WPS Medicare Resources - Medicare Coalition Meeting
Sponsored by: Indiana State Medical Association
September 13, 2013

New Location - Hot Topics Questions and Answers (Q & As)
http://wpsmedicare.com/j8macpartb/faq/departmental/customer-service-hot-topics-qandas.shtml

Recent Changes to the WPS Medicare Website (listed weekly)
http://www.wpsmedicare.com/j8macpartb/resources/website-updates/

Explanation of the revisions and deletions to IOM
CMS Internet-Only Manual, Publication 100-06, Medicare Financial Management - Chapter 3 – Overpayments
http://cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/fin106c03.pdf

CMS Internet-Only Manual, Publication 100-06, Medicare Financial Management - Chapter 4 – Debt Collection
http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/fin106c04.pdf

Medicare Learning Network (MLN) Maters Number MM8347 - Revisions and Deletions to the Internet Only Manual, Publication 100-06, Chapter 3, Overpayment (Section 50.3); Chapter 4, Debt Collection (Section 50 - 50.6 and 100.6.4) Related to Extended Repayment Schedules (ERS)
http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8347.pdf

Incident to
CMS Internet-Only Manual, Publication 100-02, Medicare Benefit Policy Manual, Chapter 15 – (Section 60.1 – Incident To Physician's Professional Services)
http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf

CMS Internet-Only Manual, Publication 100-04, Medicare Claims Processing Manual, Chapter 12 – Physicians/Nonphysician Practitioners (Section 30.6.4 - Evaluation and Management (E/M) Services Furnished Incident to Physician's Service by Nonphysician Practitioners)
http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf

CMS MLN Matters #SE0441 - *"Incident to" Services*
http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/se0441.pdf

Incarcerated Beneficiaries
CMS Incarcerated Beneficiary Claim Denial Frequently Asked Questions
http://www.cms.gov/Medicare/Medicare-Contracting/FFSProvCustSvcGen/Downloads/Incarcerated-Beneficiary-FAQs-8-1-13.pdf

Modifier 62
WPS Medicare Modifier Web Page
http://www.wpsmedicare.com/j8macpartb/resources/modifiers/

WPS Medicare Modifier 62 Fact Sheet
http://www.wpsmedicare.com/j8macpartb/resources/modifiers/modifier62.shtml

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

Transitional Care Management (TCM)
CMS Transitional Care Management Services – ICN 908628 June 2013
http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Transitional-Care-Management-Services-Fact-Sheet-ICN908628.pdf

CMS MLN Products Web Page – includes link for CMS Transitional Care Management Services Crossword Puzzle/Answer Key
http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/index.html?redirect=/MLNProducts/

Clarification New patient/Established patient status
CMS Internet-Only Manual, Publication 100-04, Medicare Claims Processing Manual, Chapter 12 (Section 30.6.7 - Payment for Office or Other Outpatient Evaluation and Management (E/M) Visits (Codes 99201 – 99215) – Subsection A – Definition of New Patient for Selection of E/M Visit Code)
http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf

Physician Quality Reporting System (PQRS)
CMS Physician Quality Reporting System Web Page
http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/How_To_Get_Started.html

Physician Quality Reporting System (PQRS): Updates for 2013 (dated 06/03/2013)
http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/2013_PQRS_Updates_Whats_New_060313.pdf

Recovery Auditor (previously referred to as Recovery Audit Contractors or RACs)
WPS Medicare Recovery Auditor Web Page
http://www.wpsmedicare.com/j8macpartb/departments/recovery_audit/

Medicare RA Region B (CGI) Website
https://racb.cgi.com/Default.aspx

RA Region B (CGI) Issues/Details
https://racb.cgi.com/Issues.aspx

PECOS Surrogate Program

CMS MLN Connects™ Provider eNews - Thursday, August 8, 2013 – includes article entitled *Streamlined Access to PECOS, EHR, and NPPES — Coming Soon*
http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-08-08-Enews.pdf

Provider Enrollment

WPS Medicare Provider Enrollment Web Page
http://www.wpsmedicare.com/j8macpartb/departments/enrollment/

CMS Provider-Supplier Enrollment Web Page
http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html

CMS Internet-based PECOS Web Page
http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/InternetbasedPECOS.html

CMS Medicare Provider-Supplier Enrollment National Educational Products
http://cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/Medicare_Provider-Supplier_Enrollment_National_Education_Products.pdf

OTHER RESOURCES

ICD-10: Implementation for Physicians, Partial Code Freeze, and MS-DRG Conversion Project MLN Connects™ Video
http://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/Downloads/082813ICDAnnouncement.pdf

