



CMS LiveWire

✧ E-News for Office Administrative Personnel ✧

Health Care Financing Division
Colorado Medical Society

January 15, 2007
Volume 2, Issue 4



WE WANT TO HEAR FROM YOU!
Send us your comments,
ideas for articles, and
coding/billing tips &
tricks.

7351 Lowry Blvd
Denver, CO 80230

PHONE:
(720) 858-6321

FAX:
(720) 859-7509

E-MAIL:
enews_editor@cms.org

WEBSITE:
www.cms.org/officestaff/
home.html



Only 127 more days
until May 23, 2007!
Do you have your NPI?

Feel free to share this in-
formation, but please ac-
knowledge the source.

The New & Improved SB198

SB 198 - the 2006 Standard Form Contract bill has been re-incarnated for the 2007 Colorado legislative session. The new bill, SB XX 07 (Bill number to be assigned) is titled Standard Health Care Provider Contract & has the same sponsors as last year - Senator Steve Johnson & House Speaker Andrew Romanoff. The bill was introduced on Friday January 12th & had 40+ co-sponsors at that time, with more to follow. [Click here](#) to read more & [here](#) to view the CMS/CAHP Mediation Agreement.

A Heartfelt "THANK YOU" to the Health Plans

We would like to thank the health plans that participated in the General Question & Answer sessions we held December 14th & 15th. The turn out was great! Representatives from Aetna, Anthem BCBS, CIGNA, Great West HealthCare, Rocky Mountain Health Plans, Sloans Lake & United HealthCare were all present for both days. Questions were submitted to the plans prior to the meetings & most were prepared with responses for the attendees. We have taken the answers from the meetings & combined them with the follow up responses we received in order to provide a complete Q & A document. (See Page 2 for links to Plan Responses.)

Medicare PFS 2007 Update Factor Change & Extension of Par/NonPar Decision Deadline

This article updates the Tax Relief & Health Care Act of 2006 changes for the 2007 conversion factor for services paid under the MPFS. This change is effective for services provided on or after January 1, 2007. The Tax Relief & Health Care Act of 2006 set the 2007 conversion factor for physician payment at the same level as in 2006 (\$37.8975), reversing the statutorily mandated 5.0 percent negative update. However, it does not maintain 2007 physician payments at 2006 levels. There are a number of other factors that affect [payment rates](#) for 2007. - *Editor's Note: The Medicare fee schedule information that was extracted 11/7/06 has now been replaced with new fees. If you accessed the fee schedule prior to Jan. 2, 2007 you will need to download the updated version.*

Medically Unlikely Edits (MUEs) Effective January 2, 2007

CMS has established units of service edits referred to as MUEs. The NCCI contractor develops & maintains MUEs. An MUE is defined as an edit that tests claim lines for the same beneficiary, HCPCS code, date of service, & billing provider against a criteria number of units of service. The MUEs will auto-deny claim line items containing units of service billed in excess of the MUE criteria or Return to Provider (RTP) claims that contain lines that have units of service that exceed an MUE criteria. [Click here](#) for more information.

Approval of the 08/05 Version of the 1500 Claim Form

The NUCC is pleased to release the revised version of the 1500 Health Insurance Claim Form (version 08/05) that accommodates the reporting of the National Provider Identifier (NPI). The Office of Management & Budget (OMB) has approved the 1500 Claim Form under OMB Number 0938-0999 with an initial expiration date of June 30, 2007. The Centers for Medicare & Medicaid Services (CMS) will begin the renewal process for the form in January 2007. [Click here](#) to access the new form.



**Wishing You a
Happy & Prosperous
New Year!
Your Friends at
CMS!**

Health Plan Bulletins

Click on the health plans below to access current bulletins:

-  [Anthem](#)
-  [Medicare](#)
-  [Medicaid](#)
-  [RMHP](#)

"BROWN BAG" TELECONFERENCES



The next Teleconference is scheduled for February 20, 2007
February's Topic:
**EFT (Electronic Funds Transfers
Vs. Extremely Frustrating
Transactions)**
Watch for details!

