



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

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MEDICARE LIMITATION OF RECOUPMENT

For Medicare overpayments discovered after April 6, 2009, CMS has issued two change requests 6183 and 5986 instructing contractors how to handle overpayment subject to the limitation of recoupment set forth in Section 935 of the Medicare Modernization Act.

There are some overpayments not subject to the new limitations of recoupment and how offsets will be handled along with how timely re-determinations and/or reconsiderations will be effected.

Here is a link to Highmark Medicare Services Provider Bulletin that goes into the details
<http://www.highmarkmedicare.com/bulletins/partb/news04062009.html>

TELL CMS YOUR SUGGESTIONS FOR PQRI REPORTING

CMS is accepting suggestions for reporting options for use in the 2010 PQRI. Check it out here:
http://www.cms.hhs.gov/PQRI/02_Spotlight.asp#TopOfPage

AMBULANCE CERTIFICATION FORM AVAILABLE ONLINE IN OHIO

Medicare will cover "medically necessary" ambulance services but they require a Physician Certification Statement (PCS). The Ohio Ambulance and Medical Transportation Association has developed a form that you may use. Here is a link to the online interactive form that you can fill out and print right from the PalmettoGBA website:

[http://www.palmettogba.com/Palmetto/Providers.nsf/files/Physician_Certification_Statement_for_Ambulance_Transportation.pdf/\\$File/Physician_Certification_Statement_for_Ambulance_Transportation.pdf](http://www.palmettogba.com/Palmetto/Providers.nsf/files/Physician_Certification_Statement_for_Ambulance_Transportation.pdf/$File/Physician_Certification_Statement_for_Ambulance_Transportation.pdf)

Medicare will use the information to establish medical necessity. Medical necessity is supported when the patient's condition is severe enough that use of any other mode of transport would endanger the patient's health. Palmetto warns that vague and general information is of little or no value. Past medical conditions can contribute to the need for the ambulance transport but are not sufficient alone. Detail specific information about the patient's current condition at the time of transport.

MEDICARE EXPANDS PET SCAN COVERAGE

CMS has a program called Coverage with Evidence Development Project and it has found PET Scans to be “Reasonable and Necessary” for initial treatment decisions of most solid tumor cancers. In the past coverage was tied to the requirement that you had to collect information about how the scans affected doctors treatment decisions. This has been lifted. For more information see on line: www.cms.hhs.gov/mcd/viewdecisionmemo.asp?id=218

UPDATE ON INTERNET-BASED ENROLLMENT (PECOS)

If you are using PECOS for provider enrollment, the following updates were implemented November 24, 2008 by CMS detailed in MLN Matters MM6231 <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6231.pdf>

- ❖ If the provider fails to submit a signed and dated certification statement to the Medicare contractor within 15 calendar days of the date on which it submitted its Internet-based PECOS CMS-855 to the contractor, the contractor may reject the application.
- ❖ For initial CMS-855 applications sent via the Internet-based PECOS, it is only necessary that the dated signature of at least one of the provider’s authorized officials be on the certification statement that must be sent in by the 15th day. The signatures of the other authorized and delegated officials will be collected through the normal application development process.
- ❖ If the provider submits an undated certification statement or a certification statement on which the Web Tracking ID does not match that in Pecos, the Medicare contractor will treat it as a non-submission.
- ❖ If your contractor determines that additional or clarifying information is needed, the contractor will send an e-mail to the provider: 1) requesting said date along with, as necessary, a signed and dated certification statement; and (2) listing a date(s) by which the information and certification statement, respectively, must be submitted to the contractor.
- ❖ Note that your contractor may, at its discretion, initiate a follow-up contact with you after sending the e-mail, but is not required to do so.
- ❖ If the provider fails to submit the requested additional/clarifying information and the accompanying certification statement within 30 calendar days from the date the contractor sent the e-mail, the contractor may reject the provider’s application.
- ❖ If the contractor receives the additional/clarifying information from the provider, the contractor will **NOT** recommence its processing of the applications until the accompanying certification statement is received in the contractor’s provider enrollment department.

