ISMA Coalition Meeting Agenda – March 22, 2013

Incident to
During an incident to visit with a non-physician practitioner what are WPS guidelines for changing from incident to into direct billing?

The basic instruction is that if the service does not meet the entire incident to guidelines, then it would be billed under the NPP's provider number. One of those requirements is that the service is provided under the plan of care of the treating physician. If the patient presents with a new problem, then the service would no longer be considered incident to. If the treating physician or a supervising physician within the same group is not in the office suite, then they would bill under the NPP number.

Colonoscopy
Will WPS be adding the diagnoses - right and left abdominal pain to their medical policy?

From the Policy department:
"No, we do not have any plans to add abdominal pain. In the past, someone had asked us about pain before and we had responded that abdominal pain by itself would not be an indication for a diagnostic colonoscopy. The patient would have additional signs or symptoms before a diagnostic test would be ordered."

You may wish to send in an LCD reconsideration request to policycomments@wpsic.com

Transitional Care Management (TCM)
Has the issue of TCM being paid only to nurse practitioner been resolved? According to the Federal Register these claims are to be paid to the physician and other qualified non-physician practitioners. Will there be mass adjustments for those claims not paid?
Also seeking clarification on how to bill if a patient is deceased before the 29 day?
What DOS to be billed?

CMS has a frequently asked question document on their website. The date of service is the 30th day. If the patient dies prior to the 30th day, TCM is not billed. The provider would instead bill for any face to face services using the appropriate CPT code. We are not aware of the CMS' intentions in regards to mass adjustments presently, nor their plan for reimbursing NPPs. You may wish to utilize the related FAQ section of the CMS website as indicated.

Here are some additional related notes from the CMS Open Door Forum, held March 12:

Transitional Care Management – There are some differences between the CPT guidelines and what is applicable for Medicare. Providers can perform these services for new patients. The required E/M service cannot be performed on the same day as a discharge management service billed by the same provider. The CPT states that the initial communication required within 2 business days can be stopped after two attempts. CMS says the attempts should continue until contact has been made. Providers cannot bill the G0181 or G0182 for the same time frame.

Clarification for Professional and Technical components performed on separate days

What date of service is to be used when the professional (26) and technical component (TC) are on separate days?

The professional service is reported using the date if was performed. If it is a different date from the TC, then the different date is reported. The reference is 100-04, Chapter 26.

Due to the sequestration beginning April 1st there will be 2% reduction in Medicare payments.

Will Medicare post a NEW fee schedule or will they just take it out on each patient on each claim? For instance will there be a reduction amount next to the payment, write off, etc? How will this be handled?

The Budget Control Act of 2011 requires, among other things, mandatory across-the-board reductions in Federal spending, also known as sequestration. The American Taxpayer Relief Act of 2012 postponed sequestration for 2 months. As required by law, President Obama issued a sequestration order on March 1, 2013. The Administration continues to urge Congress to take prompt action to address the current budget uncertainty and the economic hardships imposed by sequestration.

In general, Medicare FFS claims with dates-of-service or dates-of-discharge on or after April 1, 2013, will incur a 2 percent reduction in Medicare payment. Claims for durable medical equipment (DME), prosthetics, orthotics, and supplies, including claims under the DME Competitive Bidding Program, will be reduced by 2 percent based upon whether the date-of-service, or the start date for rental equipment or multi-day supplies, is on or after April 1, 2013.

The claims payment adjustment shall be applied to all claims **after determining coinsurance, any applicable deductible, and any applicable Medicare Secondary Payment adjustments**.

Though beneficiary payments for deductibles and coinsurance are not subject to the 2 percent payment reduction, Medicare's payment to beneficiaries for unassigned claims is subject to the 2 percent reduction. The Centers for Medicare & Medicaid Services encourages Medicare physicians, practitioners, and suppliers who bill claims on an unassigned basis to discuss with beneficiaries the impact of sequestration on Medicare's reimbursement.

As indicated above, we are hopeful that Congress will take action to eliminate the mandatory payment reductions.

To repeat from the information above, the most popular question at the moment is:

Question: Does the 2% payment reduction under sequestration apply to the payment rates reflected in Medicare fee-for-service fee schedules or does it only apply to the final payment amounts?

