

# CMS OFFICE MANAGER

*A newsletter to provide medical office staff with information on health insurance.*

February/March 2000

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## Feedback • Ideas • Articles

*If you have any of these please let us know by **phone** at (303) 779-5455 or 1-800-654-5653, ext. 2428, fax at (303) 771-8657 or e-mail at [marilyn\\_rissmiller@cms.org](mailto:marilyn_rissmiller@cms.org).*



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## Hassle Factor Project HITS THE ROAD



One of the goals of the Hassle Factor Project for this year is to get out of our office and meet with office manager groups. We want to hear from you personally about the problems you are facing and find out what ideas you have for resolution. We took our first step toward this goal last month when staff from the CMS Health Care Financing Department met with office managers from the Avista Medical Association. The group was given a complete overview of the project and plenty of time to ask us questions directly. Our next engagement is with the Arapahoe Medical Managers Association in June so we have plenty of “open” dates if you would like to have us come and meet with your group.

## Frequently Asked Questions on the “Timely Payment” Law

Beginning 1/1/2000 C.R.S. 10-16-106.5, prompt payment of claims, requires that insurance companies must process clean claims within 30 days of receipt of electronic claims or 45 days of receipt of hard-copy claims. If they don't they have to pay interest in the amount of 10% annually. Claims that are not settled within 90 days are subject to an additional 3% penalty.

**Question:** How do I find out what the definition of a clean claim is?

**Answer:** If the insurance company has not published their clean claim requirements in a recent bulletin or letter, you will need to contact each one directly for that information. It is possible that each company you deal with may have a slightly different definition.

**Question:** If I file hard-copy claims and cannot get an acknowledgement of receipt from the insurance company what do I use as the receipt date?

**Answer:** If the insurance company won't acknowledge receipt of your paper claims, add three days to the date you mailed the claims to allow time for delivery.

**Question:** How does this annual percentage rate break down into a daily or monthly rate?

**Answer:** Calculate 10% of amount owed (total amount that the insurance company will allow on the claim), divide that by 365 days, then multiple that amount by the number of days they are late.

**Example:**

- You filed a claim electronically to abc insurance company on 1/1/00.
- On 2/14/00 you have not received payment, denial or request for additional information

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# Colorado State Legislation

**"Timely Payment Law"**  
(continued)

The 2000 Colorado state legislative session started in earnest on January 5<sup>th</sup>. Just a month into the process and the CMS Government Relations staff are already hard at work monitoring over 50 bills and keeping the physicians who serve on the CMS Council on Legislation updated. Following is a brief summary of some of the bills they are watching:

**SB 54, Creation of Organ Donation Registry (Pascoe):** Creates and maintains an electronic registry of the donors of organs and tissues.

\* **SB 71, Concerning Use of Moneys Received Pursuant to the Tobacco Litigation Settlement (Anderson):** Specifies that moneys received by the state pursuant to the master settlement agreement arising from tobacco litigation are intended to supplement, and not supplant, any appropriations received by such programs. Requires the Dept. of Public Health & Environment to monitor programs that receive appropriations from the moneys received by the state pursuant to the tobacco litigation.

**SB 138, Concerning the Requirement of an Insurer with a Managed Care Arrangement under Motor Vehicle Insurance to have an Internal Appeal Process, and, in Conjunction Therewith, Notifying the Covered Person of the Right to Appeal the Internal Decision to the Personal Injury Protection Examination Panel (Sullivant):** Requires a motor vehicle insurer to adopt the internal appeal process promulgated by the insurance commissioner. Requires that a denial of PIP benefits include an explanation of why the claim was denied and advisement that the covered person may appeal the denial of benefits.

**SB 143, Concerning the Ability of Residents Receiving Medicare to Purchase Pharmaceuticals at the Rate Offered to Medicaid Participants (Matsunaka):** Requires pharmacies that offer medications to Medicare participants to charge the Medicaid reimbursement rate plus an electronic transfer fee.

**SB 148, Concerning Contracts Between Health Insurance Companies and Health Care Providers (Evans):** Prohibits contract clauses that restrict the provider's freedom to offer services in the marketplace or limits their ability to provide medically necessary treatment. Invalidates contracts providing for the holding back of fees based on the number of referrals a provider makes to other health care providers.

**SB 150, Concerning the Rights of Persons with Health Insurance Coverage in Colorado (Thiebaut):** Requires that managed care plans that offer emergent care cover benefits without preauthorization. Requires health plans that offer group benefit coverage to offer point of service coverage. Establishes ombudsman program to assist consumers in choosing health plans and resolving disputes.