Open Payments (Physician Payments Sunshine Act)
CMS National Physician Payment Transparency Program OPEN PAYMENTS Web Page
http://www.cms.gov/Regulations-and-Guidance/Legislation/National-Physician-Payment-Transparency-Program/index.html

CMS MLN Matters Number SE1330 - *OPEN PAYMENTS: An Overview for Physicians and Teaching Hospitals*
http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1330.pdf

CMS Physician Publication – Open Payments (Physician Payments Sunshine Act)
http://www.cms.gov/Regulations-and-Guidance/Legislation/National-Physician-Payment-Transparency-Program/Downloads/Physician-Publication.pdf

OTA/PTA Incident to a Therapist (May be Covered) versus OTA/PTA Incident to a Physician (Not Covered)
WPS Medicare Local Coverage Determination L28531 – Outpatient Rehabilitation Therapy Services billed to Medicare Part B
http://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=28531&ContrId=265

Information to Share

Did you know that WPS Medicare publishes a weekly list of recent changes to the WPS Medicare website? It's available at:

http://www.wpsmedicare.com/j8macpartb/resources/website-updates/

Medicare Part B - Current Updates
September 2013

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.

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

The compliance deadline for ICD-10 is **October 1, 2014**. Providers and payers need to communicate regularly. Continue to check CMS website for updated materials.

CMS International Classification of Diseases – 10th Revision (ICD-10) web page
http://www.cms.gov/Medicare/Coding/ICD10/index.html

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 weekly eNews Listserv on Monday with the most current and vital information Medicare providers need to know. The weekly e-News 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 click on "e-News" in the upper right corner. We encourage all individuals at 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

Electronic Funds Transfer (EFT)

Are you still receiving paper checks? EFT sends your Medicare payments directly to your financial institution, allows faster access to funds, deposits your payments electronically on the next business day and eliminates the risk of Medicare paper checks being lost or stolen.

To set up, please download the authorization agreement for EFT at:
http://www.cms.gov/Medicare/CMS-Forms/CMS-forms/downloads//CMS588.pdf

For EFT assistance you may also call: (866) 734-1522.

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

CR7631
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

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. Self-service tools are a way for providers to access Medicare information 24 hours a day, 7 days a week, at a time most suitable to their schedule. 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. Eligible professionals may choose to participate in three 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 Prescribing (eRX)** – Medicare Eligible Professionals (EPs) who are successful electronic prescribers. An incentive program separate from and in addition to the Physician Quality Reporting System program.

   Find more information on the eRX Incentive Program on the CMS website: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ERxIncentive/Educational_Resources.html

   Negative Payment Adjustment
   The Medicare Improvements for Patients and Providers Act of 2008 requires CMS to apply a negative payment adjustment to any Eligible Professional (EP) who is not a successful e-prescriber under the eRx Incentive Program.

   Effective January 1, 2012, EPs who are not successful electronic prescribers are subject to a negative payment adjustment. An EP receiving the negative payment adjustment would be paid 1% less than the Medicare Physicians Fee Schedule (MPFS) amount for that service. In 2013, the negative payment adjustment increases to 1.5% and in 2014 the negative payment adjustment is 2%.

CMS Quick Reference Guide for the 2012 eRx Payment Adjustment:
http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ERxIncentive/downloads/QRGuide_understanding_2012eRxPayAdj_F01-09-2012_508.pdf

Posting the Limiting Charge after applying the e-Prescribing (eRx) Negative Adjustment.
The hard copy disclosure report will explain the eRx reduced limiting charge by providing the following message: *"Limiting charge reduced based on status as an unsuccessful e-prescriber per the Electronic Prescribing (eRx) incentive Program."*

MLN Matters Article (MM7877): Posting the limiting Charge after applying the e-Prescribing (eRx) Negative Adjustment:
http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/mm7877.pdf

3. **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 will make available the PY 2012 QRURs for groups nationally that consist 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.

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

WPS Medicare Part B Quarterly CERT Error Findings Report

~INDIANA~

This report provides details of Comprehensive Error Rate Testing (CERT) errors assessed April 2013 through June 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 - 83% of total errors

Reasons for Errors:

- Missing signed physician orders or progress notes to support intent and/or documentation of medical necessity for lab tests and PET scan. An unsigned requisition does not support intent.
- Billed is diagnostic colonoscopy, gastrointestinal endoscopy with biopsy and dilatation of esophagus (CPT 45378, 43239, 43450). Submitted documentation is missing the clinical documentation to support the medical necessity of the procedures.
- Billed for injection of major bursa and Hyalgan/Supartz injection both with LT modifier (CPT 20610, J7321). Missing the treating physician's clinical documentation to support the beneficiary has failed to respond adequately to conservative nonpharmacological therapy and that the beneficiary has a reduction of medication usage for pain.
- Billed is Chiropractic Manipulation Treatment (CMT); spinal 1-2 regions (98940-AT). Missing are: a) the authenticated treatment plan proximal to billed date of service including duration & frequency of visits, specific treatment goals, and objective measures to evaluate treatment effectiveness; b) authenticated visit note from billed date of service; c) authenticated clinical records supporting this is an acute treatment; and d) an attestation statement pertaining to the typed chart notes provided.
- Billed is CMT; spinal 3-4 regions (98941-AT). Missing are: a) Medical records/documentation for the CMT services for the period covering the preceding 6 months; b) The treatment plan related to the CMT services for billed DOS including duration and frequency of visits and specific treatment goals with legible identification of the author of pertinent notes; c) Documentation to support this is an acute treatment; and d) An attestation statement from the provider pertinent to the submitted treatment record.
- Billed CMT; spinal 3-4 regions (98941-AT). Missing legible documentation of billed services, and documentation of symptoms causing patient to seek treatment, mechanism of trauma, quality and character of symptoms, onset duration, frequency, location and radiation of symptoms, aggravating or relieving factors and prior interventions, treatments and documentation of 3-4 spinal regions treated on this date of service.

- Billed is CPT 77413- Radiation treatment delivery, 3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; 6-10 MEV for three dates of service. Missing requested documentation of radiation treatment delivery 3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, and electron beam billed.
- Billed for qualitative drug screening, assay of benzodiazepines; urinalysis; assay of creatinine and assay of opiates (CPT 80102, 80154, 81005, 82570, 83925, G0431). Missing the treating physician's detailed signed and dated order or clinical documentation to support the plan or intent to order the billed tests and clinical documentation to support the medical necessity for the billed tests. Received Test Requisition form that includes all tests billed for DOS that is not signed; drug test results; and Urine Drug Test Quick Reference form. Also received a physician progress note that supports medical necessity for a beneficiary with chronic low back pain however that has an illegible signature and only documents a plan for a urine drug screen (not specific to the tests billed for DOS) and another test that is illegible.
- Billed initial hospital visit, (2) subsequent hospital care visits and hospital discharge day management. Missing the billing provider signed and dated clinical documentation supporting involvement with beneficiary inpatient care for all dates. Submitted documentation includes visit notes that are typed, dictated and signed by a nurse practitioner. Requested additional documentation from the billing provider and received altered visit notes that are now signed by the billing provider with a statement that states "Agree with NP". Visit notes are insufficient to support share/split visits since the requirements were not met per Medicare regulations.
- Billed Comprehensive Hearing Test (CPT 92557). Missing medical record documentation to support provider's order or intent to order billed service and the medical necessity of billed service.
- Billed for comprehensive audiometry threshold evaluation and speech recognition testing (CPT 92557). Missing a copy of the evaluation and report of performed testing and the treating physician's office note that supports the medical necessity of testing and the plan/intent or the order. Per CMS IOM, Pub. 100-02 Chapter 15, section 80.3, "If a beneficiary undergoes diagnostic testing performed by an audiologist without a physician order, the tests are not covered even if the audiologist discovers a pathologic condition." Per Pub. 100-04, Chapter 12, section 30.3, "The interpretation and report shall be written in the medical record by the audiologist, physician, or NPP who personally furnished any audiology service, or by the physician who supervised the service."
- Billed Percutaneous Vertebroplasty lumbar, and percutaneous Vertebroplasty under fluoroscopic guidance (CPT 22521, 72291). Missing 1) treating physician's progress notes prior to the procedure or documentation of the specific signs, symptoms and condition (such as Painful osteolytic metastasis, Multiple myeloma with painful vertebral body involvement, Painful and/or aggressive hemangiomas, Osteoporotic vertebral collapse with persistent debilitating pain, which has not responded to, accepted standard medical treatment; 2) documentation of other non-invasive corrective medical treatment has been tried and failed.
- Billed for Zoledronic acid (Zometa)(1mg) with 4 units of service and related services (J1100, J3487, 96365, 96375). Submitted records missing documentation of beneficiary's previous intolerance or contraindication for FDA approved oral Bisphosphonate and oral dosing regimens, or insurmountable issues related to absorption, compliance or dosing posture or adequate trials of FDA-approved oral Bisphosphonate result in fallen BMD and/or failure to

suppress bone turnover (e.g. persisting high bone -turnover marker measurements). Submitted documentation is insufficient to support previous use of oral Bisphosphonate as indicated by the governing LCD and Medicare guidelines.