NOTE: As of April 1, 2009, CMS has shortened the time you can retroactively bill claims on a newly enrolled provider with Medicare. Per *Part B News*, “The effective date of billing for a provider and the provider’s organization is the later of either the enrollment application filing date or the day the provider began furnishing services at the practice locations.... You have 30 days to retrospectively bill from the effective date. *Part B News* gives these four examples.

1. A physician starts a new practice location on July 1 and submitted her enrollment application on June 10. CMS says the effective date in this scenario would be July 1

since the physician could not be treating any patients prior to the opening of their practice on July 1.

2. A physician begins working at a new practice location on Aug. 15, but filed his enrollment application Sept. 1. Sept. 1 is the later of the two dates and is the effective date. The provider can retrospectively bill back to Aug. 15 – the date he started seeing patients at the new practice.

3. A physician starts work on Jan. 2, but does not get around to filing an enrollment application until March 1. The effective date in this scenario is March 1, but for billing purposes the provider can retrospectively bill for services rendered 30 days before the effective date – which is Jan. 31 (during a non-leap year).

4. A physician's billing privileges were deactivated on Oct. 1 after he had not billed Medicare for 12 months. The physician submits an enrollment application Dec. 15. The doctor's effective date is Dec. 15 and he can retrospectively bill back to Nov. 16. The doctor cannot receive payment for services provided between Oct. 1 and Nov. 15, CMS says.

CMS transmittal 286 can be viewed here:
www.cms.hhs.gov/transmittals/downloads/R286PI.pdf

CMS has changed its stance on requiring the physician only to use PECOS. Now you can share your identifying information with a third party who can then use the PECOS system on your behalf. However, be aware that the physician is totally liable for the information provided. CMS is hoping this will increase the usage of the online enrollment PECOS.

CMS also changed its stance on electronic payment restrictions to the states that you practice in. That restriction was lifted in April. See online MLN at:
<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6310.pdf>

SHOULD YOU FIGHT A MEDICARE PARTIAL REVIEW PAYMENT?

You sent a claim into the reconsideration department at Medicare it was denied, the next step was to send it to the Quality Independent Contractor (QIC). The QIC review resulted in a payment at only 80% of the claim review. You have to decide if the 20% that was denied is worth the third step of review to the Administrative Law Judge (ALJ). Remember that the ALJ has the ability to reverse the 80% that you were given by the QIC. It's worth pursuing, if you are sure of yourself. Review the QIC's review response carefully.

Part B News reports that normally CMS doesn't get involved in the ALJ level of review but it can raise any issue that wasn't in their favor if they become a party in the action. The ALJ generally looks only at the unfavorable portion of the claim review. However, be aware that the ALJ can look at the claim review in its entirety and overturn the 80% that you already received. *Part B News* quotes an attorney, Peter Keohane as stating that he has only seen the complete review addressed by the ALJ when CMS becomes an active party in the action. CMS can participate but at that level CMS can not ask the judge to look at the favorable portion but if CMS becomes a party in the action, they can raise any issue that wasn't decided in their favor. Unfortunately, you will not know if CMS intends to become a party in the action or only participate, until after you have requested the ALJ hearing.

There is also a dollar limit on those claims reviews taken to the ALJ. This link will take you to the PalmettoGBA chart explaining all levels of reconsideration and review
[http://www.palmettogba.com/palmetto/providers.nsf/\\$\\$ViewTemplate+for+Docs?ReadForm&Providers/Part+B+Carrier/Ohio/Resources/Appeals](http://www.palmettogba.com/palmetto/providers.nsf/$$ViewTemplate+for+Docs?ReadForm&Providers/Part+B+Carrier/Ohio/Resources/Appeals). This is on PalmettoGBA but applies to all carriers

as this is a CMS directive. Note that the ALJ level of hearing requires a minimum of \$120.00 for filing. You can combine claims to reach that level.

Part B News gives the following tips on combining amounts to meet the dollar limit for the ALJ. “Combine claims to reach the amount in controversy. You can combine or “aggregate” claims in order to reach the required amount in controversy for an appeal at the Administrative Law Judge level. However, each claim must have received an unfavorable decision from the QIC and you can’t appeal a claim more than 60 days after you receive the QIC’s decision. Here are some more tips for aggregating claims: 1. Two or more providers can combine claims if the claims involve the delivery of similar or related services to the same beneficiary. 2. Two or more providers or physicians or other suppliers with appeal rights may combine their claims if the claims involve common issues of law and fact for services furnished to two or more beneficiaries.

