

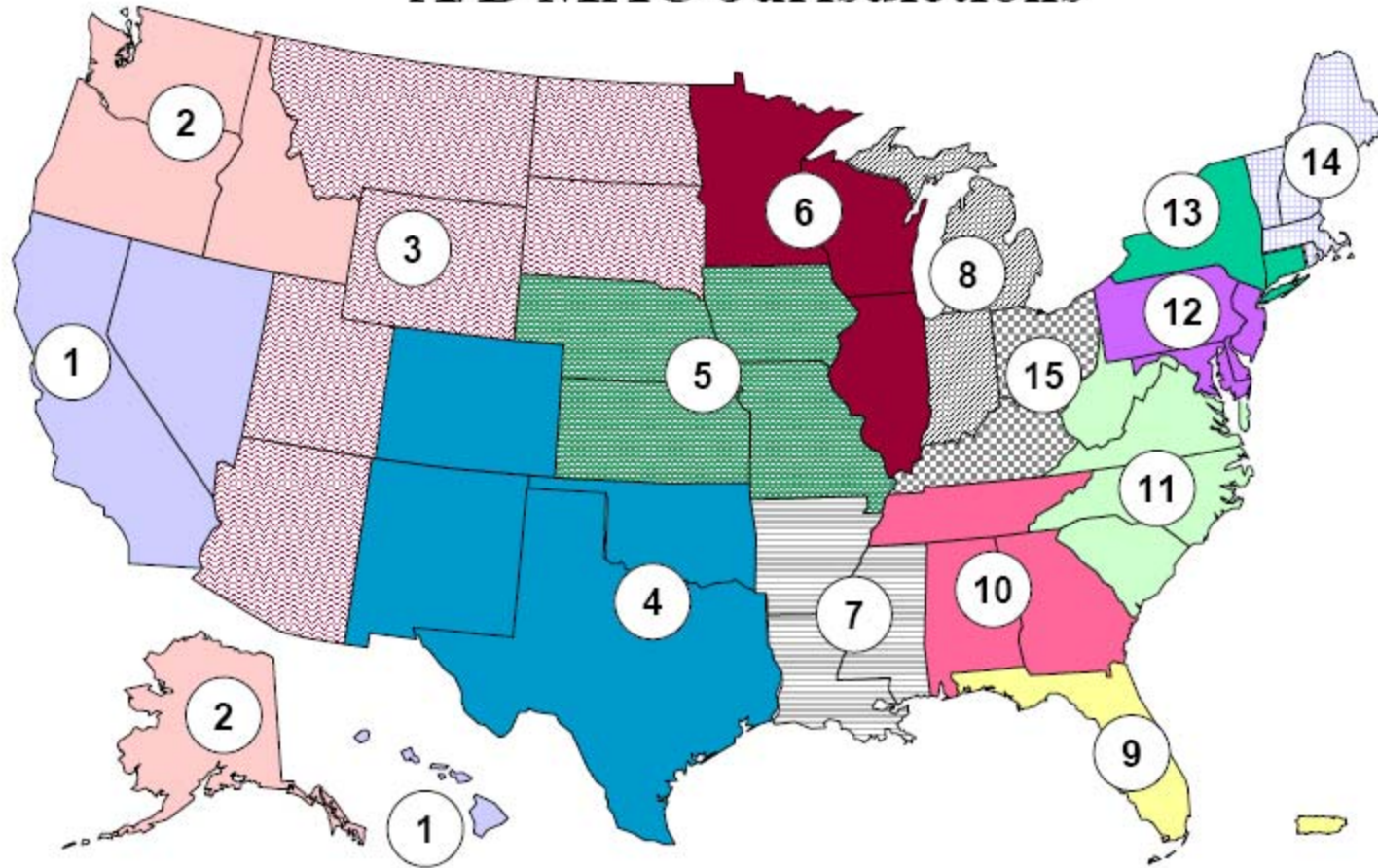
*What Medicare is up to NOW:  
An update on New Law &  
Compliance Issues*

HMWC CPAs & Business  
Advisors

G.A.B. Session

September 17, 2008

## A/B MAC Jurisdictions



## J1 MEDICARE UPDATE

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- Transition September 2, 2008
- NHIC “closed” August 25, 2008
- NHIC transitioned claims to Palmetto electronically
- NHIC transitioned incomplete enrollment applications to J1

## J1 Transition

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- Plenty of Web based seminars preparing providers
- Last phase to be implemented. Nevada and Hawaii went before us. Kinks worked out.
- Mark the web site to favorites and sign up for e-mail notices

