Medicare Part B - Current Updates
March 2014

Disclaimer

Every reasonable effort has been made to ensure the accuracy of this information. However, the provider has the ultimate responsibility for correct submission of claims. WPS Medicare bears no liability for the results or consequences of the misuse of this information. The official Medicare Program provisions are contained in the relevant laws, regulations, and rulings.

Single Point of Contact

On February 3, 2014, WPS Medicare implemented a single point of contact phone number to reach Customer Service, Part A Appeals, Part B Reopenings, Provider Enrollment or EDI. You will call a single number to reach any of these areas, and follow the prompts to be connected to the appropriate staff who will be able to assist you. **Please note: It is very important that you provide all information requested so you will be routed to the appropriate area.**

Iowa, Kansas, Missouri, and Nebraska

Call (866) 518-3285. For additional useful information on the changes, go to
http://www.wpsmedicare.com/j5macpartb/departments/customer_service/single-poc.shtml

Indiana and Michigan

Call (866) 234-7331. For additional useful information on the changes, go to
http://www.wpsmedicare.com/j8macpartb/departments/customer_service/single-poc.shtml

Comprehensive Error Rate Testing (CERT) Program

CMS uses the CERT program to measure and improve the quality and accuracy of Medicare claims submission, processing, and payment.

WPS Medicare uses the error rate information to ensure education will address and prevent the most common billing errors and claim denials.

CMS Comprehensive Error Rate Testing (CERT) Program web page
http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/CERT/index.html

Iowa, Kansas, Missouri, and Nebraska
http://www.wpsmedicare.com/j5macpartb/departments/cert/

Indiana and Michigan
http://www.wpsmedicare.com/j8macpartb/departments/cert/

ICD-10 Compliance Date is October 1, 2014

The October 1, 2014, ICD-10 compliance date is fast approaching. By now, you should be employing identified preparation strategies. For detailed timelines and checklists for activities that all providers need to carry out to prepare for ICD-10, visit the CMS ICD-10 web page at: http://www.cms.gov/Medicare/Coding/ICD10/index.html

You can also access an On-line Implementation Guide, designed especially for small and medium practices, large provider practices, small hospitals, and payers. These guides are available at: https://implementicd10.noblis.org/

To help WPS Medicare determine the readiness of our provider community for implementation of the ICD-10 codes, please complete a brief survey at: http://survey.constantcontact.com/survey/a07e8twefakhqqqm79v/a00uhqzjbk48/greeting

The survey is also posted on the ICD-10 page of the WPS Medicare website.

Iowa, Kansas, Missouri, and Nebraska
http://www.wpsmedicare.com/j5macpartb/claims/icd-10/

Michigan and Indiana
http://www.wpsmedicare.com/j8macpartb/claims/icd-10/

Revalidation of Medicare Provider Enrollment Information

Section 6401(a) of the Affordable Care Act established the requirement for providers and suppliers to revalidate their Medicare enrollment information under new enrollment screening criteria.

This requirement applies to providers and suppliers enrolled in Medicare prior to March 25, 2011. Providers and suppliers who submitted their Medicare enrollment on or after March 25, 2011, are not impacted.

Medicare Contractors will send out revalidation notices to the providers and suppliers by March 2015. Providers and suppliers **must wait to submit revalidation** until after they are asked to do so by their Medicare Contractors.

Get easy access to the revalidation process by scanning the Quick Response (QR) code with your smartphone or visit: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads//SE1126.pdf

Internet-based Provider Enrollment, Chain and Ownership System (PECOS)

Submit your Medicare Enrollment Application Using Internet-based PECOS
Do you need to enroll in the Medicare program? Change or add a practice location? Or revalidate? PECOS is the fastest, easiest way to enroll in the Medicare program or update your Medicare enrollment record.

Get easy access to Internet-based PECOS by scanning the Quick Response (QR) code with your smartphone or visit: http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/InternetbasedPECOS.html

Internet-based PECOS Education Available

CMS has available an informative 14 page CMS publication (ICN 903767), entitled *"The Basics of Internet-based Provider Enrollment, Chain and Ownership System (PECOS) for Provider and Supplier Organizations"* to help you use internet-based PECOS. You can download it here: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedEnroll_PECOS_ProviderSup_FactSheet_ICN903767.pdf

CMS has available an informative 12 page CMS publication (ICN 903764), entitled *"The Basics of Internet-based Provider Enrollment, Chain and Ownership System (PECOS) for Physicians and Non-Physician Practitioners"* to help you use internet-based PECOS. You can download it here: http://www.cms.gov/outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedEnroll_Pecos_PhysNonPhys_FactSheet_ICN903764.pdf

eNews

WPS Medicare sends out a bi-weekly eNews. The eNews sent on Monday contains the most current and vital information Medicare providers need to know. This weekly eNews contains policy updates, all current Medicare information, and changes as they happen. A second eNews is sent out on Wednesday containing educational opportunities. To sign up, visit the WPS Medicare website and select “eNews” in the upper right corner. We encourage all individuals at a provider’s office to subscribe, as there are no restrictions on how many individuals can subscribe.

Get easy access to the sign-up website by scanning the Quick Response (QR) code above with your smartphone or visit: http://corp-ws.wpsic.com/apps/commercial/unauth/medicareListservUserWelcomeLoadAction.do

Sign up for Medicare Learning Network

The Medicare Learning Network® (MLN) is the brand name for official Centers for Medicare & Medicaid Services' national provider educational products. These products are designed to share up-to-date educational information and accompany the release of new or revised Medicare program policies. These educational tools are available through various mechanisms such as National Educational Articles, Brochures, Fact Sheets, Web-Based Training Courses, Videos and Podcasts.

For more details, please visit:
http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/index.html

CMS Secure Net Access Portal (C-SNAP)

For C-SNAP Technical Support assistance, please reference the C-SNAP On Demand trainings listed below. The training may provide you with the answer to your question. Also, review our new feature "Help Center."

Iowa, Kansas, Missouri, and Nebraska
http://www.wpsmedicare.com/j5macpartb/training/on_demand/csnap-od.shtml

Indiana and Michigan
http://www.wpsmedicare.com/j8macpartb/training/on_demand/csnap-od.shtml

If you have questions that cannot be resolved after reviewing the C-SNAP On Demand Training, please contact Medicare Customer Service at: http://www.wpsmedicare.com/contact.shtml

Get easy Access to C-SNAP by scanning the Quick Response (QR) code above with your smartphone or visiting: http://medicareinfo.com

Customer Satisfaction Survey

WPS Medicare strives to continue to improve our website to meet our providers' needs. We use the ForeSee Customer Satisfaction Survey as a primary means to gather your feedback and input and gauge your satisfaction with our website. Please take time to complete the Website Satisfaction Survey that pops up when visiting the WPS Medicare website.

Medicare Quarterly Provider Compliance Newsletter

The Medicare Learning Network® (MLN) Products Provider Compliance page contains educational products that inform Medicare Fee-For-Service (FFS) providers about how to avoid common billing errors and other improper activities when dealing with the Medicare Program. Since 1996, the Centers for Medicare & Medicaid Services (CMS) have implemented several initiatives to prevent improper payments before a claim is processed and to identify and recoup improper payments after the claim is processed. The overall goal of CMS' claim review programs is to reduce payment error by identifying and addressing billing errors concerning coverage and coding made by providers.

To learn more, visit the CMS Provider Compliance page:
http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ProviderCompliance.html

Place of Service (POS) Coding Instructions - Revised and Clarified

CMS SE1104 revised and clarified POS coding instructions. Instructions are provided regarding the assignment of POS for all services paid under the Medicare Physician Fee Schedule and for certain services provided by independent labs. To learn more visit:

Internet - Only Manual (IOM) Publication 100-04, *Medicare Claims Process Manual*, Chapter 26, Sections 10.5 and 10.6
http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c26.pdf

Change Request (CR) 7631
http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads//R2679CP.pdf

MLN Matters Article (MM7631):
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7631.pdf

MLN Matters Article (SE 1104)
http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1104.pdf

WPS Medicare Resources Web Page

WPS Medicare offers a wide range of resources to assist providers. We regularly develop and improve our online resources to decrease providers' costs and time spent contacting WPS Medicare. Information regarding self-service tools is available 24 hours a day, 7 days a week, at a time most suitable to providers' schedules. The tools allow the user quick and easy access to the most current Medicare information.