NOTE: The ALJ will determine whether or not aggregated claims meet these requirements.

MISCELLANEOUS CODES

Just because a code exists in the CPT book doesn’t mean it will be paid. An example of this is the miscellaneous codes. For example 99050 “Services provided in the office at times other than regularly scheduled office hours...” If you see a patient on the weekend in your office Medicare will not pay for it because CMS has no fee schedule for that code. An easy way to check these codes is to view your Medicare fee schedule. If a code is not listed, it’s not payable.

Some commercial payers may pay for these codes but take note that 99050 – 99060, the misc. E/M codes all state, “in addition to basic service”. This means these should be billed in addition to the regular E/M codes or Consult codes. Since each carrier makes their own rules with regard to these misc. codes, check with them before billing to learn their policies.

Part B News tells us that some practices have been accused of abusing the system when they continued to submit claims for these services to Medicare carriers after “receiving denials stating the Medicare does not cover or pay for the procedure”.

However, if you are billing Medicare, as the primary carrier, for a service that you know is not covered in order to have their denial to bill the secondary carrier for that service knowing that the secondary will cover the service, be sure to use the appropriate modifier. GY – Item or service statutorily excluded or does not meet the definition of any Medicare benefit or GZ – Item or service expected to be denied as not reasonable and necessary or GA – which conveys that you know the service isn’t covered and will be denied as not reasonable and necessary and you do have on file an ABN signed by the beneficiary.

PREVENTIVE SERVICES INFORMATION ON MEDICARE LEARNING NETWORK (MLN)

The ABCs of Providing the Initial Preventive Physical examination Quick Reference chart (January 2009) is available in a two-sided laminated chart or a tear-off pad on the MLN. Medicare fee-for-service physicians and qualified non-physician practitioners may use this guide when providing the initial preventive physical examination (IPPE) or you may know it as the *Welcome to Medicare* physician exam or visit. This guide holds the components and elements of the IPPE along with the eligibility requirements and procedure codes for filing claims. It also contains FAQs and suggestions for preparing patients for the IPPE and lists references for additional information. To view and download to print this resource go to http://www.cms.hhs.gov/MLNProducts/downloads/MPS_QRI_IPPE001a.pdf

If you choose to order the laminated chart or tear-off pad at no charge, go to <http://www.cms.hhs.gov/MLNProducts/> and scroll down to *Related Links Inside CMS*. From here choose *MLN Product Ordering Page*.

You may also download and print the *Medicare Preventive Services Quick Reference Information* chart at http://www.cms.hhs.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf. This is also available at no charge in a two-sided laminated chart at http://www.cms.hhs.gov/MLNProducts/01_Overview.asp Scroll down to *Related Links Inside CMS* and choose *MLN Product Ordering Page*.

ANTHEM OFFERS FAX RESPONSES TO UTILIZATION MANAGEMENT REQUESTS

If you want to receive faxed utilization management decision letters to speed up the process you can access a form here http://www.anthem.com/provider/noapplication/f5/s1/t0/pw_b130409.pdf on the PDF page 5 to print out and send in to Anthem Blue Cross/Blue Shield. If you have any questions, please contact your Anthem representative.

RAC PROTEST SETTLED

As of February 2009 the parties involved in the protest regarding the Recovery Audit Contractor (RAC) contract awards was settled which released the stop work order from CMS.

Four RACs will contract with subcontractors to supplement their work load. The listed contractors are: Region A, initially working in Maine, New Hampshire, Vermont, Massachusetts, Rhode Island and New York: Diversified Collection Services (DCS); Region B, initially working in Michigan, Indiana and Minnesota: CGI Technologies and Solutions, Inc.; Region C, initially working in South Carolina, Florida, Colorado and New Mexico: Connolly Consulting, Inc. and Region D initially working in Montana, Wyoming, North Dakota, South Dakota and Arizona: HealthDataInsights, Inc.

