



**Professional Receivables Control, Inc.
Monthly Newsletter
June 2008**

Please route to appropriate staff

Newsletter access is also available through the help menu

OHIO/WEST VIRGINIA MEDICARE PHONE NUMBER CHANGE

As of June 2, PalmettoGBA, the Medicare adjudicator in Ohio and West Virginia added a new phone number to reach their Customer Service Representatives (CSR), 1-866-332-7025. The CSR will be available at that number from 8:30 a.m. through 4:30 p.m. The old number 1-877-567-9232 will reach the Interactive Voice Response (IVR) only and is available from 6:00 a.m. through 9:00 p.m.

CMS has directed all contractors to refer you to the IVR if you call the Customer Service Representatives for information that is attainable on the IVR.

You can use the IVR to obtain:

- Beneficiary eligibility
- Claim status
- Deductible information
- Number of claims and dollar amount pending payment
- A duplicate remittance notice
- Pricing information
- Breaking Medicare news
- Guidance on appealing a denied claim
- Steps to request a Provider Outreach and Education meeting or seminar

MEDICARE SPRING UPDATE AVAILABLE

PalmettoGBA has made available valuable information with their new Spring Update. I would suggest you either download it or print it for future reference. It deals with NPI, PQRI, RAC, Medicare Advantage Plans, Access to CMS applications, and much more. Go to:

[http://www.palmettogba.com/palmetto/providers.nsf/Attachments/EF91DF30B83FE41085257447006BB496/\\$FILE/Medicare+Part+B+Spring+Update.pdf](http://www.palmettogba.com/palmetto/providers.nsf/Attachments/EF91DF30B83FE41085257447006BB496/$FILE/Medicare+Part+B+Spring+Update.pdf)

CLARIFICATION OF NPI REQUIREMENTS ON REFERRING/ORDERING/ETC.

Further clarification of NPI requirements was disseminated by CMS in May. The following directive was in an email notice on May 14th. If you missed it this is what it boiled down to:

- If unable to obtain the NPI of the entity to be identified in the service facility location loop, no identifier should be reported in that loop.
- If unable to obtain the NPI of the ordering/referring/attending/operating/supervising/purchased service/other or prescriber, the billing provider (in the X12N 837 transactions) or the service provider (in the NCPDP 5.1 transaction) shall use its own NPI to identify those secondary providers. Medicare will not pay these claims if these secondary providers are not identified by NPIs.

If you want more information on NPI go to the CMS NPI website page:
www.cms.hhs.gov/NationalProvIdentStand

MEDICARE OVERPAY If Medicare determines that they have overpaid you, they will convey that overpayment in three ways.

1. You will see a claim adjustment on your provider remittance showing a Forwarding Balance (FB), which will include the ICN of the claim. Checking for the ICN on that remittance will show you the patient and the dates of service involved in the overpayment. The denial reason will tell you why the overpayment was created.
2. You will receive an initial overpayment letter notifying you of the overpayment, which includes the patient information and the Invoice number (previously referred to as your A/R number). Please store these letters for future reference related to the overpayment. You have a few options on resolving the overpayment:
 - You can refund the money with a copy of the letter, so you can be assured that the refund will be applied to the correct invoice number.
 - You can request an immediate offset, if you are currently receiving Medicare payments under the specific provider number.
 - You can decide to wait for the money to be withheld (offset) on, or after, the date indicated in your overpayment letter
3. If the requested refund is not received by the date listed in the original overpayment letter, interest will be accrued and a second letter will be sent. A copy of the original letter will be included for your reference. If the requested refund is not received by the date listed in the second letter, the amount will be offset from future payments.

Remember you can always ask your Medicare carrier to recheck its math. *Part B News* tells us that it is too time consuming for the carriers to check each claim if they feel there is an overpayment situation.

They give us this example: If a post-payment review audit shows 10% of 100 sample claims represent overpayments of \$9, the carrier can extrapolate that ratio to the rest of the 1,000 claims paid during a certain period. Based on this, the carrier will recoup overpayments on 100 claims (10% of 1,000) at a rate of \$9 a claim. That comes to a \$900 overpayment. **Note that effective April 18, 2008 the 3rd increase to this rate takes the interest rate for overpays and underpays to 11.375 percent.**

You have the right to appeal overpayment demands and in Transmittal 1457 to Medicare's Claims Processing Manual, CMS notes that carriers should double-check the sampling method when you disagree with its findings.

NOTE: Based on the wording of the transmittal, you must address the statistical sampling in your redetermination request, CMS says.

Transmittal 1457 can be viewed here:
www.cms.hhs.gov/transmittals/downloads/R1457CP.pdf

CLIA WAIVED TESTS

If you have a CLIA waiver and are performing lab tests in your office under that waiver you should be checking the listing of waived tests regularly. This list can be found on the CMS website at; http://www.cms.hhs.gov/CLIA/10_Categorization_of_Tests.asp#TopOfPage. New tests are added periodically throughout the year.

PQRI UPDATE

For the latest updates and tool kits go to:
[www.palmettogba.com/palmetto/palmetto.nsf/\(News\)/7349BA6B9CA960F8852573FE0067B350?OpenDocument](http://www.palmettogba.com/palmetto/palmetto.nsf/(News)/7349BA6B9CA960F8852573FE0067B350?OpenDocument)

You may still have the ability to collect a half a year's PQRI bonuses by using a CMS approved registry. A registry is a data repository that tracks patient care and outcomes and submits the information to CMS for the PQRI program on your behalf. CMS is in the process of pre-approving registries and will release a list of those pre-approved in August. Once these are released you will have to select and sign up with a registry. That registry will review your application and train you on how to submit the required information to them. There will be a registration fee for each physician or non-physician practitioner who submits data. If you are already using a registry make sure they are one of the approved by CMS or they will not be able to collect data for CMS PQRI.