Visit the WPS Medicare Resource Web Page:

Iowa, Kansas, Missouri, and Nebraska
http://www.wpsmedicare.com/j5macpartb/resources/

Indiana and Michigan
http://www.wpsmedicare.com/j8macpartb/resources/

Medicare Remit Easy Print (MREP)

Are you still receiving paper Remit Notices? MREP enables providers and suppliers to view and print 835 files, saves time and money, generates several useful reports, makes remittances easy to navigate and view**.**

Get easy Access to MREP by scanning the Quick Response (QR) code above with your smartphone or visiting the WPS Medicare website below.

Iowa, Kansas, Missouri, and Nebraska
http://www.wpsmedicare.com/j5macpartb/departments/edi_/mrep.shtml
For assistance, please contact the EDI department at (866) 503-9670

Indiana and Michigan
http://www.wpsmedicare.com/j8macpartb/departments/edi_/mrep.shtml
For assistance, please contact the EDI department at (866) 503-9670

CMS Fraud Prevention Training Modules for Providers

To help assist CMS in their efforts to prevent fraud and abuse, CMS created two fraud prevention training modules. Each module provides key information to health care practitioners and professionals on how they can be part of CMS' efforts to fight fraud and abuse.

The first module presents CMS' provider-focused fraud awareness and prevention initiatives that informs providers about how they can reduce the risk of fraud and abuse for their practices and patients. This module is located at: *http://www.medscape.org/viewarticle/764496*

The second module describes recent and on-going strategies that CMS has undertaken to detect and to prevent fraud and abuse in the Medicare and Medicaid programs. The goal of this module is to increase awareness amongst providers about the strategies CMS has undertaken

to detect and to prevent fraud and abuse in the Medicare and Medicaid programs. This module is located: *http://www.medscape.org/viewarticle/764791*

A total of 1.25 hours of continuing medical education (CME) credit can be earned for any Medscape user registered as a doctor or health care professional. Medscape accounts are free, and users do not have to be health care professionals to register for them. Registration is on the landing page of www.medscape.com.

Instructions for how to access these modules are as follows:

Step 1: Access the website: www.medscape.org. Medscape accounts are free of charge.

Step 2: Registration is on the upper right hand corner of the home page of www.medscape.org next to the log in field.

Step 3: To access the modules, first enter your membership log in information.

Step 4: To view the "Reducing Medicare and Medicaid Fraud and Abuse: Protecting Practices and Patients" module, use this link: http://www.medscape.org/viewarticle/764496

Step 5: To view the "How CMS Is Fighting Fraud: Major Program Integrity Initiatives" module, use this link: http://www.medscape.org/viewarticle/764791

For assistance, please contact the EDI department at (866) 503-9670

Medicare Incentive Programs

Incentive payments are available to eligible professionals who meet the eligibility and reporting requirements for each program. In 2014, eligible professionals may choose to participate in the following payment incentive programs.

1. Physician Quality Reporting System – Medicare eligible professionals who satisfactory report data on quality measures for covered professional services furnished to Medicare beneficiaries.

   Find more information on the Physician Quality Reporting System program on the CMS website: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html

2. Electronic Health Records (EHR) – Medicare eligible professionals, hospitals, and critical access hospitals for the "meaningful use" of certified EHR technology. Medicare eligible professionals may not earn incentives under the eRX and Electronic Health Records incentive programs at the same time.

Find more information on the EHR Incentive Program on the CMS website: http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html

Quality and Resource Use Reports (QRUR)

QRUR reports provide confidential information about the quality of care providers furnish, the resources they use to care for their Medicare-fee-for-service patients and provide comparative information so physicians can see their quality of care compared to physicians / practices in similar specialties.

The Program Year 2011 (PY2011) QRURs were available from late December 2012 - April 2013 to physicians practicing within a group of 25 or more eligible professionals within the nine states of California, Iowa, Illinois, Kansas, Michigan, Minnesota, Missouri, Nebraska, and Wisconsin. The 2011 reports are no longer available.

In mid-September 2013, CMS made available the PY 2012 QRURs for groups nationally that consisted of 25 or more eligible professionals. The implementation of the Value Based Modifier in 2015 will be based on a 2013 performance period and will impact medical practice groups rather than individual physicians. QRURs for individual physicians will not be produced in 2013.

Information regarding the QRUR, value-based modifier and the Physician Feedback Program can be found on the Physician Feedback Program page of the CMS website at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/index.html

Email questions about the physician feedback program to QRUR@cms.hhs.gov

CMS National Physician Payment Transparency Program: Open Payments Training Module for Providers

CMS has produced a training module called "Are You Ready for the National Physician Payment Transparency Program?" Accessible via Medscape (http://www.medscape.org/viewarticle/780900?src=cmsaca), and accredited by the Accreditation Council for Continuing Medical Education, physicians can receive a maximum of 1.00 AMA PRA Category 1 Credit by participating in the activity and receiving a minimum score of 70% on the post-test. Through the activity, participants will learn more about OPEN PAYMENTS, the steps involved in collecting and reporting physician data, key dates for implementation, and actions they can take to verify their information in advance of website publication. Please note that this training is valid for credit through 3/26/14.

The module features Dr. Peter Budetti, Deputy Administrator and Director of the Center for Program Integrity and Dr. Shantanu Agrawal, Medical Director of the Center for Program Integrity and Director of the Data Sharing and Partnership Group.

Medscape accounts are free and users do not have to be health care professionals to register. Registration is on the landing page of http://www.medscape.com

CMS offers Free Mobile Applications (apps) to track payments under Open Payments

In July 2012, the Centers for Medicare & Medicaid Services (CMS) introduced two free mobile applications (apps) to help physicians and health care industry users track their payments and other transfers of value that applicable manufacturers and applicable Group Purchasing Organizations (GPOs) will report under Open Payments. Created by a provision of the Affordable Care Act, Open Payments creates greater public transparency about the financial transactions among physicians, teaching hospitals, and drug and device manufacturers.

These apps are available to facilitate accurate reporting of required information, which will be available to the public and will be published annually on the Open Payments website. The mobile apps allow both industry and physician users to track payments and other transfers of value in real-time. One app is targeted specifically to physicians (*Open Payments Mobile for Physicians*) and the other one is for industry, including applicable manufacturers and applicable GPOs (*Open Payments Mobile for Industry*).

The mobile applications can be downloaded and used easily and conveniently on a mobile device. Both apps are compatible with the iOS (Apple™) and Android platforms; they are available free through the iOS Apple™ Store and Google Play™ Store.

For more information on Open Payments and the mobile app, please see the program website at http://go.cms.gov/openpayments

For more information regarding the enhancements made to the mobile apps based upon user feedback, please use the MLN Matters article on the topic. The article can be found online at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1402.pdf.

Advance Beneficiary Notice of Noncoverage (ABN), FORM- R-131 Updates

Home Health Agency (HHA): As of December 9, 2013, Home Health Agencies (HHA) are required to use the Advance Beneficiary Notice of Noncoverage (ABN) CMS Form CMS-R-131 in certain situations. The Home Health Advance Beneficiary Notice of Noncoverage (HHABN) CMS Form CMS-R-296 will no longer be recognized for option 1. The CMS Internet-Only Manual (IOM) Publication 100-04, Chapter 30, Section 50.15.4 gives examples of when an ABN is required and how to complete it for HHAs.

Outpatient Therapy Services:

The American Taxpayer Relief Act (ATRA) provides liability protection for the beneficiary; therefore, providers will be required to give patients an ABN when services are over the Medicare Therapy Cap. CMS suggests using language similar to:

"You have met your physical therapy goals, and physical therapy is no longer medically necessary. Medicare doesn't pay for physical therapy services that aren't medically reasonable and necessary."

CMS doesn't require an ABN if the therapy service is medically necessary. In such a case, the provider should continue to append the KX modifier on claims submitted.

The CMS Internet-Only Manual (IOM) Publication 100-04, Chapter 30, Section 50.15.5 provides clarification on the use of the ABN for outpatient therapy services.

