



# Medicare Changes / 2010 Updates



Wisconsin Physicians Service (WPS) Medicare  
**Michigan Medical Billers Association  
(MMBA)**

May 12, 2010 – Grand Blanc, Michigan  
*J. David Bozarth, Sr. Analyst - Presenter*



# Agenda

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- Introduction
- Medicare Part B Fee Schedule Update
- Timely Filing Requirements
  - Patient Protection and Affordable Care Act (PPACA)
- HIPAA 5010: ASC X12 Version 5010



# Agenda

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- Recovery Audit Contractor (RAC)
- Electronic Medical Record (EMR) Incentives
- Recent Updates in Appeals
- CR 6310 – Provider Enrollment Updates
- Recent Legacy CERT Errors



# Agenda *(continued)*

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- The CMS Secure Network Access Portal (C-SNAP)
- Other WPS Medicare Self-service Tools
  - eNews Listserv
  - Interactive Voice Response (IVR)
- Educational Programs available via the WPS Website



# Medicare Physician Fee Schedule Update

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## **Fees Effective**

**January 1, 2010 - May 31, 2010:**

On April 15, 2010, President Obama signed into law the "**Continuing Extension Act of 2010.**"

This law extends through **May 31, 2010**, the zero percent update to the MPFS that was in effect for claims with dates of service January 1, 2010 through March 31, 2010.



# Medicare Physician Fee Schedule Update

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The "**Continuing Extension Act of 2010**" is retroactive to April 1, 2010. The fees currently posted to the WPS website reflect the zero percent update.

**We will post the fees that are effective June 1, 2010 - December 31, 2010 once we receive them from CMS.**



# Timely Filing Requirements

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- **Patient Protection and Affordable Care Act (PPACA)**
  - Signed into law March 23, 2010
  - Aimed at curbing fraud, waste, and abuse in the Medicare Program
- **Patient Protection and Affordable Care Act (PPACA)**
  - To reduce maximum time period for submission of Medicare FFS claims to one calendar year after the date of service



# Timely Filing Requirements

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- **Section 6404 mandates that claims for services furnished before January 1, 2010, must be filed no later than December 31, 2010**
  - Dates of service before October 1, 2009, must follow the pre-PPACA timely filing rules
  - Claims with dates of service October 1, 2009, through December 31, 2009, must be submitted by December 31, 2010



# ASC X12 Version 5010

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- Next HIPAA Standard for HIPAA-covered transactions
- Transition to new format for Medicare FFS begins January 1, 2011
- By January 1, 2012 you must be ready to submit claims electronically using the X12 version 5010 to Medicare and other payers



# ASC X12 Version 5010

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- Implementation will require changes to software and procedures used for billing Medicare and other payers
- Checks with vendors / Clearinghouses on plans for transitioning to the new 5010



# ASC X12 Version 5010

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- If you fail to prepare, you may not be able to send electronic claims or receive electronic remittances, significantly impacting your business and cash flow.



# Recovery Audit Contractor (RAC)

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Section 306 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), directed a 3-year demonstration program using **Recovery Audit Contractors (RACs)** to detect and correct improper payments in the Medicare program.



# Recovery Audit Contractor (RAC)

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As a permanent part of Medicare the **Recovery Audit Contractor (RAC)** program is designed to be a cost effective means of adding resources to ensure correct payments are being made to providers and suppliers and, protect the Medicare Trust Fund.



# Recovery Audit Contractor (RAC)

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**The RAC Contractor for Region B**  
(Indiana, Michigan, Minnesota, Illinois,  
Kentucky, Ohio, and Wisconsin) is  
**CGI Federal.**

- ***Mary Hoffman***, Director at CGI, says  
that **the RAC program**  
**“is built on transparencies”.**



# Recovery Audit Contractor (RAC)

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- The goals of the program are to **maximize transparencies, reduce provider burdens, and increase accuracy of claims payment.**
  - The contact information for CGI Federal is **[RACB@cgi.com](mailto:RACB@cgi.com)**,
    - **877-316-RACB.**



# Recovery Audit Contractor (RAC)

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- CGI works at “targeted reviews”, as opposed to the CERT contractor(s) who work on random samples.
  - The RAC contractor works with contacts at hospitals and associations, and will continually update and add to its lists of contacts.



# Recovery Audit Contractor (RAC)

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- The RAC looks into to two types of issues for of Medicare processing:
  - **Automated issues**
  - **Complex issues**



# Recovery Audit Contractor (RAC)

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- **Automated issues**, such as duplicate payments, do not require medical records to complete the audit.
- **Complex issues**, such as medical necessity cases, require medical records in order to complete a review.