Answer: Payment adjustments required under sequestration are applied to all claims after determining the Medicare payment including application of the current fee schedule, coinsurance, any applicable deductible, and any applicable Medicare Secondary Payment adjustments. All fee schedules, Pricers, etc., are unchanged by sequestration; it's only the final payment amount that is reduced.

PQRS

We really need more information and clarification re: PQRS reporting for large groups of 100+ providers. We have read everything we have found but are still not clear as to the GPRO reporting and what the requirements are for HOW we have to file our PQRS claims and the entire GPRO reporting process. We have currently been sending our PQRS for each individual provider but are we now required to report as a group using registry? Also, we really aren't clear on the penalty in 2015 based on 2013 reporting using the VBM. We really aren't clear on the VBM and how it is calculated or what it is based on.

In order for a provider organization to submit and qualify as a group, they have to self-nominate and be selected by CMS. There is a document on the CMS website entitled GPRO made simple:

http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/2013_PQRSGPROMadeSimple_02012013.pdf

In addition, there is a document listing the requirements:

http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/2013_PQRS_GPRO_Requirements_v1-3.pdf

They would have to report either through a registry or a web based interface.

There is also a complete section on the GPRO you can access:

http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Group_Practice_Reporting_Option.html

POS

Education and open discussion is being requested for our physicians regarding the new POS service guidelines effective April 1, 2013 and the exception to the rule on the telephonic services such as pacemakers. Also we need clarification on when a physician provides an interpretation and report for a service that was provided to the patient in POS 22 outpatient clinic. It is the understanding that the POS used in item 24 would be POS 22 for the technical component (modifier TC) and the professional component (modifier 26). For the professional component reporting in item 32 or electronic equivalent, if the physician was at their home and rendered the interpretation and wrote the report will the report address and zip code of the office be in item 32 or electronic equivalent or the home where the service was actually provided? If it is to be reported as home, does the physician have to update their provider profile via 855 by adding the home address as a place where he physically rendered a service to the Medicare beneficiary? We believe item 32 required a 9 digit zip code, is this correct?

WPS Medicare will be hosting a teleconference on 3/21/13. The call in information is available on our website. If the physician regularly performs services from their home, then the home must be listed as a practice location via the 855. If providing services from their home is a rare event, they do not. If a rare event, they can use the office location in box 32. If a regular procedure, then the home address would be used. Item 32 does require a 9 digit zip code in some cases. As far as the information for the telephonic services such as pacemaker checks, defibrillator, home INR, home sleep studies, we have posed this question to CMS. The instruction for now from our medical directors, unless something changes, is to use the location of where the technical component is received. For example, the patient is in the home and transmits the pacemaker check, the transmission is received in the outpatient hospital, then the outpatient hospital POS is use for both the technical and professional. If CMS says differently, we will publish.

Modifier 25
On the WPS website there is a modifier 25 fact sheet.
http://www.wpsmedicare.com/j5macpartb/resources/modifiers/modifier-25.shtml
I believe an open discussion on modifier 25 is needed to help clear up some confusion.