The RAC program is permanent and CMS plans to have 4 RACs in place with each RAC being responsible for identifying overpayment and underpayments in approximately ¼ of the country. Additional states will be added to each RAC region through this year and it is required that RAC will be expanded to all 50 states no later than 2010.

Per CMS the RAC demo program has proven to be successful in returning dollars to the Medicare Trust Fund. For this reason RAC will continue permanently to be used to detect improper payments and prevent future improper payments.

GUIDELINES FOR THOSE AUTHORIZED ACCESS TO CMS COMPUTER SERVICES

CMS has issued 3 articles through MLN (MedLearn Matters) that have been updated as of February 20, 2009 to reflect current terminology and processes on CMS applications integrated with IACS (CMS computer systems). CMS will notify providers as CMS applications integrated with IACS become available and provide clear instructions specifying which providers should register in IACS to access those applications. For example SE0830 and SE0831 inform physicians how to register in the IACS (CMS computer systems) Web site to access their PQRI feedback reports. Do not register until you are notified to do so by CMS or one of its contractors and ONLY if you meet the criteria in the notice.

SE0747 <http://www.cms.hhs.gov/MLNMattersArticles/downloads/se0747.pdf> helps provider to register for access to CMS online computer services when directed to do so by CMS. SE0747 contains 11 questions and answers to get you started and an overview of the registration process for IACS-PC defined provider/supplier organization users.

SE0753 <http://www.cms.hhs.gov/MLNMattersArticles/downloads/se0753.pdf> holds 3 questions and answers about the registration process for provider organizations and links to the quick reference guides for completing the registration process for provider organizations.

SE0754 <http://www.cms.hhs.gov/MLNMattersArticles/downloads/se0754.pdf> describes the three steps providers must take to access a CMS Enterprise Provider Application including how to request a provider application role in IACS-PC.

MEDICARE ANTI-MARKUP ON DIAGNOSTIC TESTS

If you bill for “purchased diagnostic tests” you will need to know how Medicare views these tests and how much you are permitted to bill for them. This MLN article details all that information <http://www.palmettogba.com/Palmetto/Providers.nsf/docsCat/8525746A00550AA38525756F00644917?opendocument>

Anti-markup applies when a diagnostic test (excluding clinical lab tests) is performed or supervised by a physician/supplier who does not share a practice with the physician/supplier who orders and bills the test.

Basically CMS says that payment may not exceed the lowest of the following amounts: 1) The performing supplier’s net charge to the billing physician; 2) The billing physician’s actual charge; and 3) The fee schedule amount for the test that would be allowed if the performing supplier billed directly.

The MLN article gives additional information on when the anti-markup rule does not apply and key billing points.

MEDICARE REQUIREMENTS FOR THERAPY DOCUMENTATION

If you receive a request for documentation in regard to a therapy claim the following elements are required unless specifically requested otherwise. Palmetto GBA says, “Document as often as your judgment dictates but no less than the frequency required by Medicare policy.”

- ❖ Evaluation/Plan of Care (may be a single document or two separate documents). Include in the initial evaluation and any re-eval relevant to the episode being reviewed.
- ❖ Certification (physician/non-physician practitioner (NPP) approval of the plan) and recertification when records are requested after the certification/recertification is due. Certification (and recertification of the plan when applicable) are required for payment and must be submitted when records are requested after the cert or re-cert is due.
- ❖ Progress Reports (including Discharge Notes, if applicable) when records are requested after the reports are due.
- ❖ Treatment Notes for each treatment day (may also serve as Progress Reports when required information is included in the notes).
- ❖ A separate justification statement maybe included either as a separate document or within the other documents to document the practitioner’s reasoning for providing services that are more extensive than is typical for the condition treated. A separate statement is not required if the record justifies treatment without further explanation.

For more detail on Palmetto GBA requirements see: <http://www.palmettogba.com/Palmetto/Providers.nsf/DocsCat/Providers~Ohio%20Part%20B%20Carrier~Articles~Therapy~Therapy%20Service%20Documentation%20Requirements?opendocument>

For calendar year 2009, the financial limitations on outpatient therapy services have been revised as follows: 1) The annual limit on the allowed amount for outpatient physical therapy and speech-language pathology combined is \$1840. 2) The separate limit for occupational therapy is \$1840.

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