

CMS OFFICE MANAGER

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

May 2001

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*If you have any of these please let us know by **phone** at (720) 859-1001 or 1-800-654-5653, ext. 6328, **fax** at (720) 859-7509 or **e-mail** at*

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Hassle Factor Project UPDATES

- During the past year we have traveled and met with a number of office manager and specialty groups across the state. These face-to-face encounters are an important part of the project, as they provide us with the opportunity to hear from you personally. As a result of feedback we received during one of these meetings, we have changed the way we count complaints. In the past when we received a payer complaint with multiple claim examples attached, if they all concerned the same issue, we would count them as one complaint. However after re-evaluation we agreed that this really did not capture the full impact of the problem. To be sure that our data better reflects the magnitude of the problems, we are now counting the actual number of claim complaints we receive.

As of March 2001 we have logged complaints on over 8,700 claims.

- The Colorado Division of Insurance has established the Carrier-Provider Dispute Task Force with the goal *to establish a fair and equitable process of addressing conflicts between providers and carriers*. The Task Force consists of insurance and provider representatives – and yes, CMS is participating. We presented the Task Force with information on the numbers and types of complaints that have been submitted through the Hassle Factor Project. The presentation gave the Task Force members insight into the types of disputes “providers” need help resolving, and will hopefully aid in the design of a comprehensive process that can address these contentious issues. We will keep you informed regarding any progress made by the Task Force.

- Delay in payment continues to be the number one complaint we receive through the Hassle Factor Project. As part of our ongoing monitoring of the problem, we have completed a second timely payment survey of CMS members. We are currently compiling the results and will have more information available for you in a future newsletter.

Thanks to all of you who participated!

We had a 50% increase in the number of responses we received this year.

- We continue to present your *hassles* to the payers when we meet with them individually and through the CMS/CHMOA Joint Committee. And, we will continue to work for improvements in the system.

2001 Coding Insert

Enclosed with this newsletter you will find a special insert containing a comprehensive [but not complete] listing of coding changes for 2001. There were over 400 changes in the *CPT 2001* and one hundred new *ICD-9* codes for 2001. Space does not permit us to reprint all of them, but it is important that you review the codes you use frequently to be sure that they are still valid. Use of outdated codes can delay the processing of your claims.

Colorado State Legislation

The 2001 Colorado State legislative session is about three months old and the CMS Government Relations staff has been monitoring about 60 bills. Following is a brief summary of some of the bills they are watching:

SB 061, Concerning the Confidentiality of Medical Record Information, and, in Connection Therewith, Consolidating Statutory Provisions Concerning Medical Record Confidentiality (Hagedorn, Witwer): Requires patient consent, subpoena, or provision of law for medical records to be released to third parties.

SB 063, Concerning the Creation of the Breast and Cervical Cancer Prevention and Treatment Program, and Making an Appropriation Therefor (Hagedorn, Stafford): States that Colorado has opted to provide services to the breast and cervical cancer prevention and treatment program under the "Colorado Medical Assistance Act".

SB 128, Concerning the Licensure of Physician Assistants (Takis, Clapp): Changes the existing program of certification of physician assistants to a licensure program. *Amended bill passed the Senate and the House and is awaiting the governor's signature.*

HB 1021, Concerning Increased Disclosure Requirements Relating to the Provision of Automobile Personal Injury Protection Insurance (Tochtrop, Tate): Requires insurers who offer personal injury protection through managed care arrangement to disclose the identity of the entity that provides the MCA, the fact that persons who are not medical doctors may determine what type of medical care is available, and the fact that some medical and rehabilitation costs may not be covered. *Amended bill passed the Senate and the House and is awaiting the governor's signature.*

HB 1037, Concerning the Creation of Specific Requirements for Health Care Provider Networks that Conduct Insurance Business in the State of Colorado (Fairbank, Phillips): Creates specific requirements for health care provider networks that must be met in order to conduct insurance business in the State of Colorado. *The bill has been signed by the governor.*

HB 1040, Concerning Penalties for False Medicaid Claims (Young, Reeves): Makes unlawful specified actions of providers of Medicaid services involving false Medicaid claims, including offering or receiving any kickback or bribe.

HB 1079, Concerning the Older Coloradans Program (Mace): Expands the older Coloradans program to provide to eligible persons 60 years of age or older the following services: Pharmaceutical; Dental; Optometric and Audiological; Expanded in-home services; and Home repair and maintenance services.