- Billing for postoperative management only, for complex cataract surgery, with insertion of IOL (66982-55-LT). Missing follow up visit note by the surgeon to support postoperative management. Received: Operative report supporting medical necessity as nuclear sclerosis and floppy iris syndrome for complex cataract surgery with the use of a Malyugin ring; pre-op diagnostics and examinations; a post operative co-management agreement transfer of care agreement; unauthenticated 'fact form', indicating the beneficiary was seen on 11/14/2012, and released to optometrist care as of 11/15/2012. Insufficient documentation to support billed service per Medicare guidelines.

Incorrect Coding - 12% of total errors

Reasons for Errors:

- Billed 99205 (requires 3/3 key components: comprehensive history, comprehensive exam and high complexity medical decision making). Documentation supports down code to 99204 with comprehensive history, comprehensive exam and moderate MDM meeting 3/3 of the required key components.
- Billed 99214 (detailed history, detailed exam and moderate complexity MDM- 2/3 key components). Documentation supports down code from 99214 to 99213 with problem focused history, expanded problem focused exam and moderate MDM meeting 2/3 key components for this code.
- Billed CPT 85025, complete CBC with automated differential WBC. Missing signed and dated order for the billed service. Submitted physician's order is for a "CBC". The treating physician did not order a WBC differential even though one was performed. Submitted documentation supports code change to CPT 85027.
- Billed for therapeutic exercises with 2 units of services (CPT 97110-GP). Submitted includes Daily Note that documents a total session time of 38 minutes with a total of 18 minutes for therapeutic exercises and 10 minutes of "ice on knee while discussing, Description" and charged as therapeutic exercise. Documentation supports re-code to 1 UOS for therapeutic exercises billed for date.
- Billed A0427 (ALS emergency ambulance transport) with modifier IH applied indicating site of transfer between modes of ambulance transport. Transport record documents ambulance dispatched for "sick person" and that "Pt walked out of residence to EMS on arrival, sat on EMS cot " with chief complaint of dizziness of 10 minutes duration with secondary complaint of sweating, giving past medical history of HTN, chemical dependency and vertigo. Beneficiary denied pain or dyspnea. Beneficiary physical examination within normal limits, and was observed to walk with steady gait. EKG shows normal sinus rhythm without ectopy. She was administered 2 LPM oxygen via NC and patient states that"O2 has helped with dizziness and sweating has gone away". Documentation supports saline lock was placed and secured, "non emergent transport", "pt report called to ER with no orders requested and none given". Submitted documentation supports recode to A0426 (ambulance service, ALS, nonemergency transport).

Medically Unnecessary Service or Treatment – 5% of total errors

Reasons for Errors:

- Missing order for lab test, therefore venipuncture is considered not medically necessary.
- Billed CPT 33208 - Insertion of New or replacement of permanent pacemaker with transvenous electrode(S); Atrial and ventricular (dual pace maker). Review of Part A DRG and Part B records were used in the review decision. Documentation is of a Beneficiary admitted to the ER with dizziness and weakness profound bradycardia and elevated Blood Pressure. Admitted to the Hospital, electrophysiology consult. Bystolic was discontinued and Heart rate remained in the 30's-40's range. Received copies of ECHO, X-rays, progress notes, telemetry records, report of the insertion of a dual chamber pacemaker, and treatment of hypertension. Documentation submitted supports a single chamber pacemaker per the NCD. Dual chamber pacemaker is not reasonable and necessary.

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

CMS Resources

- **Ambulance Services** – CMS IOM, Pub. 100-2 Chapter 10
- **Audiology Services -** CMS IOM, Publication 100-02, Chapter 15, section 80.3 and CMS IOM, Pub. 100-04, Chapter 12, section 30.3
- **Cardiac Pacemakers** – CMS IOM, Pub. 100-3, Chapter 1, Part 1, section 20.8
- **Provider Signature Requirements** - CMS IOM, Pub. 100-08, Chapter 3, Section 3.3.2.4
- **Requirements for Ordering and Following Orders for Diagnostic Tests** - CMS Internet-Only Manual (IOM), Publication 100-02, Chapter 15, Section 80.6

WPS Medicare Resources

Local Coverage Determinations (LCDs) for:

- Bisphosphonate Drug Therapy
- Chiropractic Services
- Intra-articular Injections of Hyaluronan
- Outpatient Psychiatry and Psychology Services
- Outpatient Rehabilitation Therapy Services billed to Medicare Part B
- Qualitative Drug Testing
- Vertebroplasty (Percutaneous) and Vertebral Augmentation including cavity creation

