



2011
Medicare Part B
Update Seminar
Part 3 of 3

Richmond County Medical Society
December 17, 2010



Sign up Today!

- www.NGSConnex.com
- Use the training materials available on the Connex home page



Electronic Data Interchange (EDI)



Interested in Electronic Billing?

- Option 1 - Use a software vendor's product
- Option 2 - Employ a billing service or clearinghouse
- Option 3 - Order National Government Services' free software program, PC-ACE

Free PC-ACE Pro32 Software

- Bill Medicare Part A and Part B claims electronically
- Easy to use
- Ability to bill MSP claims
- Must be used with network service
 - Small charge involved
- Enrollment form and information on www.ngsmedicare.com under EDI tab

Administrative Simplification Compliance Act (ASCA)

- Electronic billing required since October 16, 2003
- Paper claims only allowed for providers who meet one of ten ASCA exceptions
- Exceptions include:
 - Medicare tertiary (third) payer claims
 - Providers that submit fewer than 10 claims per month
 - Physician/practitioner/supplier with fewer than 10 full-time equivalent employees (FTEs)

ASCA Enforcement

- ASCA enforcement began on July 5, 2005
- Quarterly analysis conducted - highest volume paper submitters
 - Request for Documentation letter mailed
 - Must respond within 30 calendar days
 - Response will be processed within 30 business days
 - Valid response: Approval letter mailed, provider not reviewed again for 2 years
 - Invalid or no response: Paper claims denied (91st day)

ERA and MREP

- Electronic Remittance Advice (ERA)
 - “Understanding Remittance Advice Guide” on CMS website
 - To sign up for electronic remittances (835), complete ERA agreement
 - www.ngsmedicare.com under Claims > Electronic Data Interchange > Enrollment
- Medicare Remittance Easy Print Software (MREP)
 - Print paper copies of your Medicare Remittances
 - Available as free download
 - www.ngsmedicare.com under Claims > Electronic Data Interchange > Software

EDI Helpdesk

- 877-273-4334
- Monday - Friday
- 8:00 AM - 4:00 PM (Eastern) for all EDI requests
- 4:00 PM - 6:00 PM for password resets only
- NGS_EDI_PartB@wellpoint.com



ICD-10 Implementation

ANSI 5010 Environment



ICD-10 Implementation

- **October 1, 2013** – Compliance date for implementation of ICD-10-CM (diagnoses) and ICD-10-PCS (procedures)
 - No delays
 - No grace period
- ICD-10-CM (diagnoses) will be used in all settings
- ICD-10-PCS (procedures) will be used for only inpatient procedures

ICD-10 Implementation

- ICD-9-CM codes will not be accepted for services provided on or after October 1, 2013
- ICD-10 codes will not be accepted for services prior to October 1, 2013

CPT & HCPCS

- No impact on Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes
- These will continue to be used for physician and ambulatory services

ICD-10 Differences

- ICD-10 codes are different from ICD-9-CM codes
 - They provide greater detail in describing diagnoses and procedures
 - There are more ICD-10 codes than ICD-9-CM codes
- ICD-10 codes are longer and use more alpha characters
- System changes required to accommodate ICD-10 codes

Number of Codes - 2010

- Diagnoses
 - ICD-9-CM 14,315
 - ICD-10-CM 69,099
- Procedures
 - ICD-9-CM 3,838
 - ICD-10-PCS 71,957

ICD-10-CM Structure

ICD-9-CM

3 - 5 characters

- First character is numeric or alpha (E or V)
- Characters 2-5 are numeric
- Always at least 3 characters
- Use of decimal after 3 characters

ICD-10-CM

3 - 7 characters

- Character 1 is alpha (all letters except U are used)
- Character 2 is numeric
- Characters 3 - 7 are alpha or numeric
- Use of dummy placeholder “x”
- Alpha characters are not case-sensitive