**HB 1058, Failure to Truthfully Respond to BME Complaints (Morrison):** Classifies that failure to "truthfully respond" in a manner that fully discloses all information to a complaint as unprofessional conduct.

\* **HB 1388, Concerning Use of Moneys Received Pursuant to the Tobacco Litigation Settlement, Limiting Use of Moneys to Health and Education (Lawrence)**

\* **Note:** Two different bills, one introduced in the Senate and the other introduced in the House.

If you want to see the complete listing of the bills CMS is currently monitoring and you have access to the internet, you may check the CMS Web page for updated legislative information. Go to the CMS Home Page (<http://www.cms.org>), select "CMS for Physicians" then select "Heard on the Hill" for the list of CMS legislative activity. Or you can contact the CMS Government Relations staff at (303) 779-5455 or 1-800-654-5653.

- the claim is now 15 days past due.  
- Your total charges on the claim were \$1000, but the insurance company's allowed amount totals \$800.

Multiply \$800 x 10% = \$80 is the annual rate  
Divide \$80 by 365 days = \$.219 is the daily rate  
Multiply \$.219 x 15 days = \$3.29 interest owed by abc insurance company

**Question:** How does the 3% penalty work?

**Answer:** In addition to the 10% annual interest rate the insurance company also owes you an additional 3% of the allowed amount as a penalty for not finalizing their processing in 90 days. Using the above example it would look like this:

Multiply \$.219 x 60 days (31<sup>st</sup> through 90<sup>th</sup> day) = \$13.14 interest

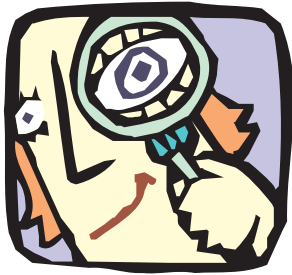
Multiply .03 x \$800 = \$24 penalty

Total money owed by insurance company = \$37.14

**Question:** Have steps been taken to better define "clean claim" or require acknowledgement of paper claims?

**Answer:** Changes to the law would require legislation. In order for the legislators to consider any changes we must have documentation demonstrating that there is a problem. That is why CMS is asking for your assistance in monitoring the effectiveness of the new law. Let us know if you notice an increase in the number of claims that are denied or lost, or any other problem that you feel may be directly related to the new law.

## OIG Work Plan for 2000



Every year the Office of the Inspector General (OIG) publishes their work plan, that is, the areas they will be looking at during the upcoming year. This list is an indication of where they have concerns about potential fraud and/or abuse. Some of the physician services that are targeted for study are:

- ⊙ **Physicians at Teaching Hospitals** - to verify compliance with the Medicare rules governing payment of physician services provided in the teaching hospital setting.
- ⊙ **Automated Encoding Systems for Billing** - determine whether errors found in Medicare billings for physician services are associated with the use of automated coding software.
- ⊙ **Reassignment of Physician Benefits** - evaluate the practice of allowing physicians to reassign their billing numbers to clinics. Clinics that employ more than one doctor may accept a reassignment of the physicians' billing numbers, thus allowing the clinic to handle all billing and keep all fees for services provided by the physicians, usually in exchange for paying a flat fee or salary to the physicians. Looking for vulnerabilities as typically in these instances the physician never sees what is billed under his or her physician number.
- ⊙ **Myocardial Perfusion Imaging** - assess the medical appropriateness of myocardial perfusion imaging and explain the high increase in utilization since 1997.
- ⊙ **Private Physician Contracting** - study the impact the private contracting provision of the 1997 Balanced Budget Act has had on Medicare beneficiaries.
- ⊙ **Advance Beneficiary Notices** - examine the use of advance notices to Medicare beneficiaries and their financial impact on the beneficiaries and providers. Physicians must provide advance notices before they provide services that they know or believe Medicare does not consider medically necessary or that Medicare will not reimburse.
- ⊙ **Improper Medicare Fee-for-Service Payments** - this is a continuation of the efforts that began after auditors found that HCFA had spent billions of dollars on improper payments. (The infamous random prepayment review of E&M codes was a result of this audit.)

Other non-physician areas the OIG is focusing on include:

- **HMO Profits** - compare the profitability of the Medicare lines of business with the operating results from HMOs' other lines of business.
- **Managed Care Organization Closings** - review to determine the impact on beneficiaries of recent closings of Medicare managed care organizations.