To find more information on using the ABN form, visit the CMS website:
http://cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c30.pdf

To Download the CMS-ABN-R-131 form and instructions:
http://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN.html

Reference the article "Advance Beneficiary Notice of Noncoverage (ABN)" found on the WPS Medicare website at:

Iowa, Kansas, Missouri, and Nebraska
http://www.wpsmedicare.com/j5macpartb/claims/submission/abn.shtml

Indiana and Michigan
http://www.wpsmedicare.com/j8macpartb/claims/submission/abn.shtml

2014 Appeals Amount in Controversy (AIC) Change

The 3rd and 5th level of the appeals process is affected by the AIC. The AIC is the dollar amount between what Medicare paid and what the provider expects to receive for the service. In 2014, the AIC for the 3rd level of appeal (Administrative Law Judge Hearing) did not change from $140 in 2013. The 5th level of appeal (Judicial Review in Federal District Court) was increased from $1400 in 2013 to $1430 in 2014. This AIC increase to $1430 is effective for appeals filed in Federal District Court on or after January 1, 2014.

To find more information regarding the Appeals process, visit the CMS website at:
http://www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/index.html

CMS Medicare Billing Certificate Program

Learn about the Medicare Program, master the specifics of billing for your provider type, and receive a certificate in Medicare billing from CMS for successful completion. Completion of the program includes: required web-based training courses and readings and a 75% or higher score on the post-assessment. To participate in either the Part A and/or Part B program, or browse the entire list of CMS prepared web-based training courses, refer to the Related Links posted on the CMS Web-Based Training (WBT) web page, located at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/WebBasedTraining.html

Manual Updates to Clarify Skilled Nursing Facility (SNF), Inpatient Rehabilitation Facility (IRF), Home Health (HH), and Outpatient (OPT) Coverage Pursuant to Jimmo vs. Sebelius

In accordance with the *Jimmo v. Sebelius* Settlement Agreement, the Centers for Medicare & Medicaid Services (CMS) has agreed to issue revised portions of the relevant program manuals used by Medicare contractors, in order to clarify that coverage of skilled nursing and skilled therapy services "…does not turn on the presence or absence of a beneficiary's potential for improvement, but rather on the beneficiary's need for skilled care." Skilled care may be necessary to improve a patient's current condition, to maintain the patient's current condition, or to prevent or slow further deterioration of the patient's condition. For more information, please see MLN Matters article MM 8458 at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8458.pdf

WPS Medicare Part B Quarterly CERT Error Findings Report

~INDIANA~

This report provides details of Comprehensive Error Rate Testing (CERT) errors assessed October 2013 through December 2013 for Indiana providers. The findings below are reported based on the type of error assessed by the CERT Contractor (e.g., insufficient documentation, incorrect coding, etc.).

Insufficient Documentation - 77% of total errors

Reasons for Errors:

- Provider billed the following: Drug Confirmation (each procedure), Benzodiazepines, Qualitative or Quantitative Urinalysis, Creatinine, Opiates, Qualitative Drug Screen, and Other than Chromatographic Drug Screen (G0431, G0434, 80102, 80154, 81005, 82570 and 83925). Missing the physician's order for the tests and or documentation supporting intent to order the tests; and the clinical records supporting the medical necessity of the tests. Documents received initially included the test results; and requisition which specified "…. Panel- Urine". No documentation was received after call to the ordering provider.
- Claim billed for drug confirmation, each procedure (2 units); benzodiazepines; methadone; and qualitative drug screen for date of service (G0431, 80102, 80154 and 83840). Missing the treating physicians order for or documentation to support the plan/intent to order the billed laboratory tests. Submitted documentation consists of test results and an unsigned test requisition form. Also received an authenticated office visit note that supports beneficiary with chronic pain in the legs, low back, and hip who is taking pain medication. Submitted documentation is insufficient to support services billed per LCD and Medicare requirements.
- Billed CPT 90838 - Psychotherapy services 60 minutes with patient and /or family when performed with E/M services. Missing the following: time spent in the psychotherapy encounter and the therapeutic maneuvers, such as behavior modification, supportive or interpretive interactions; development of a treatment plan to include type of therapy chosen and why, goals, and documentation that the client has the ability to participate and benefit from the selected therapy; and estimated duration of treatments. Requested additional documentation and received addendum to record that did not contain specific goals/treatment plan but a generalization of the session. Insufficient information to support the claim.

- Billed Psychotherapy, 30 minutes with patient and/or family member (CPT 90832) and Interactive complexity (CPT 90785). Missing clinical documentation to support the beneficiary will benefit from psychotherapy to include a treatment plan relevant for services billed. Initially submitted includes authenticated Behavioral Health Progress Note that documents a beneficiary with Alzheimer's who is oriented x1 who is doing pretty good; authenticated Psychiatry Consultation that documents a combative beneficiary with assessment of vascular dementia with psychotic features who is refusing to take all medications with a plan to hospitalize for 72 hours and giving injectable medications to get rid of psychosis in order to have the beneficiary comply with taking necessary medications for overall health (no mention of psychotherapy) . Documentation is insufficient to support this claim per the governing LCD and Medicare guidelines.
- Billed are therapeutic exercises (97110-GP for 3 units). Missing the authenticated documentation to support the therapy services billed. After follow-up request, received an altered SOAP note with the addition of the handwritten signature for the PT Assistant; b) initial evaluation by the physical therapist; and c) physician's certification of the plan of care signed & dated. Insufficient information. No signature attestation statement was submitted.
- Billing for Initial Observation Care (CPT 99220). Missing an attestation for submitted history and physical or electronic protocol to validate an electronic signature; in addition, missing the MD order for observation care. Received: Copy of the history and physical for the billed date of service that includes, “signature on file”. There is an entry with the physician’s name that includes a date and time stamp, but this is the same date and time for the dictation by this physician. Without a protocol, unable to determine if this is a valid electronic signature. Intent is used for diagnostic services only. Insufficient documentation to support services as billed.
- Billed nerve conductions studies and EMG (CPT 95908-26, 95886-26) missing clinical documentation from the treating physician to support the medical necessity of the billed services and the physician's intent to order the services as performed. Received requisition for services and signed report. Submitted documentation is insufficient to support the billed services per the governing LCD and Medicare guidelines.
- Billed for an Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report (CPT 93000-59). Missing a copy of the billed ECG with interpretation and report. Missing clinical documentation from the treating physician to support the medical necessity of the billed ECG and his intention to order it.
- Provider billed for a CBC with Automated Differential WBC Count (CPT 85025) and Basic Metabolic Panel (CPT 80048). Missing the physician’s order for the tests or documentation of intent to order the tests.
- Billed for vitamin B-12 level and homocysteine level (CPT 82607, 83090). Submitted documentation is missing the clinical documentation to support the medical necessity of testing. Submitted documentation included progress note that supports the treating physician's intent and the statement "daughter wants labs for anemia" without the clinical support of symptoms with a normal physical exam. Submitted documentation is insufficient to meet Medicare guidelines.

Incorrect Coding - 23% of total errors

Reasons for Errors:

- Submitted documentation supports CPT code 85027 (automated complete CBC), rather than CPT code 85025 (automated complete CBC and automated Differential WBC count) as billed. Physician's documented intent is for CBC only.
- Billed CPT 99204 (requires 3/3 key components; comprehensive history, comprehensive exam and moderate complexity medical decision making). Documentation supports code change to CPT 99203 with comprehensive history, detailed exam, and moderate MDM.
- Billed CPT 99205-new outpatient E/M Service requiring 3/3 components: Comprehensive history and Exam and High complexity MDM. Documentation supports a recode to 99204 also requiring 3/3 components: Comprehensive History & Exam, and Moderate MDM and meeting this level of service with 3/3 components.
- Billed 99223 (requires 3/3 key components; comprehensive history, comprehensive exam, and high complexity MDM). Documentation supports code change to 99222 with comprehensive history, comprehensive exam, and moderate MDM meeting 3/3 of the required key components.
- Billed CPT 99223. Documentation provided includes the signed, treating physician's History & Physical and supports code change to 99221 (requires 3/3 key components: detailed/comprehensive history, detailed/comprehensive exam, and straightforward/low complexity MDM). Documentation is of comprehensive history, detailed exam, and moderate MDM per 1995 E/M guidelines.
- Billed is CPT 99233 Subsequent hospital care E/M. This code requires 2 of 3 key components (detailed history, detailed exam and high complexity MDM). Submitted documentation supports code change from 99233 to 99232 which requires 2 of 3 key components (expanded history, expanded exam and moderate MDM). Documentation meets 99232 with (expanded history, comprehensive exam, and moderate MDM) per 1995 E/M guidelines.
- Billed CPT 99233. Submitted progress note supports code change to 99232 (requires 2 of 3: expanded history, expanded exam and moderate MDM). Documentation is of problem focused history, detailed exam, and moderate MDM per 1995 and problem focused history, expanded exam, and moderate MDM per 1997 E/M guidelines.

