 405.1006, including the threshold amount, as adjusted, in accordance with 42 CFR 405.1006(b).
The AIC is computed as the actual amount charged the individual for the items and services in question, reduced by –
(a) Any Medicare payments already made or awarded for the items or services; and
(b) Any deductible and coinsurance amounts applicable in the particular case.

In such cases where payment is made for items or services under section 1879 of the Act or under 42 CFR 411.400 or the liability of the beneficiary is limited under 42CFR411.402, the AIC is computed as the amount that the beneficiary would have been charged for the items or services in question if those expenses were not paid under 42 CFR 411.400 or that the liability was not limited under 42 CFR 411.402, reduced by any deductible and coinsurance amounts applicable in the particular case.

After processing the reconsideration, the QIC shall send written notification to all parties. This notice shall include any information concerning the parties' rights to an ALJ hearing, including the applicable AIC requirements and aggregation provisions.

250.3 - Aggregation of Claims to Meet the Amount in Controversy

(Rev. 2729, Issued: 06-21-13, Effective: 07-23-13, Implementation: 07-23-13)

A party appealing a QIC reconsideration to the ALJ level that does not meet the AIC threshold requirements may, under certain circumstances, aggregate claims to meet the requirements set forth in 42 CFR 405.1006. Either an individual appellant or multiple appellants may aggregate two or more claims to meet the AIC requirements for an ALJ hearing if –
(a) The claims were previously reconsidered by a QIC;
(b) The request for ALJ hearing lists all of the claims to be aggregated and is filed within 60 days after receipt of all the reconsiderations being appealed; and
(c) The ALJ determines that the claims that a single appellant seeks to aggregate involve the delivery of similar or related services, or the claims that multiple appellants seek to aggregate involve common issues of law and fact. Part A and Part B claims may be combined to meet the AIC requirements.

In cases where claims are escalated from the QIC level to the ALJ level (if parties have met all other requirements), aggregating claims may proceed under certain circumstances. Either an individual appellant or multiple appellants may aggregate two or more claims to meet the AIC for an ALJ hearing if –
(a) The claims were pending before the QIC in conjunction with the same request for reconsideration;
(b) The appellant(s) requests aggregation of the claims to the ALJ level in the same request for escalation; and
(c) The ALJ determines that the claims that a single appellant seeks to aggregate involve the delivery of similar or related services, or the claims that multiple appellants seek to aggregate involve common issues of law and fact. Part A and Part B claims may be combined to meet the AIC requirements.

When the appellant(s) seeks to aggregate claims in a request for an ALJ hearing, the appellant(s) must-

(a) Specify all of the claims the appellant(s) seeks to aggregate; and
(b) State why the appellant(s) believes that the claims involve common issues of law and fact or delivery of similar or related services.
WPS Medicare recently published an Appeals Navigator on our website. It is a new tool to help guide you to the correct Appeals form and department by asking a series of questions about your request based on your specific issue. Usage of the correct form and submission to the correct department will enhance and expedite the processing of your request. All Appeals forms are available on our website under the Forms tab, or you may link directly to them from the Appeals Navigator.

WPS Medicare Topics

1. ForeSee Website Satisfaction Survey

Please take some time to provide us with your valuable feedback on our website.

2. "Safe Harbor" Regulations

The Office of Inspector General has published safe harbor regulations that describe various payment and business practices that, although they potentially implicate the Federal anti-kickback statute, are not treated as offenses under the statute.

The OIG makes available on their website, "A Roadmap for New Physicians: Avoiding Medicare and Medicaid Fraud and Abuse" which is a booklet for physicians' self-study. There's also a companion PowerPoint presentation and speaker note set to assist in the teaching of this material. These materials summarize the five main Federal fraud and abuse laws (the false Claims Act, the Anti-Kickback Statute, the Stark Law, the Exclusion Statute, and the Civil Monetary Penalties Law) and provides tips on how physicians should comply with these laws in their relationships with payers (e.g. the Medicare & Medicaid programs), vendors (e.g., drug biologic, and medical device companies), and fellow providers (e.g., hospitals, nursing homes, and physician colleagues).

3. Therapy Functional Reporting

CMS has made several system modifications in response to the many inquiries regarding Therapy Functional Reporting (THFR). These modifications were implemented on May 5 and we believe they are significantly reducing the number of THFR claim rejections. Providers who believe that their previous claims were erroneously returned for THFR issues should resubmit those claims for re-processing.

4. WPS Medicare Education Opportunities

WPS Medicare's live training event catalog is available from a link on our Live Event Training web page. Upcoming Indiana events include Through the Eyes of Medicare Reviewers in Greenwood on July 17, 2014, the day before the next Coalition meeting.

The next J8 Part B Ask the Contractor Teleconference is June 11, 2014 from 10:00 AM – 11:30 AM.

The next Medicare J8 Making the Most of the WPS Medicare Website webinar is June 23, 2014, from 3:00 PM – 4:30 PM ET.

On Demand training is available on our On Demand Training web page. A recent addition is the audio file and handout from our April 17, 2014 Anesthesia Services Teleconference.

5. Medicare Updates

Please refer to link provided in the Resource Document for the 05/23/14 ISMA – Coalition Meeting.