## WEB ADDRESS & INFO

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- <http://www.PalmettoGBA.com/J1>.
- Make sure you select PART B for providers.
- Make sure you select California
- There is a link to the post transition page:
  - fee schedule
  - modifier lookup
  - LCD lookup
  - Denial finder
  - Other interesting sounding tools

## Jurisdiction 1 Part B

### Self Service Tools and Top Links

- [Interactive Voice Response \(IVR\) Job Aids](#)
- [Denial Finder](#)
- [Global Surgery Denial Tool](#)
- [Reason/Remark Code Lookup](#)
- [J1 A/B MAC Transition Web Site](#)
- [Modifier Lookup](#)
- [Fee Schedules](#)
- [Forms](#)
- [Provider Enrollment Applications](#)
- [Interactive CMS 1500 Claim Form](#)
- [MSP Lookup](#)

Palmetto GBA is experiencing a very high call volume related to the recent transition of the Jurisdiction 1 A/B MAC contract. The high call volume is resulting in busy signals for many of our customers. We apologize for this inconvenience and thank you for your patience. We encourage you to check the [FAQs](#) on the Palmetto GBA Transition Web site and use the Interactive Voice Response to check Claims Status to find the answers to your questions. [Find out how to use the IVR.](#) (J1 Part A IVR: 1-866-931-3899; J1 Part B IVR: 1-866-931-3903)

## News

09/12/2008

- [Iowa and Indiana Waivers Expire](#)
- [Flu Shot Reminder](#)
- [Medicare Part B Drug](#)

[Competitive Acquisition Program \(CAP\): Ask-the-Contractor Teleconference - CAP Postponement for 2009](#)

- [NPPES - Keeping It Safe and Keeping it Updated](#)

09/08/2008

- [Availability of an Interim Study of Alternative Payment Localities under the Medicare Physician Fee Schedule](#)
- [2008 Physician Quality Reporting Initiative \(PQRI\) National Provider Conference Call with Question & Answer Session](#)

- [Save the Date: National E-Prescribing Conference](#)

09/02/2008

- [Medicare Enhances Consumer Information on Hospital Care](#)
  - [Physician Quality Reporting Initiative \(PQRI\) Web Page Updates](#)
- [View All News](#)

## TODAY'S E-MAIL UPDATE (applies to J1-B)

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- Geographic indices review for PFS 2009. Last look 1997
- Flu Shot Reminder – (Medicare provides coverage without any out of pocket expense to patient).
- NPI reminder – password, keep it safe
- E-Prescribe news

## How do we know our claims were sent to Palmetto?

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- Call J1 to inquire about random accounts
- Be prepared for a busy signal (remember those?)
- Prepare a list of open Medicare claims that have been billed to NHIC
- Track paid claims closely to avoid “transitional claims” not processed.

## Will the payments look the same?

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- Yes, the EOB's will remain the same. HIPAA rules required the MAC to report using specific reason codes. Look for:
  - Change in adjudicated claims
  - Identification of providers
  - Denied claims for previously paid claims by NHIC

## Track Claims, Review Payments

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- For at least three months, accelerate the level of internal claims review.
- New LCD's to be published by J1. Can find some on the web site.
- Reason codes are listed on the post transition page

## When will we get paid?

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- Claims transferred from NHIC to Palmetto are being adjudicated (oldest first).
- First day to process claims was 9-5-08
- Expect payments 9-29-08.
- Backlog extreme... cash management needed.

## PART B ADDRESSES

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- Claims: J1 MAC-Palmetto GBA, PO Box 1051, Augusta, GA 30903-1051
- MSP: J1 MAC- Palmetto GBA, PO Box 1687, Augusta, GA 30903-1687
- Review: J1 MAC-Palmetto GBA, PO Box 1476, Augusta, GA 30903-1476
- Enrollment: J1 MAC-Palmetto GBA, PO Box 1667, Augusta, GA 30903-1667

## Local Carrier Determination(LCD)

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- New LCD's became effective on the date of transition.
- Contractor Advisory Committee (CAC) Part B provides input to the Medical Directors. Meets 2x's/year(north/south)
- J1 Contractor Medical Directors:
  - Dr. Harry Feliciano
  - Dr. Arthur Lurvey

# CLAIMS PROCESSING

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- We may see a difference in the way claims are processed. The claim may be denied/rejected when previously paid, or paid when previously rejected. The most frequent types of change are for:
  - Place of Service
  - Quantity Billed (QB)
  - Provider Specialty
  - Modifier to Procedure Code

