



**Professional Receivables Control, Inc.
Monthly Newsletter
April 2009**

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CMS RECONSIDERING PECOS RESTRICTIONS

Part B News reports that CMS is reconsidering the restrictions they have on using PECOS, the online registration service. At this time PECOS can only be used by the provider, not by a third party such as the physician's billing manager.

Due to the fact that most physicians are not willing to take the time to use PECOS, it is forcing the managers to revert back to paper applications. CMS has not yet said when they will make a final decision but they are looking at opening PECOS up to third parties to register on behalf of the physicians. I will keep you updated as information becomes available.

MEDICARE TO STOP CONDITIONAL PAYMENTS ON WORKER'S COMP

A Workers' Compensation Medicare Set-aside Arrangement (WCMSA) is an allocation of funds from a workers' compensation (WC) related settlement, judgment or award that is used to pay for an individual's future medical and/or future prescription drug treatment expenses related to a WC injury, illness or disease that would otherwise be reimbursable by Medicare.

The creation of a new Medicare secondary payer (MSP) code specifically associated with the WCMSA situation will permit Medicare to generate an automated denial of diagnosis codes associated with the open WCMSA occurrence.

When denying a claim because of these edits, Medicare will notify the beneficiary using the following Medicare summary notice message: 29.33 – "Your claim has been denied by Medicare because you may have funds set aside from your settlement to pay for your future medical expenses and prescription drug treatment related to your injury(ies)."

In addition, Medicare will use reason code 201, group code PR, and remark code MA01, on outbound claims and/or remittance advice transactions when Medicare denies claims based on the WCMSA presence. Also, on 271 inquiry reply transactions, Medicare will reflect the WCMSA on the 271 response with "EB" followed by the qualifier WC.

The effective date is July 1, 2009 with an implementation date of July 6, 2009.

Additional information is available on the CMS Web site. Here is the link to the MLN Matters article <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5371.pdf>

You can view the CMS directive here; <http://www.cms.hhs.gov/transmittals/downloads/R1665CP.pdf>

PROLONGED SERVICES

Prolonged services are not used often because of the time face-to-face with the patient that is required. But every once in a while your provider will need to bill for extended time spent with the patient. Here is a review for office and outpatient settings. There are separate rules for inpatient that you can view at the link provided. Also there is a convenient chart in your CPT book showing time segments and codes to be used. All prolonged services must be accompanied by the initial CPT for the E/M provided.

In the office or other outpatient setting, Medicare will pay for prolonged services with direct face-to-face contact that requires one hour over the usual service time by the same physician or NPP. You use code 99354 as a companion code with your E/M code. The time for E/M services are noted in the CPT code explanations. For example 99205 – Office or other outpatient visit for E and M management of a new patient is stated that the time spent is typically 60 minutes (1 hour). With prolonged care requiring an additional hour over the assigned 60 minutes your provider would have to spend 2 hours face-to-face with the patient to bill 99205 plus 99354 to cover the 2 hour time period. After the initial 1 hour of prolonged service you then use code 99355 for each additional 30 minutes. So if your provider spent 2-1/2 hours with the patient in face-to-face contact then you would bill 99205 for the first hour, 99354 for the additional hour and 99355 for the added half hour.

For more information on different settings and appropriate codes see: <http://www.cms.hhs.gov/ContractorLearningResources/downloads/JA5972.pdf>

As with any time related service charge it is required that the chart notes reflect the times spent.

They also list the expanded criteria for the HCPCS codes.

MEDICARE ADMINISTRATIVE CONTRACTORS (MACS) - WHAT TO EXPECT

According to CMS their schedule for transitioning the adjudication workload to MACs will conclude by October 2009. There will be 15 A/B jurisdictions, each one being assigned a set of states.

A/B MAC Jurisdictions

Jurisdiction #	States Included in Jurisdiction
1	American Samoa, California, Guam, Hawaii, Nevada, and Northern Mariana Islands
2	Alaska, Idaho, Oregon, and Washington
3	Arizona, Montana, North Dakota, South Dakota, Utah, and Wyoming
4	Colorado, New Mexico, Oklahoma, and Texas
5	Iowa, Kansas, Missouri, and Nebraska
6	Illinois, Minnesota, and Wisconsin
7	Arkansas, Louisiana, and Mississippi

8	Indiana and Michigan
9	Florida, Puerto Rico, and U.S. Virgin Islands
10	Alabama, Georgia, and Tennessee
11	North Carolina, South Carolina, Virginia and West Virginia
12	Delaware, District of Columbia, Maryland, New Jersey, and Pennsylvania
13	Connecticut and New York
14	Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont
15	Kentucky and Ohio

Information gathered for Jurisdiction 15 - Kentucky and Ohio

Total Number of Fee-For-Service Beneficiaries: 2,512,529 (as of July 1, 2007)
Total Number of Beneficiaries (including managed care plans): 2,908,777 (as of July 1, 2007)
Total Number of Practitioners: 66,027 (as of July 31, 2007)
Total Number of Medicare Hospitals: 339 (as of December 31, 2007)
Total Annual Claims Volume: 6.1% of national workload (as of September 30, 2007)