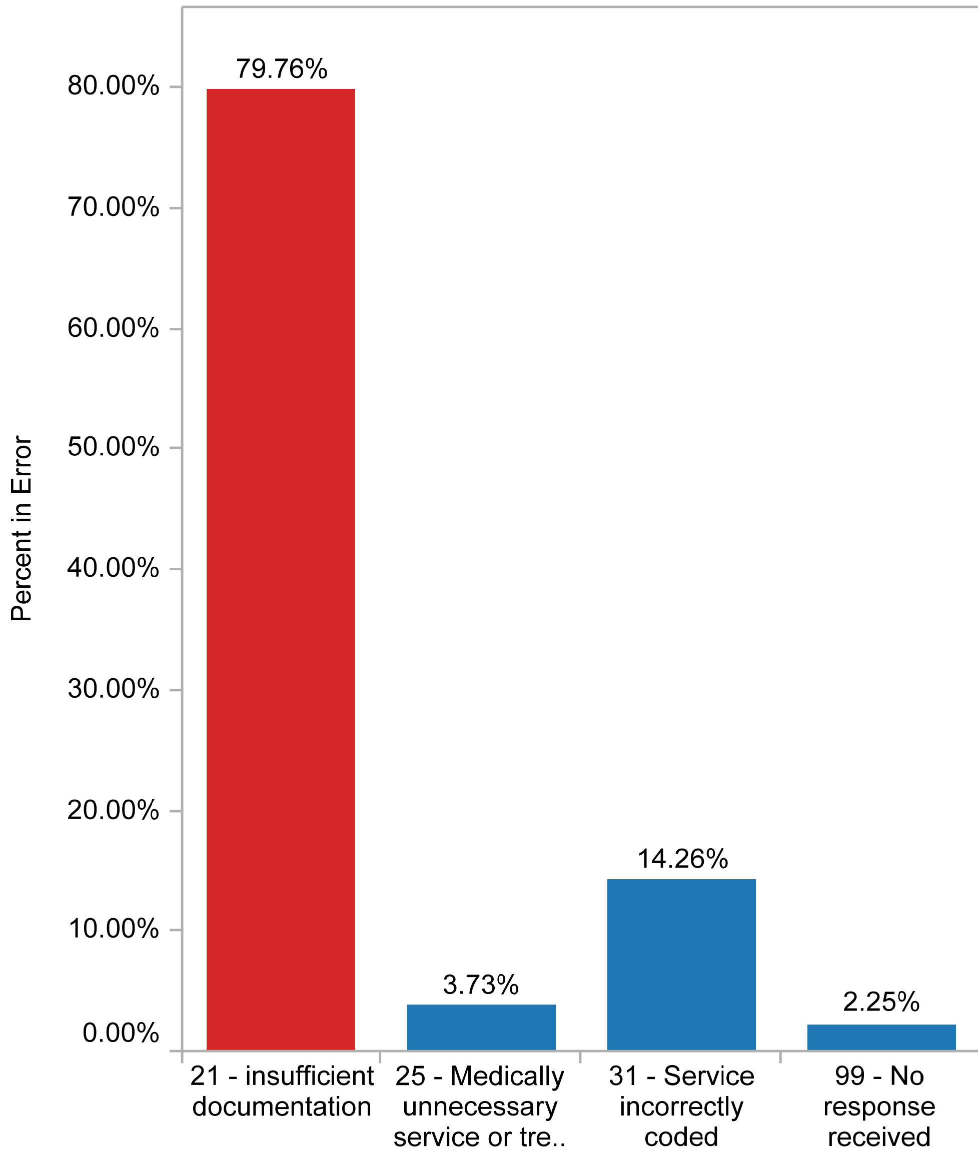
In addition to the modifier 25 fact sheet, we have On Demand training specifically on Modifier 25 at the following:

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

WPS Medicare Comprehensive Error Rate Testing (CERT)
Indiana
Findings by Error Type

