



**Professional Receivables Control, Inc.
Monthly Newsletter
December 2007**

Please route to appropriate staff

Newsletter access is also available through the help menu

QUALCHOICE TO END OLD CLAIMS PROCESSING

QualChoice Insurance went out of business as of January 1, 2007 but they have continued to process any claims for service prior to January 1, 2007. You have until December 31 to get any old claims into QualChoice for payment. After the end of this year, they will no longer process any claims. Be sure to review your open claims to make sure you have them all processed.

9 DIGIT ZIP CODE REQUIREMENT

In March 2007 Medicare put out a listing of zip codes that would require the full 9 digits. This has been updated and can be found at the link below:

<http://www.cms.hhs.gov/MLNMArticles/downloads/MM5208.pdf>

MEDICARE PART D DRUG ADMINISTRATION

In 2007 you have been able to bill Medicare for the administration of Part D covered medications with the code G0377. This will be discontinued as of January 1, 2008. In 2008 you must collect payment from the patient and the patient must submit to Medicare for reimbursement. Make sure your staff is aware of this change.

NEW INTEREST RATE FOR MEDICARE OVERPAYS AND UNDERPAYS

In the first quarter of the fiscal year 2008, Medicare provides for the assessment of interest at the higher of the current value of funds rate (four percent for calendar year 2007) or the private consumer rate as fixed by the Department of the Treasury. The Department of the Treasury has notified the Department of Health and Human Services that the private consumer rate has been changed to 12.5 percent effective October 19, 2007.

ASSISTANCE WITH PROVIDER ENROLLMENT

CMS recently made available a document that will assist physicians and non-physician practitioners in completing form CMS-855I, Medicare Provider Enrollment Application – Physicians and Non-Physician Practitioners. This document contains several enrollment scenarios and indicates where on the CMS-855I the National Provider Identifier (NPI) is to be reported. It also indicates when the CMS-855R and/or the CMS-855B need to be

completed. The document is available from the following website <http://www.cms.hhs.gov/Medicareprovidersupenroll/Downloads/EnrollmentNPI.pdf>.

Here are 5 tips to help with enrollment:

1. Ensure the name reflected on your National Provider Identifier (NPI) application form identically matches your legal business name.

Access the following Web site address or phone number to validate that the legal business name the Internal Revenue Service (IRS) has for you (CP-575) matches the business name registered with the National Plan & Provider Enumeration System (NPPES): <https://nppes.cms.hhs.gov/NPPES/Welcome.do>, 1-800-465-3203 or 1-800-692-2326 for TTY services.

Applying for an NPI is a separate process from requesting provider enrollment in the Medicare program. The Centers for Medicare & Medicaid Services (CMS) requires that providers and suppliers obtain their NPI prior to enrolling for, or updating, their Medicare enrollment information. Based on this regulation, each enrollment application form (initial applications and changes/updates) must include your NPI and a copy of the NPI notification from the NPI contractor. If your NPI and the NPI notification letter are not submitted, your enrollment into the Medicare program will be delayed.

2. Attach a copy of your Internal Revenue Service (IRS) CP-575 form.

The IRS CP-575 is a letter you receive from the IRS granting your employer identification number (EIN). This IRS form reflects your legal business name. It also provides proof of your employer tax identification number (TIN); Medicare records must have a written confirmation from the IRS validating your TIN with your legal business name. Acceptable tax documents must be generated or pre-printed by the IRS. Examples of acceptable documentation are IRS CP-575, IRS Form 8109 and IRS substitute letter 147C. A W-9 is not acceptable documentation.

3. Attach a copy of your Electronic Funds Transfer (EFT) Authorization Agreement (CMS-588 – not to be confused with CMS-855 enrollment forms).

4. Read each section of the application form(s).

For each section of the Provider Enrollment forms, CMS has provided detailed instructions. Ensure that, where applicable, boxes are checked, signatures (in ink) are provided and all required fields have been completed.

5. Include copies of all professional and business licenses.

MODERATE SEDATION AND PROCEDURE BY SAME PHYSICIAN IS PAYABLE

Prior to 2006 Medicare would not pay for sedation separately when provided by the same physician doing the procedure. However, you can bill Medicare for **moderate sedation** when provided during a procedure. See the Medicare September 2007 Advisory for more detail and specifics with regard to CPT codes. You still can not bill for local/minimal sedation during a procedure. In this case, the sedation is included in the procedure payment.