Benefits of Conversion: 5010/D.0

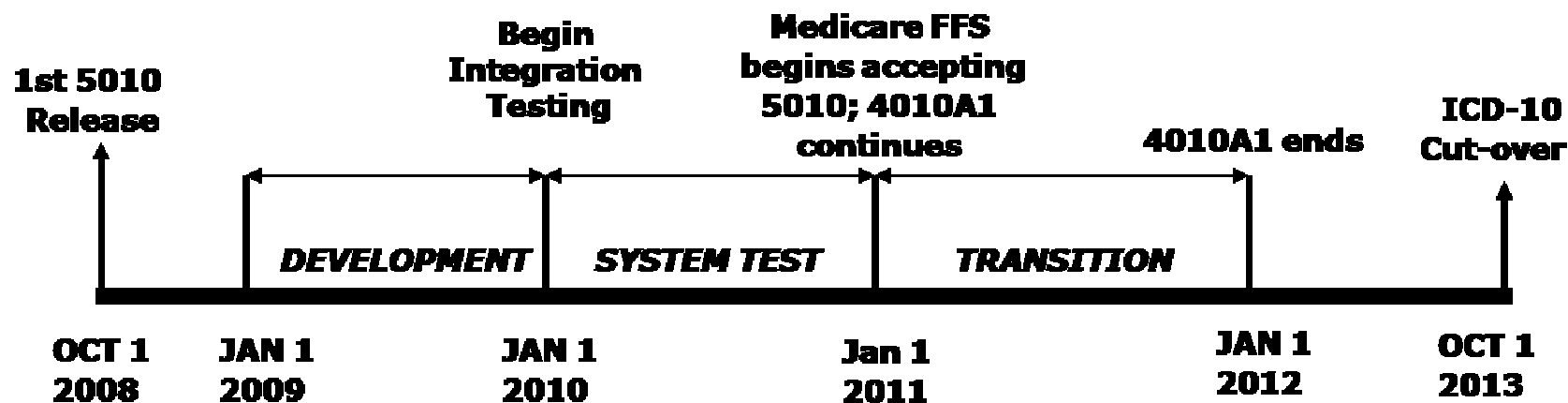
- Improved utility of the NCPDP standards, compliance with Part D requirements
- Supports standardization of companion guides across the industry
- Supports increased use of EDI between covered entities
- Supports E-Health initiatives now and in the future
- Provides infrastructure for ICD-10 and Present on Admission Indicator

5010: What You Need to Do to Prepare

Action Steps You Could Take Now for Medicare Changes

- **Contact your system vendors:**
 - Does your license include regulation updates?
 - Will the upgrade include acknowledgement transactions 277CA & 999?
 - Will the upgrade include a “readable” error report produced from these 277CA and 999 transactions?
- Inquire when your vendor is planning to upgrade your system
- Assess this response to be sure your vendor can assure your transition well before the cutoff, Jan 1 2012
- Evaluate the impact to your routine operations and begin planning for training, transition

Medicare 5010 Implementation Timeline





Electronic Health Records (EHR)



Medicare & Medicaid Electronic Health Record Incentive Programs Beginning in 2011

- Incentive payments totaling as much as \$27 billion may be made under the Medicare & Medicaid Electronic Health Record (EHR) Incentive Programs beginning in 2011. Are you eligible for an incentive? How much can an eligible professional earn? What are the key dates for these programs?
- Learn more on the Centers for Medicare & Medicaid Services EHR Incentive Programs Web site
- <http://www.cms.gov/EHRIncentivePrograms>

Electronic Health Records

- The [Certification Commission for Health Information Technology](#) (CCHIT®) announced today that it has tested and certified 33 Electronic Health Record (EHR) products under the Commission's ONC-ATCB program, which certifies that the EHRs are capable of meeting the 2011/2012 criteria supporting Stage 1 meaningful use as approved by the Secretary of Health and Human Services (HHS)
- Certification is required to qualify eligible providers and hospitals for funding under the American Recovery and Reinvestment Act (ARRA)
- The certifications include 19 Complete EHRs, which meet all of the 2011/2012 criteria for either eligible provider or hospital technology, and 14 EHR Modules, which meet one or more – but not all – of the criteria



*Alternative Process for Accessing
PQRI and E-Prescribing Reports
SE0922*



Alternative Process for Accessing PQRI and E-Prescribing Reports SE0922

- New Process eliminates the need for Eligible Providers **(EP)** to register in IACS for feedback reports
- 10/19/10 - EP's can call contractor to request 2007 & 2008 PQRI reports on their **individual** NPI
- EP's requesting a report based on **TIN or group information** will still be required to access the PQRI Portal after first registering in IACS