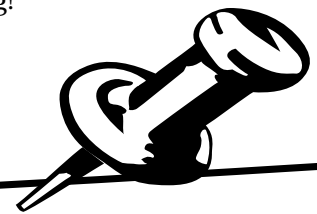
You can check out the entire work plan on the internet by going to [www.os.dhhs.gov/oig](http://www.os.dhhs.gov/oig) then click on OIG electronic reading room and then on work plan.

## What's the Importance of a Code

More than you might think if it's a diagnosis code. We all know that the diagnosis code helps to explain *why* the doctor performed the service or procedure but it seems lately more insurance companies are using it as a reason to deny or down-code your claim. So remember to:

- ✓ Be sure the ICD-9 code you use is current and carried out to the third, fourth or fifth digit as indicated in the *ICD-9*.
- ✓ Be sure that the appropriate diagnosis code is linked to each service/procedure on the 1500 form and that the first diagnosis code listed is the *primary* reason for that service or procedure. (Many of the insurance companies don't look beyond the first diagnosis before adjudicating your claim.)
- ✓ Be sure to code the *current* condition being treated, don't use chronic conditions unless the doctor is treating them at that visit, and be sure that as care of the patient progresses the doctor updates the diagnosis. (For example, the diagnosis at the patient's initial visit might be contusion but the doctor continues to see the patient due to tendonitis, if the diagnosis isn't updated the insurance company might question why it is necessary to see the patient on an ongoing basis for a bruise.)

If trying to avoid the current hassles isn't enough reason to take care with your diagnosis coding, consider what might happen in the future. Researchers, managed care organizations, and others are currently using diagnosis codes as one of the means of tracking patterns of practice and patient outcomes. The government (HCFA) is interested in taking this one step further and developing a "global" reimbursement system based on what it takes to manage a patient with a specific diagnosis. (This is already being developed for outpatient hospital services and is called Ambulatory Patient Groupings or Classifications - APGs or APCs.) Talk about the ultimate in bundling!



### note

There are several misprints on the Medicare Disclosure Reports for 2000. A number of the allowances for the "J" codes (injectible drugs) are wrong. We have been told that even though the report is wrong, their system is loaded correctly and payments should not be affected. Medicare mailed a corrected listing of the "J" code allowances last month.

In the January 2000 issue of *Colorado Medicine* we published an article on HCFA's clarification of their consultation rules. If you don't have access to the magazine and you would like a copy of the article please contact us.

## In Response to Your Question. . .

Following are just a couple of the general billing and coding questions that we respond to daily.

**Question:** Is there any law or regulation governing how far an insurance company can go back and ask for a refund?

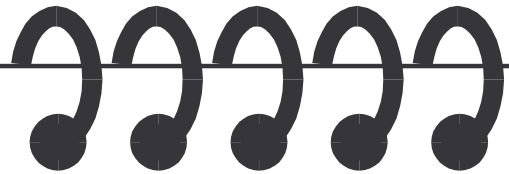
**Response:** Unfortunately there is not. We verified this with the Colorado Division of Insurance (DOI). When insurance companies contact the DOI and ask them this question, they tell them they wouldn't recommend going back any further than 3 years (based on the statute of limitation). But, don't forget to check your contract with the insurance company to see if there is any limitation mentioned in it.



**Question:** A patient who had elbow surgery performed by an out-of-town specialist was seen by our physician due to elbow pain. The patient already had a follow up appointment scheduled with the specialist. Which modifier should I use since our physician is not assuming post-op management?

**Answer:** Since your doctor did not perform the surgery and since your doctor is not taking over the post-op management no modifier is necessary. (Medicare should pay automatically, for private insurance you may have to provide an explanation.)

If you have a question you would like us to research for you, you can fax it to us at (303) 771-8657.



## Resources

If you are interested in obtaining information on how to become a "certified" coder you can contact:

- ☎ **AAPC** (American Academy of Professional Coders) at 800-626-CODE, [www.aapcnatl.org](http://www.aapcnatl.org)
- ☎ **AHIMA** (American Health Information Management Association) at (312) 787-2672
- ☎ **PRS** (Physician Reimbursement Systems) at (303) 534-0574 or 800-972-9298, [www.prscoding.com](http://www.prscoding.com)

If you are aware of other organizations that do certification please let us know so we can pass the information along.

Colorado Medical Society  
P.O. Box 17550  
Denver, Colorado 80217-0550