# Recovery Audit Contractor (RAC)

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- **The RAC does not develop policy or regulations.**
  - The RAC must adopt those policies already in place by CMS and its Medicare contractors.
- **All payments to the RAC are based on contingencies.**



# Recovery Audit Contractor (RAC)

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- For additional information and recent updates pertaining to the Recovery Audit Contractor (RAC) program, please visit the CMS Website at
- [http://www.cms.hhs.gov/RAC/03\\_RecentUpdates.asp#TopOfPage](http://www.cms.hhs.gov/RAC/03_RecentUpdates.asp#TopOfPage)



# Electronic Medical Records

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## **EMR Incentives**

A proposed rule issued by the Centers for Medicare & Medicaid Services (CMS) outlines provisions governing EMR incentives and details what constitutes meaningful use of technology – a prerequisite for receiving bonus dollars.



# Electronic Medical Records

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## **EMR Incentives** *(continued)*

A separate, interim final regulation issued by the Office of the National Coordination for Health Information Technology sets initial standards and certification criteria for the use of approved EMRs.



# Electronic Medical Records

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## **EMR Incentives** *(continued)*

- Both rules were published in the *Federal Register* on January 13, 2010, and will be open for public comment for 60 days.
- Money to support these initiatives was made available through the economic stimulus package signed in 2009.



# Electronic Medical Records

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## **EMR Incentives** *(continued)*

- One proposed objective fo EMRs is for doctors to submit at least 75% of all prescriptions electronically using certified EMR technology.
- The proposed start time for stage 1 of this incentive is sometime in 2011.



# Recent Updates in Appeals

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## **Redeterminations** vs. Reconsiderations

Medicare Part B providers and beneficiaries have 120 days to file a request for a **redetermination** from the date of receipt of the remittance notice or Medicare Summary Notice (MSN). This is the first level of appeal conducted by Medicare contractors.



# Recent Updates in Appeals

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## Redeterminations vs. **Reconsiderations**

Part B providers and beneficiaries have 180 days to file a request for a **reconsideration** from the date of receipt of notice of redetermination. This is the second level of appeal and is conducted by a Qualified Independent Contractor (QIC).



# Recent Updates in Appeals

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## **Multiple Appeal Requests**

WPS Medicare has implemented a recent change in the way we handle multiple, appeals requests. Prior to August 2009, WPS would forward multiple or duplicate appeals requests to the Qualified Independent Contractor (QIC) for consideration.



# Recent Updates in Appeals

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## **Multiple Appeal Requests**

In the past few months, WPS Medicare changed this process. Now, we will forward multiple requests for appeal to our inquiry area, who will contact the requesting provider's office to advise them that the claim or services in question have already been appealed.



# Recent Updates in Appeals

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## **Avoid Implied Appeal Requests**

Providers should indicate the reason(s) they are requesting an appeal.

We are instructing our staff to be less lenient in proceeding with an appeal request if it is incomplete. The vast majority of redetermination requests received simply state "see attached".



# Recent Updates in Appeals

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## **Avoid Implied Appeal Requests**

“See attached” usually results in a maintain decision because we do not clearly understand what the provider is actually appealing. Were they trying to change a diagnosis code, add a modifier, change a procedure code, ???

**Being specific is very important!**



# An Important Reminder Regarding Appeals

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## **How to Request a Reopening**

The Clerical Error **Reopening** process is not a part of the formal appeals process, but it allows providers to make a minor change to a previously filed claim, if the original claim was denied or reduced.



# An Important Reminder Regarding Appeals

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## **How to Request a Reopening**

Clerical Error **Reopenings** can be done on the phone or in writing, and for provider minor errors, clerical errors, or omissions. Please refer to the WPS Medicare Website for examples of services and claim situations which may be eligible to receive a Reopening.



# An Important Reminder Regarding Appeals

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## **How to Request a Reopening**

A provider, physician, or supplier may request a **Reopening** up to one year from the receipt of the initial Remittance Notice. Requests for Reopening(s) beyond one year from the initial processing require documentation to establish good cause.



# An Important Reminder Regarding Appeals

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## **Fact Sheet on Reopenings**

You may find a detailed, recently-  
updated Fact Sheet regarding  
**Reopenings** on the WPS Medicare  
Website at

[http://www.wpsmedicare.com/j5macpartb/departments/appeals/\\_files/b\\_reopening.pdf](http://www.wpsmedicare.com/j5macpartb/departments/appeals/_files/b_reopening.pdf)



# An Important Reminder Regarding Appeals

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## **Unprocessable** Returns/Rejections

As they have not been processed by Medicare, claims returned, or “rejected” as **unprocessable** are not eligible for appeal.

Please avoid such requests as they use valuable time by appeals staff, who must return them to the requestor.