CODING TIP:

For 2007, report the new CPT/HCPCS code G0394, Blood occult test (e.g., guaiac), feces, for single determination for colorectal neoplasm (i.e., patient was provided three cards or single triple card for consecutive collection). This code does not require QW modifier. HCPCS code G0105 is deleted as of 12/31/06.

Commercial Insurance Updates - **SPECIAL!**

Click on the links below to be taken to the Health Plan responses to questions submitted by the Attendees at the QAOAP's General Question & Answer meeting December 14th & 15th, 2006.

[Aetna](#) [Anthem](#) [CIGNA](#)
[Great-West Healthcare](#) [HMS, Inc./Sloans Lake](#)
[Rocky Mountain Health Plans](#) [UnitedHealthcare/Pacificare](#)

A few responses are pending from the Health Plans. The above documents will be updated with the information when received. Check back often!

Workers' Compensation Updates

Fee Schedule Implementation January 1, 2007 - [Click here](#) to read the Director's Interpretive Bulletin #13 on the impact of changes to Rule 18, Medical Fee Schedule.

DOWC Notifies Insurers Regarding Contracts Between Payers & Providers - A [letter](#) from DOWC Director Bob Summers was sent to all Work Comp insurers December 1st regarding a change under the new Rule 16-11 (D)(2), [Medical Bill Disputes](#). The new rule states that providers who request clarification for discounts taken on medical services must receive within 30 days a copy of the contract relied upon for the discount. If a copy of the contract is not provided the discount cannot be taken.

Medicaid Update

ACS Collecting NPI information - Don't forget to submit your NPI information to ASC on Provider letterhead or by using the Provider Update form on the [website](#).

2007 HCPCS - Bulletins listing the approved HCPCS codes for billing the Colorado Medicaid Program now available. Updates of general interest include: [2007 Practitioner HCPCS](#) - [2007 Immunization Update](#) - [2007 Radiology & Laboratory HCPCS](#)

Medicare Update

2007 Physician Fee Schedule Payment Policies - [Click here](#) to view additional updates to Medicare policy & coverage issues for 2007.

2007 Changes for Modifiers & HCPCS Codes - New & deleted National Level II modifiers & HCPCS are effective for dates of service on/after January 1, 2007. In compliance with the Health Insurance Portability & Accountability Act (HIPAA), CMS eliminated the 3-month grace period for discontinued codes in Change Request (CR) 3093, issued February 6, 2004. Effective for dates of services on/after January 1, 2007, the grace period no longer applies for billing discontinued HCPCS codes. [Click here](#) to view the changes.

Miscellaneous

Can We Bill Medicare For After Hours Phone Calls, CPT Codes 99371-99373 - There has been quite a bit of discussion recently on whether or not Medicare will pay separately for after hours phone calls between the patient & the health care provider. [Read more...](#)

More on Discount Cards & Health Plans - If your contract with a health plan includes an "all products" clause, the health plan could, & probably does, rent their provider networks. &, they don't need your consent to do it! [Read on...](#)

Letter to the Editor - Dear CMS Staff, First thanks so much for your work to produce Live Wire. I find it very useful. I want to comment on our experience with the pre-existing conditions & payment (*CMS LiveWire 12/15/06*). We are seeing it with increasing frequency. We detect it when we check benefits & eligibility before the first visit as part of enrollment, or when a patient's plan changes. It has been easy to find out there is a pre-existing but not what the condition or ICD-9 code is. We then ask the patient for a copy of their rider so we can verify the condition. If the patient does not have the rider readily available we agree to see patient after they pay the full charge with condition we will bill carrier. If paid we refund patient. This often motivates the patient to find the rider. We do still however have patients who enter practice get seen for a condition that is covered & then start complaining of the pre-existing condition on subsequent visits. The provider who frequently is not aware of the pre-existing works up the new problem putting payment at risk. I was absolutely delighted to see the work going on in this area. - *Linda Cisco, Interventional Pain Management*

Thought for the Day - *There is nothing right in my left brain. There is nothing left in my right brain.* - *Contributed by John Howell, VP, Clinic Service Corporation*



COLORADO MEDICAL SOCIETY
"Advocating excellence in the profession of medicine."