Claim Submission Dates: 01/01/2011 - 12/31/2011

Indiana
Percent of Dollars in Error by Type of Error

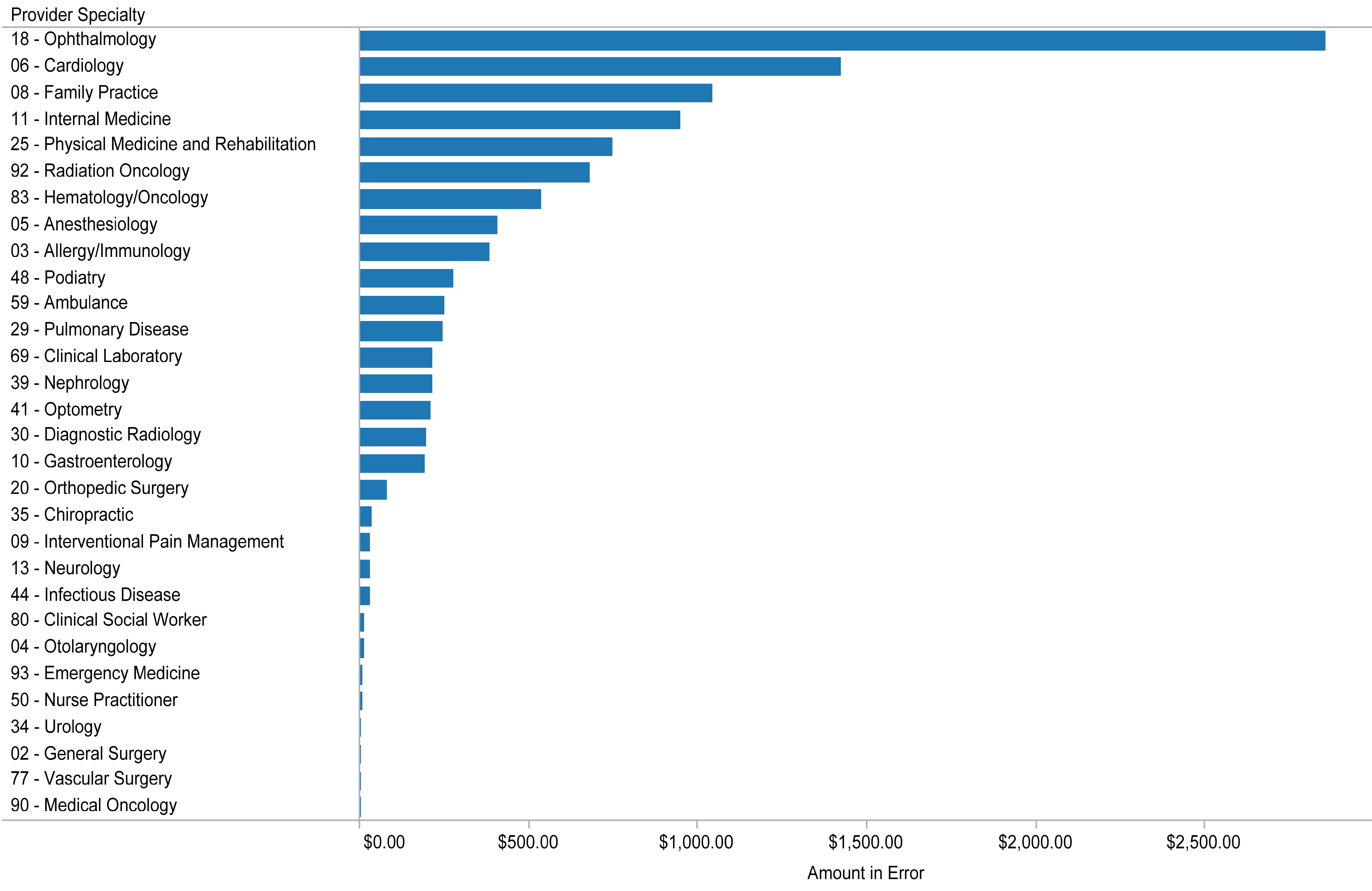


Indiana
Top Procedure Codes in Error by Error Code/Description

Error Code/Description	Procedure Code	# of Errors
21 - insufficient documentation	99233	8
	84450	4
	99223	2
	99215	2
	99291	2
25 - Medically unnecessary service or treatment	36415	6
	96375	1
	96413	1
	96415	1
	96417	1
31 - Service incorrectly coded	99233	8
	99232	6
	99223	3
	99204	2
	99222	2
99 - No response received	A0425	1
	A0428	1