Current Fiscal Intermediaries and Carriers Operating in Jurisdiction

Mutual of Omaha Insurance Company (FI for some providers in Kentucky and Ohio)
National Government Services (FI for Kentucky and Ohio; carrier for Kentucky)
Palmetto GBA (carrier for Ohio)

MAC awarded to Highmark Medicare Services

<http://www.highmarkmedicare.com>

Information gathered on Jurisdiction 6 - Illinois, Minnesota and Wisconsin

Total Number of Fee-For-Service Beneficiaries: 3,323,986 (as of July 1, 2007)
Total Number of Beneficiaries (including managed care plans): 3,865,786 (as of July 1, 2007)
Total Number of Practitioners: 97,408 (as of July 31, 2007)
Total Number of Medicare Hospitals: 501 (as of December 31, 2007)
Total Annual Claims Volume: 7.5% of national workload (as of September 30, 2007)

Current Fiscal Intermediaries and Carriers Operating in Jurisdiction

Mutual of Omaha Insurance Company (FI for some providers in Illinois, Minnesota and Wisconsin)
National Government Services (FI for Illinois and Wisconsin)
Noridian Administrative Services (FI for Minnesota)
Wisconsin Physicians Service Insurance Corporation (carrier for Illinois, Minnesota and Wisconsin)

MAC awarded to Noridian Administrative Services, LLC

<https://www.nordianmedicare.com>

Information gathered on Jurisdiction 1 – American Samoa, California, Guam, Hawaii, Nevada and Northern Mariana Islands

Total Number of Fee-For-Service Beneficiaries: 4,894,109 (as of July 1, 2007)
Total Number of Beneficiaries (including managed care plans): 6,499,251 (as of July 1, 2007)
Total Number of Practitioners: 129,537 (as of July 31, 2007)
Total Number of Medicare Hospitals: 497 (as of December 31, 2007)

Total Annual Claims Volume: 8.4% of national workload (as of September 30, 2007)

Current Fiscal Intermediaries and Carriers Operating in Jurisdiction

Mutual of Omaha Insurance Company (FI for some providers in American Samoa, California, Guam, Hawaii, Nevada and Northern Mariana Islands)

National Government Services (FI for American Samoa, California, Guam, Hawaii, Nevada, and Northern Mariana Islands)

National Heritage Insurance Company (carrier for California)

Noridian Administrative Services (carrier for American Samoa, Guam, Hawaii, Nevada, and Northern Marina Islands)

MAC awarded to Palmetto GBA

www.palmettogba.com

Information gathered on Jurisdiction 8 - Indiana and Michigan

Total Number of Fee-For-Service Beneficiaries: 2,479,017 (as of July 1, 2007)

Total Number of Beneficiaries (including managed care plans): 2,805,761 (as of July 1, 2007)

Total Number of Practitioners: 66,022 (as of July 31, 2007)

Total Number of Medicare Hospitals: 337 (as of December 31, 2007)

Total Annual Claims Volume: 6.5% of national workload (as of September 30, 2007)

Current Fiscal Intermediaries and Carriers Operating in Jurisdiction

Mutual of Omaha Insurance Company (FI for some providers in Indiana and Michigan)

National Government Services (FI for Indiana and Michigan; carrier for Indiana)

Wisconsin Physicians Service Insurance Corporation (carrier for Michigan)

MAC awarded to National Government Services

<http://www.ngsmedicare.com/ngsmedicare/HomePage.aspx>

Information gathered on Jurisdiction 9 - Florida, Puerto Rico and U.S. Virgin Islands

Total Number of Fee-For-Service Beneficiaries: 3,765,918 (as of July 1, 2007)

Total Number of Beneficiaries (including managed care plans): 4,897,597 (as of July 1, 2007)

Total Number of Practitioners: 76,754 (as of July 31, 2007)

Total Number of Medicare Hospitals: 298 (as of December 31, 2007)

Total Annual Claims Volume: 8.4% of national workload (as of September 30, 2007)

Current Fiscal Intermediaries and Carriers Operating in Jurisdiction

Cooperativa de Seguros de Vida de Puerto Rico (FI for Puerto Rico and U.S. Virgin Islands)

First Coast Service Options, Inc. (FI and carrier for Florida)

Mutual of Omaha Insurance Company (FI for some providers in Florida and U.S. Virgin Islands)

Triple S, Inc. (carrier for Puerto Rico and U.S. Virgin Islands)

MAC awarded to First Coast Service Options, Inc.