## Unprocessable/Rejected Claims

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- Message Code MA130
- Billed incorrectly
- Correct bill, submit as new claim
- Cannot be appealed
- If multiple lines on one claim, may be split (paid vs. denied)

## “BY THE BOOK” CLAIMS

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- Claim field requirements on CMS website under Publication 100-04, Chapter 1, Section 80.3.1 through 80.3.2.1.3
- <http://www.cms.hhs.gov/manuals/downloads/clm104c01.pdf>

# PAPER CLAIMS – RC MA130

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- Possible rejections:
  - Patient Signature Required, Block 12
  - Provider Signature Required, Block 31
  - Span Coding – dates must be in the same month. Do not span:
    - Chemotherapy
    - Electroconvulsive Therapy
    - Psychiatric Services
    - Chiropractic
    - Surgical Procedures

## THE ADMINISTRATIVE SIMPLIFICATION & COMPLIANCE ACT (implemented 2003)

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- Encourages providers to submit claims electronically.
- Must submit electronic claims if have fewer than 10 FTE employees (or meets one of the limited exceptions)
- May see higher volume of MA130 rejects

## PAPER CLAIMS

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- When submitting paper claims, DO NOT:
  - Do not use a dot matrix printer
  - Do not use any color ink than black
  - Do not use bold, script, italic or stylized font
  - Do not use mini font
  - Do not write on the claim
  - Do not fold
  - Do not go outside the red lines (Medi-Cal)

## APPEALS PROCESS

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- Redetermination (initial appeal) – 120 days from the date of the denial notice
- Reconsideration (independent contractor) – 180 days from receipt of the redetermination
- Administrative Law Judge (ALJ) – 60 days from receipt of the QIC decision (at least \$120 remains in controversy)

## APPEALS PROCESS

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- Departmental Appeals Board Review (DAB) – 60 days from the date of the ALJ decision or dismissal
- Federal District Court Review – 60 days from the DAB decision (minimum \$1,180 remains in controversy)

# HR6361, MEDICARE IMPROVEMENTS FOR PATIENTS & PROVIDERS ACT OF 2008

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- Effective July 1, 2008.
- Continues to be revised and stages implemented
- Three components implemented 07-08:
  - Physician Fee Schedule – no change to 2008 fee schedule
  - Therapy caps revised to permit modifiers
  - DME – Q.A. requirements in place - DMERC

## E-Prescribe

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- Future incentives for using electronic prescriptions
- Will need EMR system
- Electronic labs – requisitions, results
- Hospitals encouraging providers to use EMR. Interfaces built to deliver office medical records to hospital for patient admit.
- National conference-Boston, October 6-7

# PQRI – PHYSICIAN QUALITY REPORTING INITIATIVE

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- 2007 Payments have been paid in July 2008
- Revised reporting provisions
- Reporting criteria on J1 website
- Become aware of the criteria....it may become required

## WHERE ARE WE GOING WITH ALL THIS?

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- FIRST came HIPAA (simplification) Transaction Standards – everyone reports the same
- THEN came PQRI (you are paid for reporting certain outcomes)
- NOW we have MACs adjudicating both PART A and PART B claims....

## WHAT WILL THAT DO?

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- Compare hospital admitting codes with physician diagnosis codes used for inpatients. Match transitional discharge codes (changes occur during stay).
- Track patient outcomes from the hospital to the outpatient office visit
- Insure hospital based providers match the hospital codes for billing (cpt, icd-9)

# HEALTHCARE COMPLIANCE

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- Compliance Plan – All Medical Groups are required to have a working compliance program. Rules vary according to group size
- OIG Work plan – Prepares an annual review of the work plan (a sort of to do list). Adopts new programs to add to the work plan and a timeline for implementation

# MEDICARE PROGRAM

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- Track reimbursement – know plan coverage
- Understand LCD's
- Know your payer mix (monitor growth of Medicare practice)
- Stay informed of the Medicare program changes and work plan

## ONE MORE NOTE

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- Blue Cross authorizations:
  - Change from NIA to AIM (American Imaging) for referral authorizations.
  - AIM uses a number of criteria (ACR, LCD, etc) to determine Medical Necessity
  - Will suggest other imaging studies if the criteria does not fit
  - Imaging Centers are unable to assist with obtaining authorizations

# YOUR TURN

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- QUESTIONS.....

**THANK YOU!!**