There were 152 errors assessed for Indiana

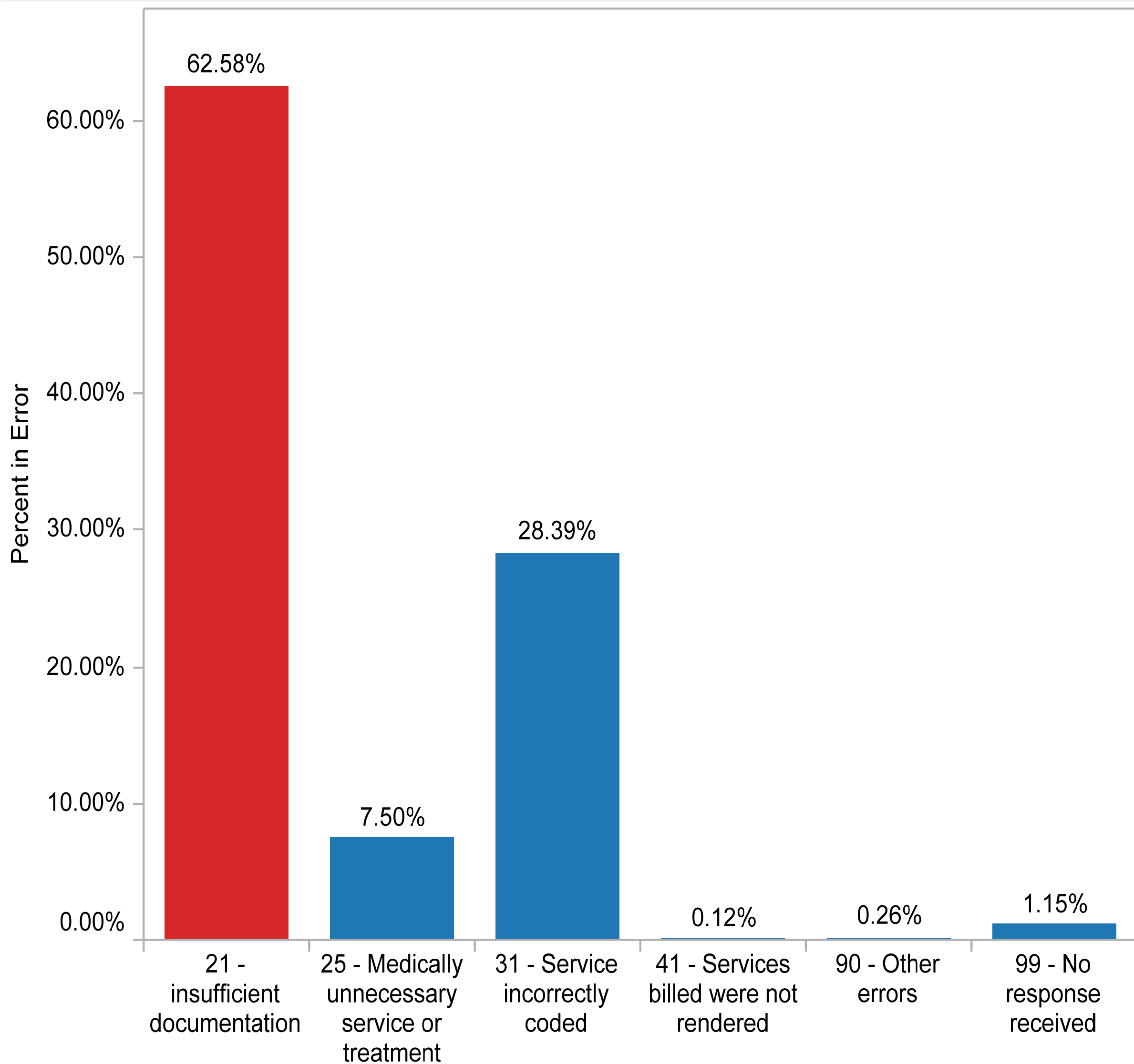
WPS Medicare Comprehensive Error Rate Testing (CERT)
Indiana
Dollars in Error by Provider Specialty
Claim Submission Dates: 01/01/2011 - 12/31/2011



WPS Medicare Comprehensive Error Rate Testing (CERT)
J8 MAC
Findings by Error Type