# An Important Reminder Regarding Appeals

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## **Fact Sheet on Appeals**

Please review an updated Fact Sheet on  
“How to Appeal a Claim Determination”  
on the WPS Medicare Website at

[http://www.wpsmedicare.com/j5macpartb/departments/appeals/\\_files/b\\_appeal.pdf](http://www.wpsmedicare.com/j5macpartb/departments/appeals/_files/b_appeal.pdf)

# CR 6310 – Provider Enrollment Updates



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Implemented in the Spring of 2009, Change Request (CR) 6310 addresses **Regulatory Changes into Chapter 10 of the Program Integrity Manual (PIM)**.

WPS hosted a Teleconference June 30, 2009 which addressed these changes. You may access this recording via the WPS Website at

[http://www.wpsmedicare.com/j5macpartb/training/on\\_demand/audio/](http://www.wpsmedicare.com/j5macpartb/training/on_demand/audio/)

# CR 6310 – Provider Enrollment Updates



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- The effective date for Medicare billing privileges for individuals and organizations identified in CR 6310 is the later of the date of filing or the date they began furnishing services at a new location.

# CR 6310 – Provider Enrollment Updates



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- Providers may retrospectively bill for services provided at the enrolled practice location **for up to 30 days prior to their effective date**; *or* 90 days prior to their effective date if a Presidentially-declared disaster precluded enrollment in advance of providing service to Medicare beneficiaries.

# CR 6310 – Provider Enrollment Updates



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- Providers must report the following within 30 days, or risk assessment of an overpayment:
  - A change in ownership;
  - A final adverse action; or
  - A change in practice location

# CR 6310 – Provider Enrollment Updates



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- CR 6310 also includes requirements for Maintaining Ordering and Referring Documentation.
- Read the **Medicare Learning Network** (MLN) Matters article (**MM6310**) at:
- <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6310.pdf>

# CR 6310 – Provider Enrollment Updates



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- For Internet-based **PECOS (Provider Enrollment, Chain and Ownership System)**, individual providers cannot appoint an Authorized Official (AO). Only groups and organizations may make such an appointment.

# CR 6310 – Provider Enrollment Updates



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- Read more about reporting changes to your Medicare B provider file at:
- <http://www.wpsmedicare.com/j5macpartb/departments/enrollment/breporrtadd.shtml>



# CERT Updates

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- A CERT Quick Link was added to the WPS Medicare Provider home page
- WPS published new articles on the CERT Web page:
  - CERT Alert – Documenting Time in Medical Records
  - Provider Signature Requirements



# CERT Updates

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- Provider Signature Requirements  
CMS Change Request (CR) 6698 –  
Signature Guidelines for Medical  
Review Purposes

[http://www.cms.gov/transmittals\\_downloads/R327PI.pdf](http://www.cms.gov/transmittals_downloads/R327PI.pdf)

- Tips to Avoid CERT Requests for  
Additional Documentation



# Recent LEGACY CERT Errors

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Based on CERT errors assessed during the recent reporting period, **trending** of the top five errors (based on the total percentage of dollars paid in error) for **2010** are:

- Services Incorrectly Coded 36.4%
- Insufficient Documentation 31.0%

*(Signature)*



# Recent LEGACY CERT Errors

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**Trending** of the top five errors (based on the total percentage of dollars paid in error) for **2010** are *(continued)*:

- Medically Unnecessary Service or Treatment 16.5%
- Insufficient documentation (all other) 15.8%
- Services billed were not rendered 0.4%



# Recent LEGACY CERT Updates

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WPS recently published new articles to the CERT page on the WPS Website. These updates emphasize the importance of complying with signature and documentation requirements.

Issues surrounding signature/documentation requirements are not exclusive to WPS or its Medicare providers, but involve CERT errors for ALL Medicare contractors.



# Recent LEGACY CERT Updates

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## **Legible Identifier**

Recent communication with the CERT contractor confirmed that the Office of the Inspector General (OIG) has made it clear that provider signatures in medical record documentation must be legible.

The legible identifier requirement applies to documentation for any service performed and billed to Medicare.



# Recent LEGACY CERT Updates

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## **Legible Identifier**

Medicare requires a legible identifier for services provided/ordered.

The method used shall be hand written or an electronic signature (stamp signatures are not acceptable) to sign an order or other medical record documentation for medical review purposes.



# The CMS Secure Network Access Portal (C-SNAP)

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- The core function of **C-SNAP** is to provide a Web-based self-service tool to the WPS Medicare provider community which allows access to patient eligibility and claim status.
- **C-SNAP** is a free self-service Internet portal available to you 24 hours a day, 7 days a week, at no cost.