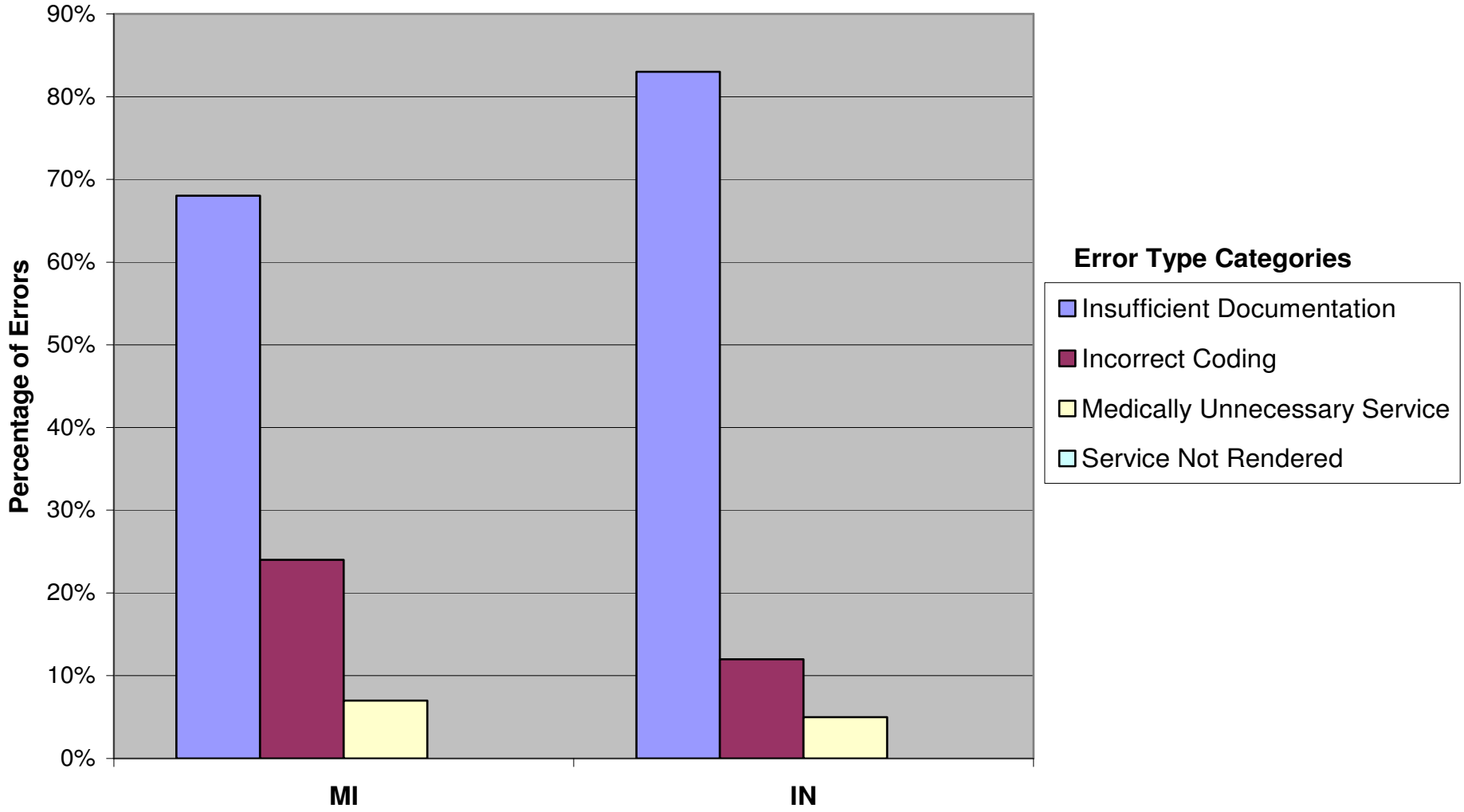
Additional WPS Medicare web page resources:

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

WPS HEALTH INSURANCE Medicare
A CMS Medicare Contractor

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

WPS Medicare Part B - J8 MAC (Indiana and Michigan)
CERT Error Findings by Error Type (Apr. 2013 - Jun. 2013)



Medicare Coalition Meeting
Held at Indiana State Medical Association
September 13, 2013

Hot Topic Questions and Answers (Q & As)
Please advise attendees of the change of location for Hot Topic Q & As

WPS Medicare response: During the 07/19/13 Medicare Coalition meeting, we announced and demonstrated the availability to access Hot Topic Q & As on the Customer Service web page on our website. These were recently moved to the FAQ (Frequently Asked Questions) section of our website, available at:
http://wpsmedicare.com/j8macpartb/faq/departmental/customer-service-hot-topics-qandas.shtml