Claim Submission Dates: 01/01/2011 - 12/31/2011

J8 MAC
Percent of Dollars in Error by Type of Error

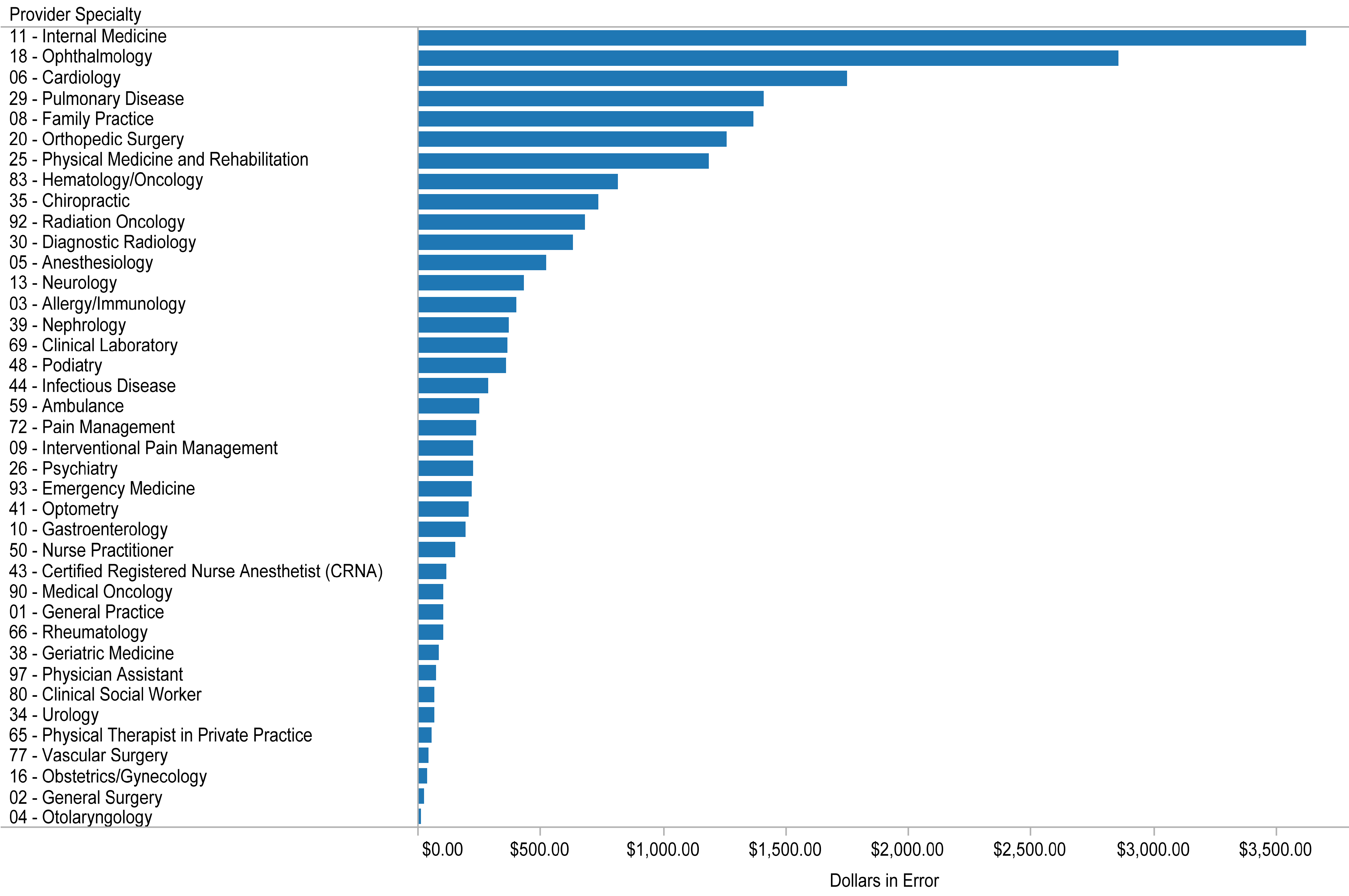


J8 MAC
Top Procedure Codes in Error by Error Code/Description

Error Code/Description	Procedure Code	# of Errors
21 - insufficient documentation	99233	9
	98941	6
	98942	7
	99291	7
	99232	6
25 - Medically unnecessary service or treatment	36415	6
	98941	3
	98942	2
	20610	2
	36514	1
31 - Service incorrectly coded	99233	30
	99223	14
	99310	11
	99232	8
	99222	7
41 - Services billed were not rendered	96372	1
	J0780	1
90 - Other errors	G0180	1
99 - No response received	A0425	1
	A0428	1

There were 333 errors assessed for J8 MAC

WPS Medicare Comprehensive Error Rate Testing (CERT)
J8 MAC
Dollars in Error by Provider Specialty
Claim Submission Dates: 01/01/2011 - 12/31/2011