# The CMS Secure Network Access Portal (C-SNAP)

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## **C-SNAP Contact Information:**

- Website:  
**<https://www.medicareinfo.com/apps/cms/home.do>** (Portal Access)
- Technical Support: (877) 476-8116
  - 8:00 am to 4:00 pm CT,
  - Monday through Friday



# The CMS Secure Network Access Portal (C-SNAP)

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- Use **C-SNAP** to check **patient eligibility** information
- Use **C-SNAP** to check **claim status** information
- Use **C-SNAP** to check **supplemental information**



# Other Self-help Tools available via WPS and CMS Websites

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## **eNews Listserv**

- Both WPS Medicare and CMS have Listservs that providers can elect to sign up to receive. Let's first look at the WPS Medicare eNews Listserv.



# Other Self-help Tools available via WPS and CMS Websites

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## **eNews Listserv**

- WPS Medicare sends out a weekly eNews Listserv with the most current and vital information Medicare providers need to know. The weekly e-mails contain the policy updates, education schedule additions, changes to the Medicare program, and much more. To register visit WPS Medicare's Website and click in the yellow box in the upper right corner with the link entitled "Sign Up for Medicare eNews."



# Other Self-help Tools available via WPS and CMS Websites

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## eNews Listserv

- The CMS Listserv system is separate from the WPS Medicare Listserv system. You can sign-up for Listserv for CMS. It allows providers to pick the topics they are interested in receiving.
- Remember, signing up for just one Listserv will not give you all the information you need to do your job. **Be sure to sign-up for both the WPS Medicare and CMS Listservs.**



# Other Self-help Tools available via WPS and CMS Websites

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## **Interactive Voice Response (IVR) Unit**

- The IVR offers providers quick and easy access to Medicare information 24 hours a day. Simply call the toll-free telephone number above to obtain Medicare claims information and patient eligibility. You may navigate the IVR by either speaking the required information or entering it using your telephone number pad.



# Other Self-help Tools available via WPS and CMS Websites

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To reach the **Interactive Voice  
Response (IVR) Unit** call  
**(866) 590-6702**

The IVR is available 24 hours a day,  
7 days a week. However, the standard hours of  
operation when all IVR functions are available  
are Monday - Friday 7:00 am - 6:00 pm CT.



# Other Self-help Tools available via WPS and CMS Websites

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The **Interactive Voice Response (IVR)** unit works through a series of prompts, or options, as follows:

- 1 "Eligibility"      2 "Claim Status"
- 3 "Provider Summary"
- 4 "Checks"    5 "Deductibles"
- 6 "Pricing"    7 "Questions"



# Educational Programs available via the WPS Website

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## Training Programs

WPS Medicare offers three formats for live training, to allow maximum provider participation. These include:

- **Seminars**, presented in person by our experienced Provider Outreach and Education staff. These usually last a half-day or full day.
- **Teleconferences**, topic driven education and/or open question and answer format. These typically run for 60-90 minutes.



# Educational Programs available via the WPS Website

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- **Webinars (Web-based seminars)**, presented live over the internet in an audiovisual format, allowing providers to view slide shows, listen to the presenter and ask questions. To view the current schedule for each format, please make a selection by using the left-hand navigation.

Also, check out our **On- Demand Training** section for recorded presentations available to you at any time.



# Educational Programs available via the WPS Website

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## **On Demand Training**

WPS Medicare understands that a provider's office is a busy place. With this in mind, WPS Medicare would like to bring the education to you. We are proud to offer on demand training to our provider community.



# Educational Programs available via the WPS Website

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## On Demand Training

To best meet your needs, WPS Medicare offers on demand training in three different formats:

- **Audio** - The specialized Audio area includes recordings of teleconferences.
- **Audio/Visual** - the Audio/Visual area provides Webinars (web-based seminars) as well as short trainings specifically created for the WPS Medicare Website
- **Slide Shows** - Slide Show area offers a variety of presentations available for viewing at any time.



# Additional Resources

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- **WPS Medicare Website**  
[www.wpsmedicare.com](http://www.wpsmedicare.com)
- Don't forget to fill out the  
**ForeSee Survey!**
- Subscribe - WPS Medicare eNews  
[www.wpsmedicare.com/listserv](http://www.wpsmedicare.com/listserv)



# Additional Resources

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- **CMS Website**

[www.cms.hhs.gov](http://www.cms.hhs.gov)

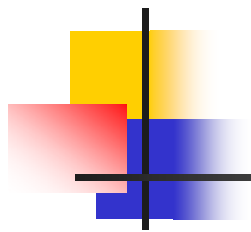
- **CMS E-mail Updates**

[http://www.cms.hhs.gov/AboutWebsite/  
20\\_EmailUpdates.asp#TopOfPage](http://www.cms.hhs.gov/AboutWebsite/20_EmailUpdates.asp#TopOfPage)



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# Questions ?



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***Thank You !***

J. David Bozarth  
WPS Medicare