Based on CERT error findings for this quarter, below are educational resources that can assist in avoiding these issues in your practice.

<u>CMS Resources</u>

- **Provider Signature Requirements** - CMS Internet-Only Manual (IOM), Publication 100-08, Chapter 3, Section 3.3.2.4
- **Requirements for Ordering and Following Orders for Diagnostic Tests** - CMS IOM, Publication 100-02, Chapter 15, Section 80.6
- **Documentation Requirements for Billing Observation or Inpatient Care Services (Including Admission and Discharge Services**) – CMS IOM, Pub. 100-4, Chapter 12, section 30.6.8.C

WPS Medicare Resources

Local Coverage Determinations (LCDs) for:

- Nerve Conduction Studies and Electromyography
- Outpatient Rehabilitation Therapy Services
- Psychiatry and Psychology Services
- Qualitative Drug Testing
- Scanning Computerized Ophthalmic Diagnostic Imaging

Additional WPS Medicare web page resources:

- CERT Articles
- CERT Error Analysis
- Evaluation & Management Services (Under Resources, Provider Specialties/Services, Provider specialties)

March 21, 2014 Medicare Coalition – WPS Medicare Resources

New CMS 1500 Claim Form – Version 02/12

CMS Medicare Learning Network (MLN) Matters Number MM8509, "CMS 1500 Claim Form Instructions: Revised for Form Version 02/12"

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8509.pdf

Therapy – how to prevent denials

WPS Medicare Therapy Web Page

http://www.wpsmedicare.com/j8macpartb/resources/provider_types/therapy.shtml

WPS Medicare Outpatient Therapy Code Modifiers Fact Sheet

http://www.wpsmedicare.com/j8macpartb/resources/modifiers/therapymodifiers.shtml

WPS Medicare Billing Therapy Service On Demand Training

http://www.wpsmedicare.com/j8macpartb/training/on_demand/therapy-od.shtml

Claims Based Data Collection Requirements for Outpatient Therapy Services

http://www.wpsmedicare.com/j8macpartb/training/on_demand/_files/2013-0117-required-reporting-ot-services-handout.pdf

G-Code Short Descriptors

http://www.wpsmedicare.com/j8macpartb/training/on_demand/_files/2013-0117-gcode-short-descriptors-handout.pdf

CMS Internet-Only Manual Publication 100-02, Medicare Benefit Policy Manual, Chapter 15 (See Section 220 and 230)

http://cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf

Cerumen Removal Changes

CMS Physician Fee Schedule Relative Value Files

http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html

ICD-10 Update

CMS ICD-10 Web Page

http://www.cms.gov/Medicare/Coding/ICD10/index.html

CMS ICD-10 Implementation Guide (for small, medium, or large providers, hospitals, or payers)

https://implementicd10.noblis.org/

WPS Medicare ICD-10 Readiness Survey

http://survey.constantcontact.com/survey/a07e8twefakhqqqm79v/a016ehsdmvlxq/greeting

Pre-op Clearance

WPS Medicare Article – "Coding Guidelines for General Coverage for Physicians Services"
http://www.wpsmedicare.com/j8macpartb/resources/provider_types/2009_0622_physervcoding.shtml

Reopenings/Redeterminations

WPS Medicare Article – "How to Request A Reopening"

http://www.wpsmedicare.com/j8macpartb/departments/appeals/b_reopening.shtml

WPS Medicare Reopening Calculator

http://www.wpsmedicare.com/j8macpartb/departments/appeals/reopening_calculators.shtml

WPS Medicare Article – "How to Appeal a Claim Determination"

http://www.wpsmedicare.com/j8macpartb/departments/appeals/b-appeal.shtml

WPS Medicare Appeals Forms

http://www.wpsmedicare.com/j8macpartb/forms/appeals/index.shtml

CMS Secure Net Access Portal (C-SNAP) Home Page

https://www.medicareinfo.com/apps/cms/home.do

C-SNAP Instructions – "Filing a Reopening through the Appeal Navigation Link"

https://wpshealth.custhelp.com/app/answers/detail/a_id/47

C-SNAP Instructions – "Filing a Redetermination through Claim Status"

https://wpshealth.custhelp.com/app/answers/detail/a_id/44

C-SNAP Instructions – "Filing a Redetermination through the Appeals Link"

https://wpshealth.custhelp.com/app/answers/detail/a_id/45

CMS Appeals Web Page

https://www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/index.html

Medicare Appeals Process Flowchart

https://wpshealth.custhelp.com/app/answers/detail/a_id/45

Modifier 22

CMS Internet-Only Manual Publication 100-04, Medicare Claims Processing Manual, Chapter 12 (Section 20.4.6 - Payment Due to Unusual Circumstances (Modifiers "-22" and "-52")

http://cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf

WPS Medicare Modifier 22 Fact Sheet

http://www.wpsmedicare.com/j8macpartb/resources/modifiers/modifier-22.shtml

WPS Medicare Article – "Clarification on the Use of Modifier 22"

http://www.wpsmedicare.com/j8macpartb/resources/modifiers/clarification-use_modifier22.shtml

WPS Medicare Article – "22 Modifier - Important Information for Billing and Documentation"

http://www.wpsmedicare.com/j8macpartb/resources/modifiers/modifier22-billing-documentation.shtml

Unlisted procedure codes (Not Otherwise Classified (NOC) codes)

WPS Medicare Modifiers Web Page

http://www.wpsmedicare.com/j8macpartb/resources/modifiers/

Documentation

WPS Medicare CERT Web Page

http://www.wpsmedicare.com/j8macpartb/departments/cert/

CMS CERT Web Page

http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/CERT/index.html?redirect=/cert

CMS CERT Reports Web Page

http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/CERT/CERT-Reports.html

99211

WPS Medicare Article – "Low Level Evaluation and Management Services - CPT 99211"

http://www.wpsmedicare.com/j8macpartb/departments/cert/low-level-99211.shtml

March 21, 2014 Coalition

New CMS 1500 Claim Form – Version 02/12

How will the new change for item 17 will be reflected on the claim, such as the qualifiers DN, DK and DQ?

WPS Medicare response: CMS published Medicare Learning Network (MLN) Matters Number MM8509, entitled CMS 1500 Claim Form Instructions: Revised for Form Version 02/12. The revised form has a number of changes. Those most notable for Medicare are new indicators to differentiate between ICD-9 and ICD-10 codes on a claim, and qualifiers to identify whether certain providers are being identified as having performed an ordering, referring, or supervising role in the furnishing of the service. In addition, the revised form uses letters, instead of numbers, as diagnosis code pointers, and expands the number of possible diagnosis codes on a claim to 12.

The qualifiers that are appropriate for identifying an ordering, referring, or supervising role are as follows:

- DN – Referring Provider
- DK – Ordering Provider
- DQ – Supervising Provider

Providers should enter the qualifier to the left of the dotted vertical line on item 17.

Therapy – how to prevent denials

A quick tutorial is being requested on how to prevent denials and the use of the severity/complexity modifiers.

WPS Medicare response: The CMS requires three separate pieces of information (as appropriate) when a provider submits a claim for physical therapy, speech language pathology, or occupational therapy. These include the procedure code representing the actual service provided to the patient, a functional G status code to show the patient's functional status (when required by the timing of the service), and a severity/complexity modifier to show the patient's functional status. These three elements are required for specified therapy services, not just those services over the therapy cap limitation. For each claim, when required, there will be at least two functional G status codes submitted along with a severity/complexity modifier. There are two exceptions; when therapy services are billed under more than one plan of care (physical therapy, speech language pathology, or occupational therapy), or if the service is a one-time therapy visit. If you are not submitting all three pieces of information when required, Medicare will deny payment.

We have a dedicated Therapy web page; a central location for all therapy information coming from WPS Medicare. It's located at J8 MAC Part B>>Resources>>Provider Types>>Therapy

This web page also contains links to important CMS Resources. We have published modifier fact sheets on the outpatient therapy modifiers (GN, GO, GP or KX that is required for some services) and on therapy severity/complexity modifiers. You can also access a recording of a WPS Medicare

teleconference on the requirements for billing therapy services on our On-Demand Training web page. To view, refer to J8 MAC Part B>>Training>>On Demand>>Therapy On Demand Training

CMS has complete information on the correct billing of therapy services in the Internet-Only Manual (IOM) Publication 100-02, Chapter 15, Section 220 and 230.