WPS HEALTH INSURANCE **Medicare** A CMS Medicare Contractor

ISMA Coalition – Additional Updates – March 22, 2013

1. Plan to Mitigate Risk for a Smooth ICD-10 Transition

To make your transition to ICD-10 smooth, consider following these steps:
 Establish a transition plan. Outline the steps your practice intends to follow to comply with ICD-10 requirements. Establish milestones to keep your practice on track. Share your transition plan with your EHR and practice management system vendors and billing services. Talk to them about how you can set up testing before the deadline.
 Communicate with your vendors regularly; encourage them to take action now to avoid reimbursement delays. Talk to your vendors about making sure your practice management systems will be able to handle ICD-10 transactions. Ask them about their schedule for training your practice's staff on the system changes. Make sure you and your vendors allow ample time for testing ICD-10 systems.

 Identify everywhere that your practice uses ICD-9. Any function where you currently use ICD-9 will be affected by the transition to ICD-10. By taking a look at where you use ICD-9, you will see where you need to be prepared to use ICD-10 codes.

 Plan for staff training. Decide who needs training, what type of training they need, and when they need it. Anyone who will test ICD-10 systems before the transition will need training in advance so they can perform meaningful testing. Others who use ICD codes can be trained 6 to 9 months before the October 1, 2014, transition.

 Network with peers. Talking with your peers in other practices can help you to identify best practices and opportunities for sharing resources.

 Set up an emergency fund to cover potential cash-flow disruptions from claims processing. If you think you might have a serious disruption in getting claims processed after the transition, having a cash reserve on hand could be helpful.

 Process ICD-9 transactions before the deadline. Get claims with ICD-9 transactions processed before the deadline to avoid facing a major backlog after the October 1, 2014, ICD-10 transition.

Keep Up to Date on ICD-10 Visit the CMS ICD-10 website for the latest news and resources to help you prepare for the *October 1, 2014*, deadline.
For practical transition tips:
 Read recent ICD-10 email update messages
 Access the ICD-10 continuing medical education modules developed by CMS in partnership with Medscape

2. Revised 2013 Purchase Diagnostic Test Payment File

CMS has identified a problem with the calculation of payment rates for purchased diagnostic tests. The rate calculation did not include the extension of the 1.0 floor on the physician work geographic practice cost index (GPCI) mandated by the American Taxpayer Relief Act of 2012. This issue has resulted in lower payment amounts than appropriate for claims processed by contractors in certain payment localities for dates of service on and after January 1, 2013.
CMS expects the problem to be resolved within the next 2-3 weeks. No action on the part of providers/suppliers is necessary. Affected claims will be identified and automatically reprocessed by the appropriate Medicare claims administration contractors.

3. Date of Service for the Professional Component

Many diagnostic services have two components; a technical and professional component. The date of service submitted to Medicare for the professional component is the date the professional component is performed. When the technical and professional components of a radiology service are performed on different days, the services are not global and should be separated into their separate parts and each component should reflect the actual date performed. For example, the technical component is performed on Tuesday, January 8, 2013 and the professional is performed on Wednesday, January 9, 2013. You can find this information in the Centers for Medicare & Medicaid Services (CMS) Internet Only Manual (IOM) Publication 100-04, Chapter 26,Adobe Portable Document Format Section 10.4 item 24A.

WPS provided education on Radiology Services on January 8, 2013. You can find the material and the recording of the teleconference on our On Demand Training page.

4. Medication Therapy Management

A beneficiary's Medicare Part D plan or a Medicare Advantage plan may reimburse CPT procedure code 99605, 99606, and/or 99607 for medication therapy management. Medicare Part B does not make reimbursement for these services. Providers have sent us copies of industry articles discussing billing the medication therapy management using evaluation and management (E/M) procedure codes and billing under the incident to guidelines. This is not an appropriate action. Medicare considers changing an accurate procedure code to another code in order to receive reimbursement a fraudulent practice.