HB 1156, Concerning Mandatory Insurance Coverage for Medical Foods for Persons with Inherited Metabolic Disorders (Lawrence): Creates a mandated health care coverage for medical foods for home use which a physician issued a written or electronic order and that are appropriate for inherited diseases in newborn and infant children that involve inherited enzymatic disorders affecting the metabolism of proteins, carbohydrates, and fats and for which standard medical methods of diagnosis, treatment and monitoring exist.

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>) <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 (720) 859-1001 or 1-800-654-5653.

Some CCI Edits are Retracted

HCFA suspended a number of the Correct Coding Initiative (CCI) edits that were added with the October 30, 2000 update. The edits bundled 66 E&M codes, as well as the ophthalmological codes 92002-92014 into over 800 "procedures" with a global period of XXX. The coding pairs included medicine, lab, x-ray, surgery and ophthalmology services. When an E&M service was billed with any of these codes, it would be denied. The change was made retroactive to October 30, 2000, however, the affected claims will not be automatically reprocessed. If you think you had a claim denied in error due to one of these edits, you will need to contact the Medicare carrier to request a reconsideration. HCFA is reevaluating these edits and may reinstate some of them later this year.

Note: The HCPCS codes for the vaccine costs of Influenza (G0008), Pneumococcal (G0009) and Hepatitis B (G0010) were included in the suspended edits. If you had an E&M service (other than 99211) denied because it was billed with one of these immunizations on the same day, you should contact the Medicare carrier to have the claim reprocessed.

•WARNING•

If you don't want to be left "holding the bag," be sure to check the Medicaid recipient's card for payer (traditional or HMO) and eligibility at every visit. It's possible that the payer and the patient's eligibility could change from one month to another. (This even applies to guaranteed eligibility situations; e.g., pregnancy.)

Medicare “Only”

Coding Changes:

- **Care plan oversight (CPO) in skilled nursing facilities and hospices** - The CPT definitions for codes 99375 and 99378 were changed and are no longer consistent with Medicare coverage policy since Medicare **does not pay separately for CPO in a nursing home**. HCFA has added two new HCPCS codes that are to be used in place of the CPT codes when billing Medicare. They are:

G0181 CPO for home health and G0182 CPO for hospice.

- **Physician certification/re-certification of home health services** - Medicare will now pay separately for the services of the physician certification/re-certification and development of plan of care for covered home health services. Use codes:

G0180 for physician certification and G0179 for re-certification.

- **Clarifications: Observation care codes (99234-99236)** - to receive payment for these codes the patient must be in observation status for a minimum of 8 hours; otherwise only the admission code (99218-99220) should be billed.

Antigen immunotherapy - The definition of a “dose” of allergen immunotherapy (95165) has been revised to a one cc aliquot from a single multidose vial.

- **Modifier -60 Altered Surgical Field:** The CPT added this modifier to identify certain procedures that involve significantly increased operative complexity and/or time due to a significantly altered surgical field as a result of the effects of prior surgery, marked scarring, adhesions, inflammation, or distorted anatomy, irradiation, infection, very low weight (ie, neonates) and/or trauma.

Note: Medicare does not recognize modifier -60, they want you to continue to use modifier -22.

Benefit Changes:

- **Medicare Benefits Improvement and Protection Act (BIPA)** - There will be some **additional coverage changes effective 7/1/01** as a result of this law.

Screening mammogram - The frequency is changing from once every 3 years to **once every 2 years**. In addition, patients with a personal history of breast cancer can now receive the screening mammogram using CPT code 76092 and the V76.12 diagnosis code. (This allows them to take advantage of the fact that there is no deductible.) If a unilateral screening mammogram is performed, because the patient only has one breast, use code 76092 and add modifier 52, the charge should be reduced accordingly.

Screening pap smear and pelvic exam - The frequency is changing from once every 3 years to **once every 2 years**.

Screening colonoscopy - Medicare will now cover this service for patients at high or **average risk** for developing colorectal cancer.

- **Mandatory assignment of drugs and biologicals (“J” codes)** - effective for dates of service on or after **February 1, 2001** you must accept assignment for drugs and biologicals covered under Part B. (These are the “J” codes for the cost of medications administered in the physician’s office.)