Cerumen Removal Changes

2013 – CPT 69210 – Removal of impacted cerumen (separate procedure), 1 or both ears

2014 – CPT 69210 – Removal impacted cerumen requiring instrumentation, unilateral

WPS Medicare response: Based on the payment logic associated with the 2014 Relative Value File, Medicare payment for 69210 is based on bilateral indicator **2** (see CMS italicized verbiage below), even though the CPT description states that this is a unilateral service.

***2**=150% payment adjustment does not apply. RVUs are already based on the procedure being performed as a bilateral procedure. If the procedure is reported with modifier -50 or is reported twice on the same day by any other means (e.g., with RT and LT modifiers or with a 2 in the units field), base the payment for both sides on the lower of (a) the total actual charge by the physician for both sides, or (b) 100% of the fee schedule for a single code. Example: The fee schedule amount for code YYYYY is $125. The physician reports code YYYYY-LT with an actual charge of $100 and YYYYY-RT with an actual charge of $100. Payment should be based on the fee schedule amount ($125) since it is lower than the total actual charges for the left and right sides ($200).*

The RVUs are based on a bilateral procedure because (a) the code descriptor specifically states that the procedure is bilateral, (b) the code descriptor states that the procedure may be performed either unilaterally or bilaterally, or (c) the procedure is usually performed as a bilateral procedure

WPS Medicare B is currently denying CPT code 69210 when billed using Modifier 50, Modifier RT and/or LT, or when submitted with 2 units of service. The CMS Medically Unlikely Edits (MUEs) have this listed as allowing 1 service per day.

The correct billing of this service for Medicare purposes is with one unit of service and no Modifier 50 or RT/LT. Other types of submissions will be denied, based on the fact that the CPT code descriptor states "unilateral" and the RVU file indicators indicates payment is based on "bilateral" pricing methodologies.

Please make any needed changes to your billing methods. Previous claims denied for incorrect use of modifiers, or incorrect units of service can be submitted using one unit of service and not using the 50 or RT/LT modifiers. Should CMS make changes to the description, indicators, and/or MUEs on this service, WPS Medicare will publish additional information.

ICD-10 Update

No delay per CMS administrator Tavenner. When will there be testing for physicians?

WPS Medicare response: Testing was held the week of March 3, 2014 – March 7, 2014. Change Request 8465 instructed all Medicare MACs and the DME MACs CEDI contractor to implement an ICD-10 testing week with trading partners. The concept of trading partner testing was originally designed to validate the trading partners' ability to meet technical compliance and performance processing

standards during the HIPAA 5010 implementation. The ICD-10 testing week was created to generate awareness and interest and to instill confidence in the provider community that CMS and the MACs are ready and prepared for the ICD-10 implementation.

WPS Medicare and all other MAC contractors were required to report certain information to CMS, such as the number of trading partners conducting testing during the testing week, the percent of trading partners that conducted testing during the testing week (versus number of trading partners supported) by contract, the percent of test claims accepted versus rejected and any significant issues found during testing.

Please complete the ICD-10 Readiness Survey on the WPS Medicare website. It's located at J8 MAC Part B>>Claims>>ICD–10

Pre-op Clearance

Due to recent confusion could WPS provide us with a quick tutorial on the proper diagnosis order on claims?

WPS Medicare response: The following guidance is posted at J8 MAC Part B>> Resources>>Provider Types>>Coding Guidelines For General Coverage For Physicians Services
http://www.wpsmedicare.com/j8macpartb/resources/provider_types/2009_0622_physervcoding.shtml

Billing for Preoperative Examinations

1. List the appropriate ICD-9 code for the preoperative examination (V72.81 through V72.84). List in item 21 position 1. This is your primary diagnosis.
2. If available, list the ICD-9 codes for the condition(s) that prompted surgery and for conditions that prompted the preoperative medical evaluation (if any). List in item 21 position 2-4.
3. The ICD-9 code referenced in item 24e must be the primary reason for the preoperative examination.

Reopenings/Redeterminations

What is the difference between a reopening and a redetermination? What level of appeals can go through C-SNAP? Does the information provided from C-SNAP contain all the information that is needed to go the second level of appeals?

WPS Medicare response: The Clerical Error Reopening process allows providers to make a minor change to a previously filed claim, if the original claim has been denied or reduced. CMS provides the instructions for reopening activities conducted by MACs. Section 937 of the Medicare Modernization Act (MMA) required CMS to establish a process whereby providers, physicians, and suppliers could correct minor error or omissions outside of the appeals process.

CMS issued interim final regulations, which state that clerical errors (which CMS likens to MMA's minor errors or omissions), are defined as human or mechanical errors on the part of the party or the contractor. Examples of these appear in an article on our website, located at J8 MAC Part B>>Departments>>Appeals>>How To Request A Reopening

Clerical error reopenings can be done on the phone or in writing, and for provider minor errors, clerical errors, or omissions. The MAC reserves the right to refuse to adjust a claim as requested if it appears that such an adjustment would risk incorrect payment on any claims not identified for correction.

A provider, physician, or supplier may request a reopening up to one year from the receipt of the initial Remittance Notice. If the provider, physician, or supplier would like to request a reopening after the one-year time limit has expired, they may request the reopening in writing. Documentation supporting good cause to waive the timeliness requirement must be included.

Per CMS directives, WPS Medicare will not perform a "statistical reopening" to correct Medicare files when there is no payment differential unless the resulting correction would affect payment on another claim. Providers should document their files to show the change. If part of a medical review, the provider can use this documentation to appeal the denial.

Registered C-SNAP users can use C-SNAP to access Reopening forms and to file a Reopening through the Appeal Navigation Link.

The first level of appeal in the CMS formal appeals process is the Redetermination. Part B providers and beneficiaries have 120 days to file a request for a Redetermination from the date of receipt of the remittance notice or Medicare Summary Notice (MSN). There is no minimum amount in controversy.

Registered C-SNAP users can use C-SNAP to access Redetermination forms and to File a Redetermination through the Claim Status Link or to File a Redetermination through the Appeals Link. When a Redetermination is completed, the decision letter is sent to the registered C-SNAP user that requested the Redetermination. The letter can be printed and used to submit with a request for Reconsideration, if needed. Reconsideration is the second level in the CMS appeals process. That level of appeal is performed by the Qualified Independent Contractor (QIC), not by WPS Medicare.

Modifier 22

Although the modifier 22 fact sheet if very helpful, confusion continues on the proper use of modifier 22 and how additional payment is determined.

WPS Medicare response: The following is excerpted from CMS Internet-Only Manual Publication 100-04, Medicare Claims Processing Manual, Chapter 12:

20.4.6 - Payment Due to Unusual Circumstances (Modifiers "-22" and "-52")

(Rev. 1, 10-01-03)

B3-15028

The fees for services represent the average work effort and practice expenses required to provide a service. For any given procedure code, there could typically be a range of work effort or practice expense required to provide the service. Thus, carriers may increase or decrease the payment for a service only under very unusual circumstances based upon review of medical records and other documentation.

The 22 modifier reports work required to provide a service that is substantially greater than the work typically required and the surgeon is unable to report a secondary code that would claim the additional work. The use of specialized technology (for example, a laparoscope or laser) does not automatically

qualify for use of Modifier 22. Documentation must demonstrate the substantial additional work and the reason for the additional work. Abuse of modifier 22 may attract unwanted scrutiny. Repeated misuse could trigger an audit.

Providers need be cognizant that submitting documentation does not guarantee additional reimbursement. It does ensure that Medicare medical staff will review the documentation and will be able to make a decision using Medicare guidelines.

Unlisted procedure codes (Not Otherwise Classified (NOC) codes)

A reminder is needed that it is inappropriate to use modifiers with unlisted procedure codes.

WPS Medicare response: The purpose of an NOC code is to report services having absolutely no existing true code. The purpose of a modifier is to add information or change the description of the reported service. Appending a modifier is done to improve accuracy or specificity for the reported service. When there is no true code, it is not appropriate to use a modifier to change the description of service, since no description exists.

As a reminder, you can find several Modifier Fact Sheets, including tips for appropriate modifier use, on the WPS Medicare website. Please refer to J8 MAC Part B>>Resources>>Modifiers

Documentation

WPS Medicare response: Documentation continues to be the number one category of CERT errors assessed for J8. Please refer to the handout with details of Indiana Part B CERT errors assessed for October 2013 through December 2013. The findings in the report are based on the type of error assessed by the CERT contractor, with 77% of total errors in 4th Quarter of 2013 attributed to insufficient documentation.