5. Medicare Secondary Payer Denial Change

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 7355Adobe Portable Document Format on August 3, 2012, for services processed January 1, 2013, and after. This CR discusses the appropriate billing of claims for conditional payment. One of the requirements listed in

this CR is that for those beneficiaries that have a Group Health Plan (GHP) primary to Medicare and either a liability, no-fault or workers compensation claim, the charges must be submitted to the GHP prior to submission to Medicare for the conditional payment. If the claims do not show the disposition from the GHP, Medicare will deny the charges as Contractual Obligation (CO). This means the beneficiary is not liable for the charges. Providers should take the appropriate actions prior to resubmitting the claim to Medicare. Please visit the CMS website to access CR 7355Adobe Portable Document Format and the related Medicare Learning Network Matters (MLN) article MM 7355Adobe Portable Document Format.

6. Physician Open Door Forum - 03/12/13

The Ordering/Referring edits are getting ready to go into effect. The ordering/referring provider must be an individual person not a group number. This will apply to both the professional and technical components. The website will show who can order/refer.

Questions

1. One provider stated the statute does not require an ordering/referring for both the professional and technical component.
    a. CMS said yes.
2. How often is the list updated?
    a. Quarterly
3. If there is a denial for the ordering/referring is this patient responsibility or provider liability and would they need an ABN?
    a. CMS is still developing the response. They will publish.
4. If the provider was not enrolled at the time of the service, but then enrolls, can the radiology provider submit the service again?
    a. Only if the enrollment date goes back to cover the service. If it does not, then the service is not payable.

Additional TCM Questions from ODF

Questions

1. Can the service be performed in a primary care exception location for residents?
    a. At this time, no, the regular teaching physician rules would apply.
2. Is CMS sure they want the 30th day reported when the E/M is not provided on that day?
    a. Yes, as the service is a 30 day service.
3. Why can't a provider report the TCM if the patient dies?
    a. The service is a 30 day service. If the patient dies before the 30th day, the provider can report an appropriate E/M service.
4. Will CMS pay additional medically necessary E/M during the 30 day period?
    a. Yes.
5. Can both the initial communication and the visit be performed on the same day?
    a. Yes.
6. How should providers count the days?
    a. Discharge is day 1. The communication must be started within the discharge day and 2 full days following discharge. The date of service for the TCM is the 30th day. It should not be billed on day 31 or day 32.

7. Will CMS do a transmittal adding information on the TCM to the manuals?
    a. Yes, this is currently being developed.
8. Can the TCM be provided in an outpatient setting?
    a. Yes, the code is valued also for an outpatient setting. There is a facility-based payment differential.
9. What documentation is required for the initial communication (2 day)?
    a. See the CPT and E/M guidelines.
10. Can a resident perform the service under the incident to guidelines?
    a. CMS is developing an answer on this one.
11. Can a resident perform the service when using the GC modifier?
    a. CMS is developing an answer.

Other Questions

1. Regarding the MLN on the AWV overpayments and the OPPS. When the service is performed in a facility, can they bill both the facility and professional fee?
    a. They can only bill the professional fee, there is a statutory difference.
2. How will the sequester reduction affect the calculation of the shared saving program for Accountable Care Organizations?
    a. CMS did not have a response.

7. Medicare Providers – Is your address up to date?

We recently sent out 622 E/M CBRs to Indiana providers. As of today, we have gotten 125 letters (20%) returned as undeliverable because the address in our Medicare file was not up to date. This is a very high returned mail rate compared to similar project in our other states.

WPS Medicare often mails important educational information, requests for medical record documentation and results of claim reviews to providers based on the address listed in their Medicare file. We have noted recent instances where our correspondence is returned as undeliverable because the address on file for the provider is no longer valid. This can result in unnecessary claim denials or missing out on important educational initiatives. We would like to remind providers that changes in practice location must be reported to Medicare within 30 days of the effective date of the change. Failure to comply with this requirement may result in revocation of the provider's Medicare billing privileges.

For more information on **Reporting Changes of Information** to Medicare, please refer to the article on our Provider Enrollment web page located here:
http://www.wpsmedicare.com/j5macpartb/departments/enrollment/breportadd.shtml
http://www.wpsmedicare.com/j8macpartb/departments/enrollment/breportadd.shtml
http://www.wpsmedicare.com/part_b/departments/enrollment/add_chng_report.shtml

Next meeting: May 17, 2013