PQRI

- 2009 Incentive payments being processed and distributed 10/25/10; completed 11/12/10
- **LE** indicator along with four-digit code **PQ09** will be displayed on electronic remittance
- Paper remittance will indicate “This is a PQRI incentive payment”. The year will not be included



*2010 Electronic Prescribing
Incentive Program Reminder*



eRx Qualified Reporting System Requirements

- Eligible professionals must have adopted a “qualified” eRx system
- There are two types of systems: A system for eRx only (stand-alone) or an electronic health record (EHR) system with eRx functionality

eRx Reporting Requirements

- To be considered a successful eRx prescriber and be eligible to receive an incentive payment, you must generate and report one or more electronic prescriptions associated with an eligible patient visit—a minimum of 25 unique visits per year
- Each visit must be accompanied by the eRx G-code (numerator code) attesting that during the patient visit at least one prescription was electronically prescribed
- Electronically generated refills do not count and faxes do not qualify as eRx. New prescriptions not associated with a code in the denominator of the measure specification are not accepted as an eligible patient visit and do not count towards the minimum 25 unique Rx events
- The eligible professional's Medicare Part B PFS allowed charges for services in the eRx measure's denominator should be comprised of 10 percent or more of the eligible professional's total 2010 estimated allowed charges



Recovery Audit Contractors

RAC

*The RAC Program Mission:
Detect and correct past improper payments so that
CMS and Carriers, FI's, and MAC's can implement
actions that will prevent future improper payments*



Medicare Claims

- **Medicare receives over 1.2 billion claims per year.**
This equates to:
 - 4.5 million claims per work day
 - 574,000 claims per hour
 - 9,579 claims per minute

What does a RAC do?

RAC Review Process

- RACs review claims on a post-payment basis
- RACs use the same Medicare policies as Carriers, FIs and MACs
 - NCDs, LCDs, and CMS Manuals
- Two types of review:
 - Automated (no medical record needed)
 - Complex (medical record required)
- RACs will not be able to review claims paid prior to October 1, 2007
 - RACs will be able to look back three years from the date the claim was paid
- RACs are required to employ a staff consisting of nurses or therapists, certified coders, and a physician CMD

RAC Contractors

Diversified Collection Services, Inc (DCS) – Region A

333 North Canyons Parkway, Suite 100
Livermore, CA 94551-7661

Region A: Vermont, New Hampshire, Maine,
Massachusetts, Rhode Island, **Connecticut, New
York**, New Jersey, Delaware, Maryland, Washington
DC, Pennsylvania

RAC Websites

- Region A: Diversified Collection Services, Inc: www.dcsrac.com
- RAC Web site: www.cms.hhs.gov/RAC
- RAC E-mail: RAC@cms.hhs.gov

RAC Appeal

- The appeal process for RAC denials **is the same** as the appeal process for Carrier/FI/MAC denials
- Do not confuse the “RAC Discussion Period” with the Appeals process
 - If you disagree with the RAC determination:
 - Do not stop with sending a discussion letter; and
 - File an appeal before the 120th day after the Demand letter.



Comprehensive Error Rate Testing

CERT



Comprehensive Error Rate Testing

- Began 2002
- First reports November 2003
- Fee-for-service only
- Determine a National Error Rate
- Measure of contractor performance
- Local, Regional, and National Error Rate Patterns

CERT Contractors

- **CERT Documentation Contractor (CDC)**
 - The CDC, located in Maryland, is responsible for requesting and obtaining documentation to support the payments for the selected claims.
- **CERT Review Contractor (CRC)**
 - The CRC, located in Virginia, is responsible for reviewing the submitted documentation to determine if Medicare payment was supported

CERT Process

- Randomly select sample of claims
- Request medical records from the billing provider
- Review claims along with medical records
- Determine if the claim or service is billed in error
- Appeal Rights
- Produce Reports

Review

- CERT reviews according to:
 - Local coverage determination (LCDs)
 - National coverage determination (NCDs)
 - Medicare coverage regulations

Goals

- CMS Goals for CERT
 - Reduce National Medicare Fee-for-Service Paid Claims Error Rate
 - Decrease Contractor Specific Paid Claims Error Rate
- Providers/Suppliers
 - Reduce unnecessary denials