For additional CERT education, please refer to our CERT web page, located at J8 MAC Part B>>Departments>>Comprehensive Error Rate Testing (CERT)

99211

There have been an increased number of questions regarding the use of 99211, specifically, when using the 81000 series of codes for urinalysis. If all you are doing is the urine test, can you bill 99211? According to the 99211 fact sheet, the 99211 is not allowed. Please verify the use of this code.

WPS Medicare response: Services billed to Medicare under CPT code 99211 must be reasonable and necessary for the diagnosis and treatment of an illness or injury. Furthermore, a face-to-face patient encounter with elements of both evaluation and management is required. The evaluation portion is substantiated when the record includes documentation of a clinically relevant and necessary exchange of information between provider and patient. The management portion is substantiated when the record demonstrates an influence on patient care (ex., medical decision making, patient education, etc.).

CPT 99211 should not be used for:

- Phone calls to patients
- Drawing of blood for laboratory analysis or when performing other diagnostic tests
- Administration of medications when an injection or infusion code is submitted separately

Our website includes several educational publications on 99211. To find these, search “99211.”

March 21, 2014 Coalition

New CMS 1500 Claim Form – Version 02/12

How will the new change for item 17 will be reflected on the claim, such as the qualifiers DN, DK and DQ?

WPS Medicare response: CMS published Medicare Learning Network (MLN) Matters Number MM8509, entitled CMS 1500 Claim Form Instructions: Revised for Form Version 02/12. The revised form has a number of changes. Those most notable for Medicare are new indicators to differentiate between ICD-9 and ICD-10 codes on a claim, and qualifiers to identify whether certain providers are being identified as having performed an ordering, referring, or supervising role in the furnishing of the service. In addition, the revised form uses letters, instead of numbers, as diagnosis code pointers, and expands the number of possible diagnosis codes on a claim to 12.

The qualifiers that are appropriate for identifying an ordering, referring, or supervising role are as follows:

- DN – Referring Provider
- DK – Ordering Provider
- DQ – Supervising Provider

Providers should enter the qualifier to the left of the dotted vertical line on item 17.

Therapy – how to prevent denials

A quick tutorial is being requested on how to prevent denials and the use of the severity/complexity modifiers.

WPS Medicare response: The CMS requires three separate pieces of information (as appropriate) when a provider submits a claim for physical therapy, speech language pathology, or occupational therapy. These include the procedure code representing the actual service provided to the patient, a functional G status code to show the patient's functional status (when required by the timing of the service), and a severity/complexity modifier to show the patient's functional status. These three elements are required for specified therapy services, not just those services over the therapy cap limitation. For each claim, when required, there will be at least two functional G status codes submitted along with a severity/complexity modifier. There are two exceptions; when therapy services are billed under more than one plan of care (physical therapy, speech language pathology, or occupational therapy), or if the service is a one-time therapy visit. If you are not submitting all three pieces of information when required, Medicare will deny payment.

We have a dedicated Therapy web page; a central location for all therapy information coming from WPS Medicare. It's located at J8 MAC Part B>>Resources>>Provider Types>>Therapy

This web page also contains links to important CMS Resources. We have published modifier fact sheets on the outpatient therapy modifiers (GN, GO, GP or KX that is required for some services) and on therapy severity/complexity modifiers. You can also access a recording of a WPS Medicare

teleconference on the requirements for billing therapy services on our On-Demand Training web page. To view, refer to J8 MAC Part B>>Training>>On Demand>>Therapy On Demand Training

CMS has complete information on the correct billing of therapy services in the Internet-Only Manual (IOM) Publication 100-02, Chapter 15, Section 220 and 230.

Cerumen Removal Changes

2013 – CPT 69210 – Removal of impacted cerumen (separate procedure), 1 or both ears

2014 – CPT 69210 – Removal impacted cerumen requiring instrumentation, unilateral

WPS Medicare response: Based on the payment logic associated with the 2014 Relative Value File, Medicare payment for 69210 is based on bilateral indicator **2** (see CMS italicized verbiage below), even though the CPT description states that this is a unilateral service.

***2**=150% payment adjustment does not apply. RVUs are already based on the procedure being performed as a bilateral procedure. If the procedure is reported with modifier -50 or is reported twice on the same day by any other means (e.g., with RT and LT modifiers or with a 2 in the units field), base the payment for both sides on the lower of (a) the total actual charge by the physician for both sides, or (b) 100% of the fee schedule for a single code. Example: The fee schedule amount for code YYYYY is $125. The physician reports code YYYYY-LT with an actual charge of $100 and YYYYY-RT with an actual charge of $100. Payment should be based on the fee schedule amount ($125) since it is lower than the total actual charges for the left and right sides ($200).*

The RVUs are based on a bilateral procedure because (a) the code descriptor specifically states that the procedure is bilateral, (b) the code descriptor states that the procedure may be performed either unilaterally or bilaterally, or (c) the procedure is usually performed as a bilateral procedure

WPS Medicare B is currently denying CPT code 69210 when billed using Modifier 50, Modifier RT and/or LT, or when submitted with 2 units of service. The CMS Medically Unlikely Edits (MUEs) have this listed as allowing 1 service per day.

The correct billing of this service for Medicare purposes is with one unit of service and no Modifier 50 or RT/LT. Other types of submissions will be denied, based on the fact that the CPT code descriptor states "unilateral" and the RVU file indicators indicates payment is based on "bilateral" pricing methodologies.

Please make any needed changes to your billing methods. Previous claims denied for incorrect use of modifiers, or incorrect units of service can be submitted using one unit of service and not using the 50 or RT/LT modifiers. Should CMS make changes to the description, indicators, and/or MUEs on this service, WPS Medicare will publish additional information.

ICD-10 Update

No delay per CMS administrator Tavenner. When will there be testing for physicians?

WPS Medicare response: Testing was held the week of March 3, 2014 – March 7, 2014. Change Request 8465 instructed all Medicare MACs and the DME MACs CEDI contractor to implement an ICD-10 testing week with trading partners. The concept of trading partner testing was originally designed to validate the trading partners' ability to meet technical compliance and performance processing

standards during the HIPAA 5010 implementation. The ICD-10 testing week was created to generate awareness and interest and to instill confidence in the provider community that CMS and the MACs are ready and prepared for the ICD-10 implementation.

WPS Medicare and all other MAC contractors were required to report certain information to CMS, such as the number of trading partners conducting testing during the testing week, the percent of trading partners that conducted testing during the testing week (versus number of trading partners supported) by contract, the percent of test claims accepted versus rejected and any significant issues found during testing.

Please complete the ICD-10 Readiness Survey on the WPS Medicare website. It's located at J8 MAC Part B>>Claims>>ICD–10

Pre-op Clearance

Due to recent confusion could WPS provide us with a quick tutorial on the proper diagnosis order on claims?

WPS Medicare response: The following guidance is posted at J8 MAC Part B>> Resources>>Provider Types>>Coding Guidelines For General Coverage For Physicians Services
http://www.wpsmedicare.com/j8macpartb/resources/provider_types/2009_0622_physervcoding.shtml

Billing for Preoperative Examinations

1. List the appropriate ICD-9 code for the preoperative examination (V72.81 through V72.84). List in item 21 position 1. This is your primary diagnosis.
2. If available, list the ICD-9 codes for the condition(s) that prompted surgery and for conditions that prompted the preoperative medical evaluation (if any). List in item 21 position 2-4.
3. The ICD-9 code referenced in item 24e must be the primary reason for the preoperative examination.

Reopenings/Redeterminations

What is the difference between a reopening and a redetermination? What level of appeals can go through C-SNAP? Does the information provided from C-SNAP contain all the information that is needed to go the second level of appeals?

WPS Medicare response: The Clerical Error Reopening process allows providers to make a minor change to a previously filed claim, if the original claim has been denied or reduced. CMS provides the instructions for reopening activities conducted by MACs. Section 937 of the Medicare Modernization Act (MMA) required CMS to establish a process whereby providers, physicians, and suppliers could correct minor error or omissions outside of the appeals process.

CMS issued interim final regulations, which state that clerical errors (which CMS likens to MMA's minor errors or omissions), are defined as human or mechanical errors on the part of the party or the contractor. Examples of these appear in an article on our website, located at J8 MAC Part B>>Departments>>Appeals>>How To Request A Reopening

Clerical error reopenings can be done on the phone or in writing, and for provider minor errors, clerical errors, or omissions. The MAC reserves the right to refuse to adjust a claim as requested if it appears that such an adjustment would risk incorrect payment on any claims not identified for correction.

