



PRC MEDICAL

**Monthly Newsletter
May 2010**

Please route to appropriate staff

Newsletter access is also available at www.prcmedical.com or through the help menu on StreamlinePM+. If any of the links in this newsletter do not work, please copy and paste them into your browser.

CMS WEBSITE ADDRESS CHANGE

On April 2, 2010, CMS changed its web address from www.cms.hhs.gov to www.cms.gov. However, the old address will forward you to the new address for a time. Existing links on other sites to CMS's site will continue to work.

PURCHASED DIAGNOSTIC TEST CHANGE

CMS has changed the name for "purchased diagnostic tests" to "anti-markup tests". In the future all references to "purchased diagnostic tests" in the Medicare Claims Processing Manual and the Medicare Program Integrity Manual will be changed to "anti-markup tests".

This change over will be a gradual process during the process of entering into the manual all the changes affected by the new anti-markup rule. However, all carriers have been instructed to start using the new terminology now.

FDA EMAIL UPDATES

If you aren't on the FDA Email Update list you should consider signing up for them. Go to: <http://www.fda.gov/default.htm> and click on the Get Updates "E-mail Updates" in the box on the upper right. Stay on top of drug and equipment alerts for usage and recalls.

PROVIDER IDENTITY THEFT SCAM

AdvanceMed is the Program Safeguard Contractor for Medicare in Ohio/Kentucky/Minnesota. AdvanceMed has issued a warning that there is an identity theft scam being waged in our area. The scam was identified first in 2008 and as of this writing no one has reported it in Ohio or Kentucky but it has been found in Arizona so the authorities feel it's only a matter of time till it appears here.

This is what to watch for: you will receive a legitimate looking letter, with a counterfeit letterhead, from your local carrier. The letter will say that the carrier is updating their provider enrollment file and demand a response from the physician within 48 hours or they will experience a disruption in their payments.

If you receive a letter contact your local carrier provider enrollment office to verify if it was sent by them. DO NOT SEND ANY INFORMATION TO ANYONE WITHOUT TELEPHONE CONFIRMATION. DO NOT CONFIRM USING A TELEPHONE NUMBER SUPPLIED IN THE LETTER.



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AdvanceMed encourages the following steps to be taken in order to help in identity theft protection:

- Shred all sensitive documents
- Do criminal background checks when hiring new employees
- Monitor any correspondence that leaves your office outbound for Medicare and other insurance companies
- Protect your own information in the same way that you protect your patients information
- If you receive a request from the carrier for a provider enrollment update via facsimile, call the carrier to confirm that it originated with them. Do not use the phone number listed on the facsimile transmittal
- When applying for new positions, do extensive research about your potential employer before giving out personal information
- Do not post your resume that includes identifying provider numbers on the Internet
- Educate your staff members regarding the importance of protecting your provider information
- If you suspect that you have been the victim of identity theft, contact the carrier immediately

Visit the Web site <http://www.ftc.gov/bcp/edu/microsites/idtheft/> published by the Federal Trade Commission for more information on identity theft.

UPDATED eRX EDUCATIONAL PRODUCTS

http://www.cms.hhs.gov/ERxIncentive/Downloads/WhatsNew2010eRxFS020310f_022210_FINAL.pdf here is where you will find downloads for the 2010 eRx Incentive Program Fact Sheet with what is new for 2010.

http://www.cms.hhs.gov/ERxIncentive/Downloads/2010eRxMadeSimpleFS020310f_022210_FINAL.pdf here is where you will find downloads for EHR-based reporting for 2010 eRx which have been updated for "Alternative Reporting Mechanism" page of the eRx Web page.

UPDATED INFORMATION ON PQRI FOR 2010

CMS has a lot of information available on their website for 2010 PQRI. This link has new resource documents under "Educational Resources". Also see updates under "Alternative Reporting Mechanism". <http://www.cms.hhs.gov/PQRI> .

CMS FINAL RULE ON FACIAL LIPODYSTROPHY SYNDROME TREATMENT

Since July 16, 2009 CMS has been tracking Dermal Injections for Treatment of Facial Lipodystrophy Syndrome. After reviewing all the evidence, CMS has made the following decision.

"Dermal injections for facial Lipodystrophy Syndrome (LDS) are only reasonable and necessary using dermal fillers approved by the Food and Drug Administration (FDA) for this purpose and then only in HIV infected beneficiaries when facial LDS caused by antiretroviral HIV treatment is a significant contributor to their depression. All other indications are noncovered".