<http://www.floridamedicare.com/index.asp>

Information gathered on Jurisdiction 10 - Alabama, Georgia and Tennessee

Total Number of Fee-For-Service Beneficiaries: 2,864,390 (as of July 1, 2007)

Total Number of Beneficiaries (including managed care plans): 3,287,910 (as of July 1, 2007)

Total Number of Practitioners: 73,824 (as of July 31, 2007)

Total Number of Medicare Hospitals: 458 (as of December 31, 2007)

Total Annual Claims Volume: 7.2% of national workload (as of September 30, 2007)

Current Fiscal Intermediaries and Carriers Operating in Jurisdiction

Blue Cross and Blue Shield of Georgia, Inc. (FI for Georgia)

Cahaba GBA (FI and carrier for Alabama; carrier for Georgia)

CIGNA Government Services (carrier for Tennessee)

Riverbend Government Benefits Administrator (FI for Tennessee)

Mutual of Omaha Insurance Company (FI for some providers in Alabama, Georgia and Tennessee)

MAC awarded to Cahaba Government Benefit Administrators, LLC

<https://www.cahabaqba.com>

Information gathered on Jurisdiction 12* - Delaware, District of Columbia, Maryland, New Jersey and Pennsylvania

Total Number of Fee-For-Service Beneficiaries: 4,377,094 (as of July 1, 2007)

Total Number of Beneficiaries (including managed care plans): 5,281,116 (as of July 1, 2007)

Total Number of Practitioners: 139,573 (as of July 31, 2007)

Total Number of Medicare Hospitals: 436 (as of December 31, 2007)

Total Annual Claims Volume: 11% of national workload (as of September 30, 2007)

Current Fiscal Intermediaries and Carriers Operating in Jurisdiction

Highmark Medicare Services (FI for District of Columbia, Maryland, and Pennsylvania; carrier for Pennsylvania)

Mutual of Omaha Insurance Company (FI for some providers in Delaware, District of Columbia, Maryland, New Jersey and Pennsylvania)

National Government Services (FI for Delaware; carrier for New Jersey)

Riverbend Government Benefits Administrators (FI for New Jersey)

TrailBlazer Health Enterprises, LLC (carrier for Delaware, District of Columbia and Maryland)

MAC awarded To – Highmark Medicare Services

<http://www.highmarkmedicareservices.com/>

* Special Note: For Part B services, A/B MAC Jurisdiction 12 includes the Counties of Arlington and Fairfax in Virginia along with the City of Alexandria in Virginia. Services for the rest of the state of Virginia will be covered under A/B MAC Jurisdiction 11.

CMS is telling us that the switch to these new MACs will improve provider services by;

- 1) Simplifying the interface with a single MAC for Part A and Part B processing and other services;
- 2) Competition between MACs will encourage them to deliver better service to providers; and
- 3) CMS is requiring MACs to focus on financial management resulting in more accurate claims payments and greater consistency in payment decisions.

As with all change, you can expect initial problems at start-up with new MACs. The best thing to do is be prepared for errors and problems by educating yourself with your MACs websites. Learn

how to maneuver to find your needed information. They will all be working under the same directives but they do disseminate that information differently per websites.

If you find a problem contact the MAC immediately. More than likely you are not the only one having the problem and the MACs will appreciate knowing that the problem exists so they can handle it in a timely manner.

Remember that the people working at the Macs, those contact personnel in the provider call centers are doing their best to address your questions. Be polite; develop a good working relationship with their employees. Basically treat them with courtesy and respect and you will get a much better result. It's just common sense to remember that we are all in this transition together hoping for the same results.

PROTHROMBIN TIME MONITORING FOR HOME ANTICOAG MANAGEMENT

If you missed the update on the PT monitoring in MedLearn Matters MM6313 where they added particular ICD-9 codes you can find it here <http://www.palmettogba.com/palmetto/providers.nsf/DocsCat/Ohio%20Part%20B%20Carrier~Articles~General~8525746A00550AA38525753F00640BBC>

DISPUTES OVER MEDICARE FEE FOR SERVICE PAYMENTS

If you have exhausted all avenues of dispute with the Medicare Private Fee-for-Service plan when you are not satisfied with their payment you now have another place to go. CMS has assigned First Coast Options, Inc. as an independent adjudicator. See <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0902.pdf> for more information.

CO-13 DENIAL FROM MEDICARE

This denial code, "Date of death precedes service date" can be handled effectively if you provided services on the date of death. All you have to do is prove that you provided the services prior to the **time** of death on that date. Send your appeal with a copy of the death certificate showing the time of death. Include a copy of each service provided showing the time supplied. You should have no trouble getting payment.

CMS ADDS MORE DX CODE FOR PROTHROMBIN TIME

Part B News tells us that CMS has added several more applicable diagnosis codes for PT (**G0248-G0250**). **V43.3** – organ or tissue replaced by other means, heart valve; **289.81** – primary hypercoagulable state; **451.0-451.9** includes **451.11**, **451.19**, **451.2**, **451.80-451.84** and **451.89** – phlebitis & thrombophlebitis; **453.0-453.49**, includes **453.40-453.42**, **453.8-453.9** – venous embolism and thrombosis of the deep vessels of the lower extremity, and other specified veins/unspecified sites; **415.11-415.12**, **415.19** – pulmonary embolism & infarction; and **427.31** – atrial fibrillation, est., paroxysmal.

See CMS transmittal 1663 here: www.cms.hhs.gov/transmittals/downloads/R1663CP.pdf

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