Error Categories

- **No Documentation** – Claims are placed in this category when the provider/supplier fails to respond to repeated attempts to obtain the medical records in support of the claim
- **Insufficient Documentation** – Claims are placed into this category when the medical documentation submitted does not include pertinent patient facts
- **Medically Unnecessary** – Claims are placed into this category when claim review staff identify enough documentation in the medical records to make an informed decision that the services billed were not medically necessary based on Medicare Coverage Policies
- **Incorrect Coding** – Claims are placed into this category when providers submitted medical documentation support a lower or higher code than the code submitted
- **Other** – This represents claims that do not fit into any other category (service not rendered)

Common Errors

- **No Documentation** – No medical record received
- **Insufficient Documentation** –
 - **Physical Therapy** - Documentation received included the initial evaluation signed by the physical therapist. Missing were the order, and/or plan of care signed by the ordering physician and treatment notes.
 - Missing or illegible signatures.
- **Medically Unnecessary** –
 - **Inpatient Hospital Stay** - Payment was made for a one day inpatient hospital stay. The patient was admitted with a diagnosis of abdominal pain and stayed less than 12 hours. The patient failed to meet medical necessity criteria for an inpatient admission. Service could have been provided with the patient in an outpatient observation status.

Important Notes

- Please be sure documentation submitted is legible along with a legible physician signature or service will be denied
- Please submit records for all dates of service on the claim
- Please ensure that the medical records submitted provide proof that the service's was rendered and justification to support the medical necessity

Submitting Documentation

- Not a violation of the HIPAA Privacy Rule
- Bar code cover sheet/CID #
 - Preferred method of submitting records is via fax number 240-568-6222

Overnight Mail Option

CERT Documentation Contractor

Attn CID #: XXXXXX

Suite 9

9090 Junction Drive

Annapolis Junction, MD 20701

Toll-free number: 888-779-7477

Additional Resources

- www.cms.hhs.gov/cert
 - CERT information and CERT published reports
- www.certprovider.com
 - CERT newsletters, CERT sample letters, and provider address directory



HIGLAS
Healthcare Integrated
General Ledger Accounting
System



What is HIGLAS?

- HIGLAS is an integrated dual-entry accounting system
- HIGLAS will replace the accounting system currently used
- Early December there will be a last Multi-Carrier System (MCS) payment cycle and HIGLAS transition begins

HIGLAS Transition Timeline

<i>Date</i>	<i>Action</i>
February 9, 2011	Release payments for all claims already approved to pay
February 9, 2011	Last MCS payment cycle (payment floors reduced to zero)
February 10, 2011	HIGLAS transition begins
February 10 through February 14, 2011	No payments will be issued - ERAs and paper RAs are not produced
February 14, 2011	HIGLAS transition completed – payment floors reinstated
February 15, 2011	Production & distribution of ERAs and paper RAs resume
February 14, 2011	Begin processing backlogged files and issuing payments
February 14, 2011 through February 28, 2011	Providers may experience a significant reduction in payments due to the early claim payments issued immediately prior to the transition. Providers need to monitor and manage their cash flows during this time period.

HIGLAS Transition Timeline

- February 9, 2011
 - Last Multi-Carrier System (MCS) payment cycle and HIGLAS transition begins
 - Release payments for claims already approved to pay
 - Online systems go down at 10 p.m. EST
 - Payment floors reduced to zero

HIGLAS Transition Timeline

- February 10 - 14, 2011
 - No payments issued
 - Electronic Remittance Advices (ERAs) and paper Remittance Advices (RAs) are not produced
 - HIGLAS transition begins

HIGLAS Transition Timeline

- February 14, 2011
 - HIGLAS transition completed – payment floors reinstated
 - Production and distribution of ERAs and paper RAs resume
 - Begin processing backlogged files and issuing payments

HIGLAS Transition Timeline

- February 14 - 28, 2011
 - Providers may experience a significant reduction in payments due to early claim payments
 - Providers need to monitor and manage their cash flows during this time period

Medicare University

MU

- Educational Program designed to provide a broad variety of Medicare related training.
- View events on National Government Services Web site
- All teleconferences, Webinars, CBTs, and many seminars are FREE
- Registration is required.
- Earn MUC Credits - Self Report after Training/ Print Report Card of all Training www.NGS Medicare.com,