For the complete decision go to:

<http://www.cms.hhs.gov/mcd/viewdecisionmemo.asp?from2=viewdecisionmemo.asp&id=234&>



CMS OFFERING RAC 101 INFORMATION CALLS

If you missed CMS's offering of informational phone conferences in the past, CMS is offering them again. They won't be much different from the previous calls but if you have questions about the RAC operational process this is where to get the answers.

The CMS staff will present the information and there will be time for questions and answers after the presentation.

Here is the schedule and the information:

May 4, 2010, 1:00 p.m. – 2:30 p.m. EST: Nationwide RAC 101 Call for **Home health and Hospice Providers**, 1-877-251-0301, meeting ID: 66524952.

May 5, 2010, 1:00 p.m. – 2:30 p.m. EST: Nationwide RAC 101 Call for **DMEPOS**, 1-877-251-0301, meeting ID 66527260.

May 12, 2010, 1:00 p.m. – 2:30 p.m. EST: Nationwide RAC 101 Call for **Physicians**, 1-877-251-0301, meeting ID 66529242.

CMS DEFINES eRX REQUIREMENTS

The question was asked of CMS, "What type of electronic prescribing system must I have in order to participate in the Electronic Prescribing (e-prescribing) Incentive Program?"

Per CMS: "Eligible professionals must have adopted a "qualified" e-prescribing system. There are two types of systems: a system for e-prescribing only (stand-alone) or an electronic health record (EHR system) with e-prescribing functionality. Regardless of the type of system used, to be considered "qualified" it must be based on all of the following capabilities:

- Generating a complete active medication list incorporating electronic data received from applicable pharmacies and benefit managers (PMBs) if available.
- Selecting medications, printing prescriptions, electronically transmitting prescriptions, and conducting all alerts (defined below).
- Providing information related to lower cost, therapeutically appropriate alternative (if any) (the availability of an e-prescribing system to receive tiered formulary information, if available, would meet this requirement for 2009).
- Providing information on formulary or tiered formulary medications, patient eligibility, and authorization requirements received electronically from the patient's drug plan, if available."

Source: CMS Questions and Answers on www.cms.hhs.gov

For additional information see: <http://www.cms.hhs.gov/ERxIncentive/>

CMS QUESTION AND ANSWER

Question: “If a patient calls to refill prescription or requests a new prescription and there is no associated office visit (encounter) related to the phoned in request, will this count towards the Electronic Prescribing Incentive Program (eRx)?”

Answer: “No. To qualify for reporting the e-prescribing measure, there must be a covered Medicare Physician Fee Schedule (PFS) service furnished during the reporting period at the time the prescription is electronically prescribed, which meets the coding specified in the measure’s denominator. Prescriptions generated without an encounter do not meet the denominator inclusion criteria for eRx. Please refer to the appropriate eRx measure specification for service codes found in the denominator.”

Source: CMS Website Questions

HEALTH CARE RECONCILIATION BILL & AFFORDABLE HEALTH CARE FOR AMERICA ACT

I don’t know how many of you know that I live in Florida. Since moving here, a few years ago, I have done volunteer work in a local free clinic. The following information that I’m sharing with you was disseminated by the Volunteers in Medicine Alliance. Here is a simplified summary of the major provisions of the new healthcare law:

WITHIN A YEAR

- Provides a \$250 rebate to Medicare prescription drug plan beneficiaries whose initial benefits run out.

AFTER 90 DAYS

- Provides immediate access to high-risk insurance pools for people who have no insurance because of preexisting conditions.

AFTER SIX MONTHS

- Bars insurers from denying people coverage when they get sick
- Prevents insurers from denying coverage to children who have preexisting conditions.
- Bars insurers from imposing lifetime caps on coverage.
- Requires insurers to allow young people to stay on their parents’ policies until age 26.

2011

- Requires individual and small group insurance plans to spend at least 80% of premium dollars on medical services. Large group plans would have to spend at least 85%.

2013

- Increases the Medicare payroll tax and expands it to dividend, interest and other unearned income for singles earning more than \$200,000 a year and joint filers making more than \$250,000.

2014

- Provides subsidies for families earning up to 400% of the poverty level to purchase health insurance.

- Requires most employers to provide coverage or face penalties.
- Requires most people to obtain coverage or face penalties.

2018

- Imposes a 40% excise tax on high-end policies.

BY 2019

- Expands insurance coverage to 32 million more people.

Note: CMS is urging us all to watch for their notices and updates. According to the new law signed by President Obama on March 23, 2010 there are many changes up-coming. According to CMS these changes have varying effective dates and are being handled, in turn, by those dates.