The navigation path is:
Home >>J8 MAC Part B>> FAQ >> Departmental>>Customer Service>> Hot Topic Q&As

Did you know that WPS Medicare publishes a weekly list of recent changes to the WPS Medicare website? It is available at:
http://www.wpsmedicare.com/j8macpartb/resources/website-updates/

Explanation of the revisions and deletions to the Internet-Only Manual (IOM)
Revisions and Deletions to the Internet-Only Manual, Publication 100-06, Chapter 3, Overpayment (Section 50.3); Chapter 4, Debt Collection (Section 50 - 50.6 and 100.6.4) Related to Extended Repayment Schedules (ERS)

WPS Medicare response: Change Request (CR) 8347 is a policy change that streamlines the Extended Repayment Schedules (ERS) process by updating the policy language and standard practices.
The following points are based on the revised manual, "Medicare Financial Management," Chapter 4—Debt Collection.

• Medicare contractors are charged with establishing an ERS formerly called an Extended Repayment Plan (ERP). Contractors must process ERS requests within 30 days of receipt and make certain providers complete all instructions. Contractors are required to post information and instructions on their websites and supply paper copies if requested.
• Your Medicare contractor will approve/disapprove an ERS request from 6 months up to 36 months and the CMS for an ERS up to 60 months—again within 30 days of receipt.
• Your Medicare contractor will not refund monies recouped during the review process. The recouped amounts will be applied to the overpayment.
• Contractors will notify a provider of approval or no approval within 5 days of decision.

• Contractors will recoup ERS payments from a provider's future Medicare payment, unless the contractor determines there is a valid reason to send in a check.
• Chapter 4, Section 100.6.4 details the ERS process that occurs if a request is received by the Recovery Audit Contractor (RAC) from a provider. The point of contact information for the ERS at the RAC location will be provided in a separate instruction.

CMS Internet-Only Manual, Publication 100-06, Medicare Financial Management - Chapter 3 – Overpayments
http://cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/fin106c03.pdf

CMS Internet-Only Manual, Publication 100-06, Medicare Financial Management - Chapter 4 – Debt Collection
http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/fin106c04.pdf

Medicare Learning Network (MLN) Maters Number MM8347 - *Revisions and Deletions to the Internet Only Manual, Publication 100-06, Chapter 3, Overpayment (Section 50.3); Chapter 4, Debt Collection (Section 50 - 50.6 and 100.6.4) Related to Extended Repayment Schedules (ERS)*
http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8347.pdf

Incident to

It appears according 42 CFR Chapter IV § 410.26 a physician who is not enrolled in Medicare can bill incident to another physician. Does WPS support a physician billing incident to another physician?

WPS Medicare Response: WPS Medicare follows CMS Internet-Only Manual instructions (Publication 100-02, Chapter 15, Section 60.1) when considering payments based on Medicare's incident to concept. Documentation must support all incident to criterion is met, when submitting a claim for services rendered by a qualified provider and billed by a qualified provider.

This topic is being addressed in the current proposed rule. Until the information is final and is manualized (published by CMS), we are unable to address this at this time.

CMS Internet-Only Manual, Publication 100-02, Medicare Benefit Policy Manual, Chapter 15 – (Section 60.1 – Incident To Physician's Professional Services)
http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf

CMS Internet-Only Manual, Publication 100-04, Medicare Claims Processing Manual, Chapter 12 – Physicians/Nonphysician Practitioners (Section 30.6.4 - Evaluation and Management (E/M) Services Furnished Incident to Physician's Service by Nonphysician Practitioners)
http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf

CMS MLN Matters #SE0441 - *"Incident to" Services*
http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/se0441.pdf

Incarcerated beneficiaries

Has there been any update on the incarcerated beneficiary issue since the questions and answer link. http://www.cms.gov/Medicare/Medicare-Contracting/FFSProvCustSvcGen/Downloads/Incarcerated-Beneficiary-FAQs-8-1-13.pdf

WPS Medicare Response: According to CMS, the resolution of this situation will require a series of complex actions including the restoration of the original data on the Medicare Enrollment Data Base, the identification of the overpayments that will need to be abated or refunded, and the creation of claims processing system utilities to effectuate the necessary changes. We do not yet have a firm target date, but anticipate that the process will not be completed before October. We will advise you as additional information becomes available.

Modifier 62

It is important that all practices under the correct use of modifier 62 and the use of item 19 on the claim form. Please provide a quick tutorial on modifier 62.