A provider, physician, or supplier may request a reopening up to one year from the receipt of the initial Remittance Notice. If the provider, physician, or supplier would like to request a reopening after the one-year time limit has expired, they may request the reopening in writing. Documentation supporting good cause to waive the timeliness requirement must be included.

Per CMS directives, WPS Medicare will not perform a "statistical reopening" to correct Medicare files when there is no payment differential unless the resulting correction would affect payment on another claim. Providers should document their files to show the change. If part of a medical review, the provider can use this documentation to appeal the denial.

Registered C-SNAP users can use C-SNAP to access Reopening forms and to file a Reopening through the Appeal Navigation Link.

The first level of appeal in the CMS formal appeals process is the Redetermination. Part B providers and beneficiaries have 120 days to file a request for a Redetermination from the date of receipt of the remittance notice or Medicare Summary Notice (MSN). There is no minimum amount in controversy.

Registered C-SNAP users can use C-SNAP to access Redetermination forms and to File a Redetermination through the Claim Status Link or to File a Redetermination through the Appeals Link. When a Redetermination is completed, the decision letter is sent to the registered C-SNAP user that requested the Redetermination. The letter can be printed and used to submit with a request for Reconsideration, if needed. Reconsideration is the second level in the CMS appeals process. That level of appeal is performed by the Qualified Independent Contractor (QIC), not by WPS Medicare.

Modifier 22

Although the modifier 22 fact sheet if very helpful, confusion continues on the proper use of modifier 22 and how additional payment is determined.

WPS Medicare response: The following is excerpted from CMS Internet-Only Manual Publication 100-04, Medicare Claims Processing Manual, Chapter 12:

20.4.6 - Payment Due to Unusual Circumstances (Modifiers "-22" and "-52")

(Rev. 1, 10-01-03)

B3-15028

The fees for services represent the average work effort and practice expenses required to provide a service. For any given procedure code, there could typically be a range of work effort or practice expense required to provide the service. Thus, carriers may increase or decrease the payment for a service only under very unusual circumstances based upon review of medical records and other documentation.

The 22 modifier reports work required to provide a service that is substantially greater than the work typically required and the surgeon is unable to report a secondary code that would claim the additional work. The use of specialized technology (for example, a laparoscope or laser) does not automatically

qualify for use of Modifier 22. Documentation must demonstrate the substantial additional work and the reason for the additional work. Abuse of modifier 22 may attract unwanted scrutiny. Repeated misuse could trigger an audit.

Providers need be cognizant that submitting documentation does not guarantee additional reimbursement. It does ensure that Medicare medical staff will review the documentation and will be able to make a decision using Medicare guidelines.

Unlisted procedure codes (Not Otherwise Classified (NOC) codes)

A reminder is needed that it is inappropriate to use modifiers with unlisted procedure codes.

WPS Medicare response: The purpose of an NOC code is to report services having absolutely no existing true code. The purpose of a modifier is to add information or change the description of the reported service. Appending a modifier is done to improve accuracy or specificity for the reported service. When there is no true code, it is not appropriate to use a modifier to change the description of service, since no description exists.

As a reminder, you can find several Modifier Fact Sheets, including tips for appropriate modifier use, on the WPS Medicare website. Please refer to J8 MAC Part B>>Resources>>Modifiers

Documentation

WPS Medicare response: Documentation continues to be the number one category of CERT errors assessed for J8. Please refer to the handout with details of Indiana Part B CERT errors assessed for October 2013 through December 2013. The findings in the report are based on the type of error assessed by the CERT contractor, with 77% of total errors in 4th Quarter of 2013 attributed to insufficient documentation.

For additional CERT education, please refer to our CERT web page, located at J8 MAC Part B>>Departments>>Comprehensive Error Rate Testing (CERT)

99211

There have been an increased number of questions regarding the use of 99211, specifically, when using the 81000 series of codes for urinalysis. If all you are doing is the urine test, can you bill 99211? According to the 99211 fact sheet, the 99211 is not allowed. Please verify the use of this code.

WPS Medicare response: Services billed to Medicare under CPT code 99211 must be reasonable and necessary for the diagnosis and treatment of an illness or injury. Furthermore, a face-to-face patient encounter with elements of both evaluation and management is required. The evaluation portion is substantiated when the record includes documentation of a clinically relevant and necessary exchange of information between provider and patient. The management portion is substantiated when the record demonstrates an influence on patient care (ex., medical decision making, patient education, etc.).

CPT 99211 should not be used for:

- Phone calls to patients
- Drawing of blood for laboratory analysis or when performing other diagnostic tests
- Administration of medications when an injection or infusion code is submitted separately

Our website includes several educational publications on 99211. To find these, search “99211.”

March 21, 2014 Coalition

New CMS 1500 Claim Form – Version 02/12

How will the new change for item 17 will be reflected on the claim, such as the qualifiers DN, DK and DQ?

WPS Medicare response: CMS published Medicare Learning Network (MLN) Matters Number MM8509, entitled CMS 1500 Claim Form Instructions: Revised for Form Version 02/12. The revised form has a number of changes. Those most notable for Medicare are new indicators to differentiate between ICD-9 and ICD-10 codes on a claim, and qualifiers to identify whether certain providers are being identified as having performed an ordering, referring, or supervising role in the furnishing of the service. In addition, the revised form uses letters, instead of numbers, as diagnosis code pointers, and expands the number of possible diagnosis codes on a claim to 12.

The qualifiers that are appropriate for identifying an ordering, referring, or supervising role are as follows:

- DN – Referring Provider
- DK – Ordering Provider
- DQ – Supervising Provider

Providers should enter the qualifier to the left of the dotted vertical line on item 17.

Therapy – how to prevent denials

A quick tutorial is being requested on how to prevent denials and the use of the severity/complexity modifiers.

WPS Medicare response: The CMS requires three separate pieces of information (as appropriate) when a provider submits a claim for physical therapy, speech language pathology, or occupational therapy. These include the procedure code representing the actual service provided to the patient, a functional G status code to show the patient's functional status (when required by the timing of the service), and a severity/complexity modifier to show the patient's functional status. These three elements are required for specified therapy services, not just those services over the therapy cap limitation. For each claim, when required, there will be at least two functional G status codes submitted along with a severity/complexity modifier. There are two exceptions; when therapy services are billed under more than one plan of care (physical therapy, speech language pathology, or occupational therapy), or if the service is a one-time therapy visit. If you are not submitting all three pieces of information when required, Medicare will deny payment.

We have a dedicated Therapy web page; a central location for all therapy information coming from WPS Medicare. It's located at J8 MAC Part B>>Resources>>Provider Types>>Therapy

This web page also contains links to important CMS Resources. We have published modifier fact sheets on the outpatient therapy modifiers (GN, GO, GP or KX that is required for some services) and on therapy severity/complexity modifiers. You can also access a recording of a WPS Medicare

teleconference on the requirements for billing therapy services on our On-Demand Training web page. To view, refer to J8 MAC Part B>>Training>>On Demand>>Therapy On Demand Training

CMS has complete information on the correct billing of therapy services in the Internet-Only Manual (IOM) Publication 100-02, Chapter 15, Section 220 and 230.

Cerumen Removal Changes

2013 – CPT 69210 – Removal of impacted cerumen (separate procedure), 1 or both ears

2014 – CPT 69210 – Removal impacted cerumen requiring instrumentation, unilateral

WPS Medicare response: Based on the payment logic associated with the 2014 Relative Value File, Medicare payment for 69210 is based on bilateral indicator **2** (see CMS italicized verbiage below), even though the CPT description states that this is a unilateral service.

***2**=150% payment adjustment does not apply. RVUs are already based on the procedure being performed as a bilateral procedure. If the procedure is reported with modifier -50 or is reported twice on the same day by any other means (e.g., with RT and LT modifiers or with a 2 in the units field), base the payment for both sides on the lower of (a) the total actual charge by the physician for both sides, or (b) 100% of the fee schedule for a single code. Example: The fee schedule amount for code YYYYY is $125. The physician reports code YYYYY-LT with an actual charge of $100 and YYYYY-RT with an actual charge of $100. Payment should be based on the fee schedule amount ($125) since it is lower than the total actual charges for the left and right sides ($200).*

The RVUs are based on a bilateral procedure because (a) the code descriptor specifically states that the procedure is bilateral, (b) the code descriptor states that the procedure may be performed either unilaterally or bilaterally, or (c) the procedure is usually performed as a bilateral procedure

WPS Medicare B is currently denying CPT code 69210 when billed using Modifier 50, Modifier RT and/or LT, or when submitted with 2 units of service. The CMS Medically Unlikely Edits (MUEs) have this listed as allowing 1 service per day.