REMITTANCE ADVICE REMARK & PAYMENT ADJUSTMENT CODE UPDATES

There are two sets of codes that must be used for any payment adjustment on a Medicare EOB. Check here for information on April 2008 updates;
[http://www.palmettogba.com/palmetto/providers.nsf/\(Docs\)/76E43EFAEA3BA1548525740A0056CB01?OpenDocument](http://www.palmettogba.com/palmetto/providers.nsf/(Docs)/76E43EFAEA3BA1548525740A0056CB01?OpenDocument)

UNITED HEALTHCARE CERTIFICATION FOR IMAGING

From MedLearn Matters:

"United Healthcare (UHc) plans to require all facilities that perform diagnostic imaging to obtain appropriate accreditation by the third quarter of 2008 (July through September) in order to continue receiving reimbursements. The payer will notify imaging facilities 30 days before the program becomes effective in their areas. As long as the imaging site has submitted its application by its effective start date, it will be in compliance with the accreditation program. Those that have not applied for accreditation will not be eligible for reimbursement from UHc. Although other payers require imaging accreditation at the local or state level, UHc is the first to implement a national imaging accreditation program.

A complete list of CPT codes that fall under UHc's accreditation mandate can be found at www.UnitedHealthcareOnline.com. Use the search function and type "accreditation."

Look for a document entitled An Imaging Accreditation Overview, which lists the codes that require accreditation and other important information."

IMAGING DENIALS

Part B News tells us that there are 3 ways to avoid imaging denials.

Firstly you need to review CMS and your local carrier policies with regard to coverage. Any time you add an imaging service to the services you provide you should familiarize yourself with the coverage policies.

In addition to reviewing CMS and local policies your physicians need to spend more time during the E/M visit asking detailed questions to get to a specific diagnosis for the imaging procedure. Don't settle for "pain" only but try to find out why they are in pain.

Second, if you are seeing the patient on referral, be sure to get as much clinical history as possible from the referring physician. For example, if the patient comes to you from the ER, and all the ER imaging exams were normal with no other information than "Motor Vehicle Accident" you need to get quick answers from the referring physician's office with regard to the patient's condition when seen by them. You should be doing this any time the diagnosis doesn't meet coverage criteria.

Third, last but not least, use the ABN. Some patient's are demanding of testing. They want a fast answer to their questions and often patient's have just enough knowledge to demand certain tests. For instance, you may be seeing a patient with severe headache who is demanding an MRA. This is the time you use the ABN. Remember the new version of the ABN is out now and you can start using it. However, use of the new ABN won't be **required** until September 1, 2008.

EXTENSION OF LOCUM TENENS

CMS has extended the 60 days limit for substitute physicians if your physician is called to active military duty. This was extended through June 30, 2008. You can find more information here; <http://www.cms.hhs.gov/transmittals/downloads/R1486CP.pdf>

CMS CHANGES TO THRESHOLD DOLLAR AMOUNTS

Medicare Office Billing & Collections Alert gives us this flow chart:

CMS directed all of its carriers to increase the Administrative Law Judge and Federal District Court Amount in Controversy threshold amounts. The ALJ hearing request threshold was \$110 and is now \$120 after Jan. 1. The AIC threshold amount was \$1,130 and is now \$1,180 after Jan. 1. Take a look at this chart to see how your appeals will flow in 2008.

Appeal Level Time Limit Threshold

1. **Redeterminations** 120 days from the date of receipt of the initial determination notice
2. **Reconsiderations** 180 days from the date of receipt of the redetermination
3. **Administrative Law Judge (ALJ) Hearing** 60 days from the date of receipt of the reconsideration \$120
4. **Medicare Appeals** 60 days from the date of receipt of the ALJ hearing decision None Council (MAC) Review
5. **Judicial Review** 60 days from the date of receipt of MAC decision or declination \$1,180 in U.S. District Court of review by MAC

Note: Medicare carriers will reconsider a redetermination or reconsideration past the 120 day time limit, if you can prove the error was the carrier's fault. This is the only instance where the time limit will be overlooked.

Durable Medical Supplier Medicare Certification Update

CMS has announced that you must apply for accreditation as soon as possible if you provide DME. Practices need to receive accreditation every three years. *Part B News* tells us that the professional medical organizations are fighting to push back the deadline urging CMS to exempt healthcare providers from the accreditation process. However, during a phone conference with CMS, *Part B News* was told that there will be no exceptions to the requirement that all suppliers of equipment to a Medicare patient needs to be accredited by September 30, 2009.

CMS did exempt "treating physicians" from the Medicare DMEPOS Competitive Bidding Program but you still have to be accredited to supply to Medicare patients.

There is apt to be a logjam of applications so to avoid delays you should apply as soon as possible. The process could take up to 7 months to complete (some think it could take 8 to 12 months depending on the number of applicants), keep in mind the deadline date if September 30, 2009.

Part B News tells us that CMS recommends that you contract one of the accrediting organizations to begin the process. The costs will depend on the size of the practice but generally is estimated to start at \$3,000 and up. Also you need to provide CMS with a \$65,000 surety bond. CMS states this bond helps prevent fraudulent suppliers from operating. The bond costs about \$2,000 a year or 3% of the bond value.

END STAGE RENAL DISEASE FACT SHEET

Here is a link to the fact sheet provided by CMS covering outpatient management of dialysis in End Stage Renal Disease. It contains general information as well as separate billable services and items and a composite payment rate system.

<http://www.cms.hhs.gov/MLNProducts/downloads/ESRDpaymtfctsh08-508.pdf>

Mable Scott
mrscott@comcast.net