WPS Medicare Response: The Modifier web page on our website includes numerous links for general modifier information and Modifier Fact Sheets. It is available here: http://www.wpsmedicare.com/j8macpartb/resources/modifiers/

A Fact Sheet for Modifier 62 is available here: http://www.wpsmedicare.com/j8macpartb/resources/modifiers/modifier62.shtml

The following is excerpted from the above referenced Modifier 62 Fact Sheet:

Definition: Two surgeons (each in a different specialty) are required to perform a specific procedure.

Appropriate Use:

- If two surgeons (each in a different specialty) are required to perform a specific procedure, each surgeon bills for the procedure, and both surgeons need to report the same surgery code with the modifier 62. If one surgeon bills with a modifier 62, and one surgeon bills with no modifier, the claim with the modifier will suspend for review. Documentation of the medical necessity for two surgeons is required for certain services identified in the MPFSDB. Global surgery rules apply to each of the physicians participating in a co-surgery.
- Reimbursement is at 62.5% of the global surgery fee schedule amount for co-surgeons.
- The following MPFSDB* indicators identify services for which two surgeons, each in a different specialty, may be paid:

  0 = Co-surgeons not permitted for this procedure.
  1 = Co-surgeons may be paid if supporting documentation is supplied to establish medical necessity.
  2 = Co-surgeons permitted. No documentation is required if two specialty requirement is met.

*MPFSDB is available on the CMS website at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html

Claim Requirement:

Paper Claim: Indicate "additional information available upon request" in field 19 of the 1500 form.

Electronic Claim: Indicate "additional information available upon request" on loop 2300 NTE for the claim level or loop 2400 NTE segment for the line level in your electronic claim. We will send a development letter asking for the additional information.

Transitional Care Management (TCM)

Multiple articles, including the AMA, are being circulated stating the physician that discharges the patient cannot bill for TCM services. Clarification is being sought in this since the CMS, TCM ICN908628, June 2013, states the same physician may bill for the discharge and TCM services.

WPS Medicare Response: WPS Medicare does not endorse education provided by any entity other than CMS or WPS Medicare. In their published education on this topic, CMS states that the same health care professional may discharge the beneficiary from the hospital, report hospital or observation discharge services, and bill TCM services. However, the required face-to-face visit may not take place on the same day discharge day management services are reported.

Clarification New patient/Established patient status

Is "group practice" defined for the purpose of establishing new patient/established patient status determined by federal tax identification number or Medicare PTAN? For example multiple primary care practices could be billing under one federal tax identification number but each practice has their own PTAN assigned by Medicare. A patient could see Doctor A Internal Medicine at one practice location and billed under that practice location PTAN and then see Doctor B Internal Medicine at a different practice location billing under that practice location PTAN. Both practice PTAN report under the same federal tax identification number. Is the patient a new patient or established patient type when seeing Doctor B?

WPS Medicare Response: Medicare regulation states: *"Physicians in the same group practice who are in the same specialty must bill and be paid as though they were a single physician."* The same physician concept also applies when the exact same physician performs services.

For purposes of billing for Evaluation and Management (E/M) services, patients are identified as either new or established, depending on previous encounters with the provider.

A **new patient** is defined as an individual who has not received any professional services from the physician/non-physician practitioner (NPP) or another physician of the same specialty who belongs to the same group practice within the previous three years.

An **established patient** is an individual who has received professional services from the physician/NPP or another physician of the same specialty who belongs to the same group practice within the previous three years.

The federal tax identification number, not the group Provider Transaction Access Number (PTAN), is used to identify providers in the same group practice.

Physician Quality Reporting System (PQRS)

When physicians are struggling with PQRS is there someone at WPS Medicare who can assist to better the reporting and documentation in order to qualify and avoid the penalty. Is WPS or The Help Desk the first course of action?

WPS Medicare Response: CMS has made available a plethora of educational materials to assist providers in proper reporting and documentation to avoid the payment adjustment. One informative publication is an August, 2013 Physician Quality Reporting System (PQRS) Overview which includes several links to related materials, including reporting methods and selecting measures. This document also states that eligible practitioners who have questions or need assistance with PQRS reporting should contact the QualityNet Help Desk.

The help desk is available Monday–Friday; 7:00 AM–7:00 PM CST.
Phone: 1-866-288-8912
TTY: 1-877-715-6222
Email: Qnetsupport@sdps.org

2012 CPT code 76377- 3-D rendering with interpretation and reporting of CT, MRI, ultrasound, or other tomographic modality requiring image post processing on an independent work station

WPS is recovering payment on this code, but physicians do not understand the reasoning for the recoupment.

The reason for denial is date range not valid with units submitted. One unit and one date of service is being billed. This is due to a recovery audit program review.