Watch for details on these changes in a future Medicare bulletin.

Sloans Lake HMO - What you need to know:

Anthem Blue Cross and Blue Shield has provided the following information concerning their transaction with the Sloans Lake Health Plan (HMO).

- Sloans Lake Health Plan (SHLP) signed a management agreement with Anthem Blue Cross and Blue Shield (Anthem) that was effective 12/01/00. The agreement states that Anthem will immediately assume responsibility for administering the day-to-day business of SLHP HMO/POS and Sloans Lake Health Insurance Company products.
- Claims filing, customer service, medical management and provider service functions and contact information for SHLP and Sloans Lake Health Insurance Company ARE UNCHANGED. Anthem has hired about 85% of SLHP employees and they continue administering the business in the usual manner from their offices on Colorado Boulevard. Additionally, the SLHP web site remains operational and health care providers can check eligibility and claims status by going to www.sloanslake.com and clicking the “Provider” button.
- SHLP and Sloans Lake Health Insurance Company will cease operations as of June 1, 2001. Between now and June 1, SLHP and Sloans Lake Health Insurance Company customers will have the following choices:
 - Continue with SHLP or Sloans Lake Health Insurance Company until June 1, in which case access to SLHP health care providers is unaffected.
 - Move their health insurance programs to Anthem or to another health plan, in which case members will get new I.D. cards and new authorizations will need to be established.
 - After June 1, all SHLP and Sloans Lake Health Insurance Company customers will have moved to another health plan. Health care providers should be reminded to verify current insurance information.
- Questions about the transaction and conversion process can be directed to a SHLP Provider Service Representative or to a Customer Service Representative by calling 1-800-850-5888.
- Health Care Providers who are not currently in Anthem’s provider network who are interested in exploring Anthem network participation can call Anthem directly at 303-831-0801 (or 1-800-544-3879).
- Anthem’s transaction with SLHP **DOES NOT** include the PPO or PIP operations of Sloans Lake Managed Care.

FYI - The sale of Sloans Lake Managed Care (i.e., the PPO and Auto divisions) has been finalized and Blair Tikker is the new CEO.

Note

- Medicare’s 2001 conversion factor for surgery and medicine was increased to \$38.251. The new anesthesia conversion factor is \$17.26.
- HCFA published the 2001 changes to the RBRVS in the November 1, 2000 issue of the Federal Register. If you want to order a copy of this information you should send your request to: New Orders, Superintendent of Documents, PO Box 371954, Pittsburgh, PA 15250-7954. Specify that you want the Federal Register dated Wednesday, November 1, 2000 and enclose a check or money order payable to the Superintendent of Documents, or enclose your Visa, Discover, or MasterCard number and expiration date. The cost is \$8.00.

In Response to Your Question. . .

Question: Why won't insurance companies recognize modifier -25 on an E&M code when used to identify a problem during a preventive exam?

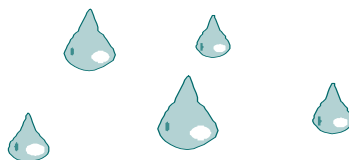
Answer: Many insurance companies are using the same or similar editing software in their claims processing systems, and most do not allow both preventive and E&M codes on the same day. This is not correct according to the CPT coding guidelines, however they are making their own "policy" determinations. And even though the *details* of the plan's bundling policies are not spelled out in advance, if the doctor is participating, there is probably a general statement in the contract that indicates that the doctor agrees to "abide by the plan's policies".

In general, we are finding that plans do not recognize modifier -25 and routinely deny an E&M visit when billed with a procedure on the same day. Some plans will pay both if there are two completely different diagnosis codes involved, and some will allow the E&M visit on appeal. If the plan hasn't published their policy regarding modifier -25 you may want to consider writing their provider relations department for a written explanation.

If you have a questions you would like us to research for you, you can fax it to us at (720) 859-7509



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Resources

Are you connected?

Does your office have access to the internet yet? If not, you may want to consider it. More payers are expanding the information and services available on their web sites. In addition to having provider directories and manuals available, some payers will let you check eligibility or claim status online. And some payers are doing pilot testing of prior authorizations and claims submission over the internet. To find out what's available locally, check with the insurance company's provider services department, or visit their web site. But you'll have to be connected to take advantage of the information and opportunities.