CLAIM STATUS CODE UPDATES

HIPAA requires all payers to use the same set of claim status codes which have been approved by the National Code Maintenance Committee. During the January 2010 meeting those codes were updated. To view the lists of codes approved go to: <http://www.wpc-edi.com/content/view/180/223/>

AUTOMATIC IMPLANTABLE CARDIAC DEFIBRILLATOR IN CLINICAL STUDY

CR 6867 updates the list of ICD-9-CM diagnosis codes that do not required modifier Q0 for implantable cardiac defibrillator (ICD) services provided in a clinical study. ICD-9-CM diagnosis code V12.53, personal history of sudden cardiac arrest, has been added to the diagnosis codes that do not require either modifier QR (for dates of service prior to January 1, 2008) or modifier Q0 (for dates of service on or after January 1, 2008).

Note: Medicare contractors will adjust claims brought to their attention that were denied because the diagnosis code V12.53 was submitted and the claim lacked modifier Q0 for dates of service on or after January 1, 2008, or modifier QR for dates of service prior to January 1, 2008.

See the 6867 Change Request here:

<http://www.cms.hhs.gov/MLN MattersArticles/downloads/MM6867.pdf>

MEDICARE TIMELY FILING UPDATE

When President Obama signed the Patient Protection and Affordable Care Act (PPACA) on March 23 of this year, that law amended the time period for filing Medicare fee-for-service claims. Section 6404 of the PPACA reduced the timely period to one calendar year after the date of service.

Under the new PPACA, services provided on or after January 1, 2010 must be filed within one year of the date of service. PPACA also mandates that services furnished before January 1, 2010, specifically service dates from October 1, 2009 through December 31, 2009, must be filed no later than December 31, 2010

For claims with dates of service before October 1, 2009 you will still follow the old timely filing rules. I did an article in the February Newsletter reviewing the claims filing rules.

Be alert for upcoming updates as this new rule also allows the Secretary of HHS to exempt some claims from the filing rules. However, at this time, no exceptions have been made.

OTHER THERAPY CAP EXTENSION

Another item in the PPACA is the continuation of the therapy cap extension for services through December 31, 2010. You may continue to add the KX modifier when an exception is appropriate. The cap for 2010 remains \$1,860 per year for combined physical therapy and speech-language therapy and \$1,860 for occupational therapy. Remember that deductible and coinsurance amounts count toward the amount accrued before a cap is reached.

PROVIDER ENROLLMENT, CHAIN AND OWNERSHIP SYSTEM (PECOS)

If you haven't enrolled in the PECOS files yet, time is running out. You have until January 3, 2011 to get into the system or you will not be able to refer/order services for your Medicare patients.

As of October 5, 2009 if you aren't enrolled in PECOS and refer a patient for services, the billing provider will still be paid but a notice is applied to the claim on the Medicare EOB stating the claim failed the Ordering/Referring Edit. Note that if the billed service requires a referring/ordering provider and one is not listed on the claim, that claim will be rejected.

However, as of January 3, 2011 any claim received, that requires a referring/ordering physician, and the referring/ordering provider is not in the PECOS system, those claims will be rejected. This means the service billing provider will not be paid for the items you ordered.

As of January 2010, CMS has made available for download the Ordering Referring Report which lists in alphabetical order of the last name, the NPI and the name (last name, first name) of all the physician and non-physician practitioners in the PECOS system. At any given time, only one report, the most current, will be available for downloading. Go to <http://www.cms.gov/MedicareProviderSupEnroll> and click on "Ordering Referring Report" (on the left). You can enroll here by clicking on the "Enrollment Application" link (on the left).

It can take up to 60 days for your PECOS application to process so don't wait till the last minute. You can use the Internet-based PECOS, as mentioned above, or complete the paper enrollment CMS-8551. If you reassign your Medicare payments to a group or clinic, you will also need to complete the CMS-855R.

ANTHEM REFERRAL AND PRE-AUTH STATUS ONLINE

If you request referral authorizations or pre-authorizations for services to Anthem, you now have an online tool to access the status of those requests.

Go to anthem.com > provider (enter state) > and log in to MyAnthem. Per Anthem you can access more information by visiting anthem.com > provider (enter state) > Rapid Updates. If you have not yet registered your Tax ID with Anthem for secure access to personalized information you can register at <http://www.anthem.com/>, click on *provider* and choose your state, then scroll down to *esolutions for Providers*. From this page click on *Register Now* on the left side menu and follow the instructions.

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