The correct billing of this service for Medicare purposes is with one unit of service and no Modifier 50 or RT/LT. Other types of submissions will be denied, based on the fact that the CPT code descriptor states "unilateral" and the RVU file indicators indicates payment is based on "bilateral" pricing methodologies.

Please make any needed changes to your billing methods. Previous claims denied for incorrect use of modifiers, or incorrect units of service can be submitted using one unit of service and not using the 50 or RT/LT modifiers. Should CMS make changes to the description, indicators, and/or MUEs on this service, WPS Medicare will publish additional information.

ICD-10 Update

No delay per CMS administrator Tavenner. When will there be testing for physicians?

WPS Medicare response: Testing was held the week of March 3, 2014 – March 7, 2014. Change Request 8465 instructed all Medicare MACs and the DME MACs CEDI contractor to implement an ICD-10 testing week with trading partners. The concept of trading partner testing was originally designed to validate the trading partners' ability to meet technical compliance and performance processing

standards during the HIPAA 5010 implementation. The ICD-10 testing week was created to generate awareness and interest and to instill confidence in the provider community that CMS and the MACs are ready and prepared for the ICD-10 implementation.

WPS Medicare and all other MAC contractors were required to report certain information to CMS, such as the number of trading partners conducting testing during the testing week, the percent of trading partners that conducted testing during the testing week (versus number of trading partners supported) by contract, the percent of test claims accepted versus rejected and any significant issues found during testing.

Please complete the ICD-10 Readiness Survey on the WPS Medicare website. It's located at J8 MAC Part B>>Claims>>ICD–10

Pre-op Clearance

Due to recent confusion could WPS provide us with a quick tutorial on the proper diagnosis order on claims?

WPS Medicare response: The following guidance is posted at J8 MAC Part B>> Resources>>Provider Types>>Coding Guidelines For General Coverage For Physicians Services
http://www.wpsmedicare.com/j8macpartb/resources/provider_types/2009_0622_physervcoding.shtml

Billing for Preoperative Examinations

1. List the appropriate ICD-9 code for the preoperative examination (V72.81 through V72.84). List in item 21 position 1. This is your primary diagnosis.
2. If available, list the ICD-9 codes for the condition(s) that prompted surgery and for conditions that prompted the preoperative medical evaluation (if any). List in item 21 position 2-4.
3. The ICD-9 code referenced in item 24e must be the primary reason for the preoperative examination.

Reopenings/Redeterminations

What is the difference between a reopening and a redetermination? What level of appeals can go through C-SNAP? Does the information provided from C-SNAP contain all the information that is needed to go the second level of appeals?

WPS Medicare response: The Clerical Error Reopening process allows providers to make a minor change to a previously filed claim, if the original claim has been denied or reduced. CMS provides the instructions for reopening activities conducted by MACs. Section 937 of the Medicare Modernization Act (MMA) required CMS to establish a process whereby providers, physicians, and suppliers could correct minor error or omissions outside of the appeals process.

CMS issued interim final regulations, which state that clerical errors (which CMS likens to MMA's minor errors or omissions), are defined as human or mechanical errors on the part of the party or the contractor. Examples of these appear in an article on our website, located at J8 MAC Part B>>Departments>>Appeals>>How To Request A Reopening

Clerical error reopenings can be done on the phone or in writing, and for provider minor errors, clerical errors, or omissions. The MAC reserves the right to refuse to adjust a claim as requested if it appears that such an adjustment would risk incorrect payment on any claims not identified for correction.

A provider, physician, or supplier may request a reopening up to one year from the receipt of the initial Remittance Notice. If the provider, physician, or supplier would like to request a reopening after the one-year time limit has expired, they may request the reopening in writing. Documentation supporting good cause to waive the timeliness requirement must be included.

Per CMS directives, WPS Medicare will not perform a "statistical reopening" to correct Medicare files when there is no payment differential unless the resulting correction would affect payment on another claim. Providers should document their files to show the change. If part of a medical review, the provider can use this documentation to appeal the denial.

Registered C-SNAP users can use C-SNAP to access Reopening forms and to file a Reopening through the Appeal Navigation Link.

The first level of appeal in the CMS formal appeals process is the Redetermination. Part B providers and beneficiaries have 120 days to file a request for a Redetermination from the date of receipt of the remittance notice or Medicare Summary Notice (MSN). There is no minimum amount in controversy.

Registered C-SNAP users can use C-SNAP to access Redetermination forms and to File a Redetermination through the Claim Status Link or to File a Redetermination through the Appeals Link. When a Redetermination is completed, the decision letter is sent to the registered C-SNAP user that requested the Redetermination. The letter can be printed and used to submit with a request for Reconsideration, if needed. Reconsideration is the second level in the CMS appeals process. That level of appeal is performed by the Qualified Independent Contractor (QIC), not by WPS Medicare.

Modifier 22

Although the modifier 22 fact sheet if very helpful, confusion continues on the proper use of modifier 22 and how additional payment is determined.

WPS Medicare response: The following is excerpted from CMS Internet-Only Manual Publication 100-04, Medicare Claims Processing Manual, Chapter 12:

20.4.6 - Payment Due to Unusual Circumstances (Modifiers "-22" and "-52")

(Rev. 1, 10-01-03)

B3-15028

The fees for services represent the average work effort and practice expenses required to provide a service. For any given procedure code, there could typically be a range of work effort or practice expense required to provide the service. Thus, carriers may increase or decrease the payment for a service only under very unusual circumstances based upon review of medical records and other documentation.

The 22 modifier reports work required to provide a service that is substantially greater than the work typically required and the surgeon is unable to report a secondary code that would claim the additional work. The use of specialized technology (for example, a laparoscope or laser) does not automatically

qualify for use of Modifier 22. Documentation must demonstrate the substantial additional work and the reason for the additional work. Abuse of modifier 22 may attract unwanted scrutiny. Repeated misuse could trigger an audit.

Providers need be cognizant that submitting documentation does not guarantee additional reimbursement. It does ensure that Medicare medical staff will review the documentation and will be able to make a decision using Medicare guidelines.

Unlisted procedure codes (Not Otherwise Classified (NOC) codes)

A reminder is needed that it is inappropriate to use modifiers with unlisted procedure codes.

WPS Medicare response: The purpose of an NOC code is to report services having absolutely no existing true code. The purpose of a modifier is to add information or change the description of the reported service. Appending a modifier is done to improve accuracy or specificity for the reported service. When there is no true code, it is not appropriate to use a modifier to change the description of service, since no description exists.

As a reminder, you can find several Modifier Fact Sheets, including tips for appropriate modifier use, on the WPS Medicare website. Please refer to J8 MAC Part B>>Resources>>Modifiers

Documentation

WPS Medicare response: Documentation continues to be the number one category of CERT errors assessed for J8. Please refer to the handout with details of Indiana Part B CERT errors assessed for October 2013 through December 2013. The findings in the report are based on the type of error assessed by the CERT contractor, with 77% of total errors in 4th Quarter of 2013 attributed to insufficient documentation.

For additional CERT education, please refer to our CERT web page, located at J8 MAC Part B>>Departments>>Comprehensive Error Rate Testing (CERT)

99211

There have been an increased number of questions regarding the use of 99211, specifically, when using the 81000 series of codes for urinalysis. If all you are doing is the urine test, can you bill 99211? According to the 99211 fact sheet, the 99211 is not allowed. Please verify the use of this code.

WPS Medicare response: Services billed to Medicare under CPT code 99211 must be reasonable and necessary for the diagnosis and treatment of an illness or injury. Furthermore, a face-to-face patient encounter with elements of both evaluation and management is required. The evaluation portion is substantiated when the record includes documentation of a clinically relevant and necessary exchange of information between provider and patient. The management portion is substantiated when the record demonstrates an influence on patient care (ex., medical decision making, patient education, etc.).

CPT 99211 should not be used for:

- Phone calls to patients
- Drawing of blood for laboratory analysis or when performing other diagnostic tests
- Administration of medications when an injection or infusion code is submitted separately

Our website includes several educational publications on 99211. To find these, search “99211.”