INTERACTIVE RECONSIDERATION REQUEST FORM

If you are a full service client of PRC you know that we do the first stage of asking Medicare to look at a denied claim a second time. This is the Redetermination phase. Once that service is complete, if Medicare upholds the original denial, you have the opportunity to ask Medicare for a Reconsideration of the Redetermination.

Palmetto GBA has made your redetermination requests easier. Now you can access an interactive Redetermination Request Form on the Palmetto GBA website, www.palmettogba.com under Quick Links drop down menu, choose Ohio Part B and then choose forms. You will see the Redetermination Request Form under Appeal Forms. This form allows you to fill in the blanks right on your computer. You have the option of downloading the form on your computer or using it online. Once you fill it out you must print the form, attach any supporting information.

If you are using the Ohio form, mail it to:

First Coast Service Options, Inc.
QIC Part B North Reconsiderations
PO Box 45208
Jacksonville, FL 32232-5208

If you are using the West Virginia form, mail it to:

Q2 Administrators, LLC
Part B QIC South Operations
PO Box 183092
Columbus, OH 43218-3092

LCD CHANGES FOR NONINVASIVE VASCULAR TESTING

PalmettoGBA has deleted ICD-9 code V58.49 as supporting medical necessity for CPT codes 93875-93882, 93931, and 93965-93971 effective 1/1/08.

Addition of ICD-9 code V58.73 as supporting medical necessity for CPT codes 93875-93882, 93931, and 93965-93971 - effective 1/1/07.

This was done due to the change in the 2007 description of V58.49. This code will be replaced by V58.73. The effective date for the deletion of V58.49 will be 1/1/08. The effective date of the replacement code, V58.73 will be 1/1/07.

ANTHEM

Anthem started migrating their BlueCard and National business to a new system for claims adjudication which will combine it with their local products this fall. As a result there will be changes in items you receive from Anthem.

Anthem remittance advice for BlueCard and National business will be similar to what you already receive for local products. There will be a specific phone number for each claim which represents the contact for questions on your claim.

You will begin to receive letters detailing overpayments for BlueCard and National business as they move into the new system. These letters will also be similar to what you now receive on local products. Previously, this information was on the remittance advice.

Refunds will also be on the remittance advice for BlueCard, Local and National business acknowledging receipt of refunds. This was phased in throughout 2007 based on the line of business and the type of refund.

The refund information will be a new line titled REFUND below the current INTEREST PAID LINE displayed in the PROVIDER RESPONSIBILITY column. The product summary TOTAL NET AMOUNT DUE will show the refund. The total of all refunds will show in the NET AMOUNT DUE. Remit totals will not be affected by the application of a refund unless the amount refunded is not adequate to correct the overpayment.

All refunds should be sent to: Central Region-CCOA Lockbox, P. O. Box 73651, Cleveland, OH 44193-1177

While in this transfer process, to the new system, you may receive letters requesting additional information on claims. Eventually this will go back to being printed on the remittance advice.

TAMPER-PROOF RX PAD REQUIREMENT

CMS has moved the date for Medicaid tamper-proof prescriptions back to on or after April 1, 2008.

MEDICARE 2008 PHYSICIAN FEE SCHEDULE FINAL RULE

From Palmetto GBA; "The 2008 Medicare Physician Fee Schedule (MPFS) Final Rule, effective for services on or after January 1, 2008, is on display in the Federal Register and will be published on November 27, 2007. The rule identifies 119 measures CMS has selected for eligible professionals to use to report quality-of-care information under the 2008 PQRI. The rule can be found at: <http://www.cms.hhs.gov/center/physicians.asp>. The Physician Quality Reporting Initiative (PQRI) provisions begin on page 653. A summary of these provisions is available at: http://www.cms.hhs.gov/PQRI/35_2008PQRIInformation.asp, in the 2008 PQRI Information section of the PQRI Web page. Click on the "PQRI Provisions of the 2008 Physician Fee Schedule Proposed Rule" file in the Downloads section to view the summary."

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