WPS Medicare Response: The CGI website FAQ web page includes links for helpful information to assist providers in the understanding their process, provider options for overpayment determinations, and a provider request for discussion form. This web page is available at:
http://racb.cgi.com/FAQ.aspx

The CGI website also includes a listing of all issue details, available at:
https://racb.cgi.com/Issues.aspx

Based on details posted on the CGI website, it appears this review, for 3D Radiation Reconstruction without Supporting Diagnosis Codes will identify that an issue exists when either only the Secondary diagnosis is reported or no diagnosis is reported when reporting 3D Radiology Reconstruction procedures 76376 and/or 76377. Without the primary diagnoses, the 3D Radiology Reconstruction services are considered unsupported.

When requested by the Recovery Auditor, WPS Medicare will adjust and issue the Remittance Advice to the provider; however, WPS Medicare is prohibited from educating providers on RAC related issues. We recommend that providers follow instructions on CGI's website in order to initiate a discussion, send a rebuttal, or request a redetermination. For additional details on these actions, please choose the Provider Options for RAC Overpayment Determinations link, available on the aforementioned CGI FAQ web page.

PECOS Surrogate Program

At the end of August 2013, CMS is launching a PECOS surrogate program. Where will CMS draw the e-mail addresses to submit to the providers? If drawn from NPPES, they will only have the contact person's e-mail (which is generally not the provider in the case of the one that is credentialed). If the surrogate has to put in a request to CMS, then how do they know that the email address requested actually belongs to the provider?

WPS Medicare Response: CMS published a related announcement in their MLN Connects™ Provider eNews on Thursday, August 8, 2013. You can access this document at: http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-08-08-Enews.pdf

Streamlined Access to PECOS, EHR, and NPPES — Coming Soon
Changes are being made to simplify the way Providers and Suppliers access the Provider Enrollment Chain and Ownership System (PECOS), the Electronic Health Records (EHR) Incentive Program, and the National Plan and Provider Enumeration System (NPPES). These updates will improve the user experience when registering as an individual practitioner, authorized or delegated official of an organization, or someone working within PECOS on behalf of a provider or supplier (also known as a surrogate).

The new process will:
• Allow registered users to manage and reset their user ID and password online without calling a CMS Help Desk.
• Provide a simple and secure way for providers and suppliers to authorize individuals or groups of individuals to act on their behalf in PECOS and EHR.
• Allow designated authorized officials already on file with Medicare, to be quickly approved to access PECOS without the need to submit documentation to CMS for verification prior to submitting the application.
• Allow organizations with potentially large numbers of credentialing or support staff to manage staff access to the various functions.
• Increase security to reduce the risk of Provider identity theft and unauthorized access to systems.
Important Note: If you already have a user ID and password from NPPES, or currently access PECOS, NPPES, and/or EHR, your accounts will not be affected by this change. You can continue to utilize your established user ID and password to access the systems.

More information will be available in the near future.

Provider – Supplier Enrollment

ISMA is aware WPS is now working to expedite the regular application. A question regarding revalidation is being asked. Why is revalidation (remember these are providers who already have billing privilege, they are revalidating their privilege) being triaged with other enrollment issues? Note that the initial review by WPS is more than 30 days ago. What has happened since that time? We are being told that each analyst has their own workload and that they are each at different dates. What is the plan for getting timely with enrollment?

WPS Medicare Provider Enrollment response: We are working diligently to reduce the current pending levels for all Provider Enrollment applications. Revalidations are not being given priority over other

Provider-Supplier enrollment activities, all of which have very strict follow up dates that we must follow. Each month, we implement new automation to assist us with processing applications more timely and more efficiently to decrease the backlogs.

Our workloads are assigned based on the analyst's training/experience. We have some that have initial training that can work certain types of applications, while others are more experienced and can work the more difficult applications. (The lesser trained staff handle the easier changes thus they do complete their applications faster than the staff handling the more difficult applications.)

After the last Coalition meeting, we expedited some of the new/pending 855B group applications so that when we reached those dates, the primary application would be ready and complete, depending on development responses. We continue to look at ways to complete these types of applications on a timely regular basis.

Please keep in mind that an application that does not require development is processed much faster than those that do. If two applications are submitted for an applicant and one is developed, it holds up both applications.

If clinics or groups are aware of a group change or new group, it is helpful for us to receive that application prior to the (group) members' application. The group application must be completed prior to the members of the group applications. This is also true of development. If we need to hold a group application for additional information, then all the members are also pended, awaiting that response.

For a very large group that has significant changes or new enrollments, it is helpful if the provider contacts us prior to submission of an application. In some situations, we can expedite the enrollment process if we know that there are a significant number of same group/same changes.