

CMS OFFICE MANAGER

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

September/October 1999

What's Inside

Colorado State
Legislation. page 2

Timely Payment
Survey page 2

Medicare Patients'
Choices page 3

A Hassle By Any
Other Name page 3

Good News &
Other News page 4

Resources page 4

Hassle Factor Project TIMELY PAYMENT SURVEY

As we indicated in our last newsletter all CMS members were sent a *Health Plan Survey – Timeliness of Payment* for completion. About 200 surveys were returned, representing input from almost 1,500 physicians. The preliminary review indicates that only 5 of the 17 payers listed on the survey processed claims within 45 days (**none** of the payers processed claims within 30 days). These results seem to underscore the importance for you to be aware of how the Colorado law requiring prompt payment of health insurance claims will work next year. (See related story on page 2.) The final survey results will be used to establish a baseline on the performance of health plans. At the end of next year we will repeat the survey to determine if there has been an improvement.

Did You Know There is More Than One Kind of Medicare Audit?

In fact there are four currently conducted by the Medicare Carrier. They are the pre-payment review, the Focused Medical Review, the Comprehensive Medical Review and the audit of Electronic Claims Submission.

- The *pre-payment review* has been mandated by HCFA to see how well physicians are doing on their E & M documentation. HCFA rotates the E & M codes to be reviewed and the Carrier must randomly select 4% of the claims submitted with the “chosen” codes for review prior to payment. Based on review of the documentation provided, the claim will either be paid as billed, down-coded or denied. These pre-payment reviews are happening nationally and are part of HCFA's initiative to *pay claims right the first time*.
- The *Focused Medical Review (FMR)* is just that, the Carrier is looking at specific services post-payment. Each year HCFA supplies the Carrier with data that shows those services, supplies and procedures that are above the national norm in Colorado. From this information the Carrier then looks for those doctors in Colorado who are providing the services in question and *focuses* on those at the high end. If your doctor is part of a Focused Medical Review, you will receive a letter from the Carrier requesting a limited number of records (usually not more than eight) for one particular date of service. You will receive notification from the Carrier if your doctor passes or fails the audit. A doctor who does not pass the FMR may be subjected to additional audits, including a Comprehensive Medical Review.
- The *Comprehensive Medical Review (CMR)* is also a post-payment audit but it is more serious. It entails a thorough analysis of a cross-section of services on at least fifteen claims. A doctor is generally chosen for a CMR because his/her pattern of practice is significantly different from others in the same specialty and location. The outcome of the audit will vary depending on what problems are identified. There will usually be some type of educational contact made by the Carrier. There could be a request for repayment of claims found to be overpaid. The doctor could be placed on additional periodic post-payment reviews, or the doctor could be placed on pre-payment review.

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.*

This newsletter is provided to you free of cost by the Colorado Medical Society.

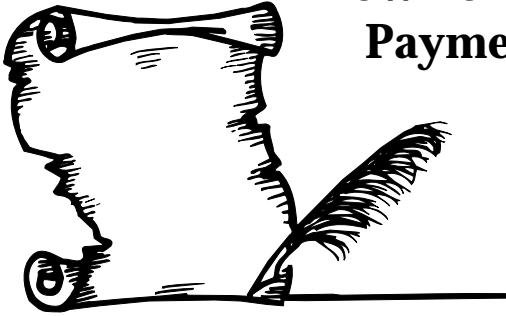
Please share this information with others, but we ask that you acknowledge the source.

Medicare Audit - continued on page 2

Colorado State Legislation

DOI has a Brochure
to Help Physicians

How To Make The Timely Payment Law Work For You



Beginning January 1, 2000 health insurance entities are required to pay deny or settle "clean" claims (i.e., those filed on the insurer's standard form and containing all necessary information) within 30 days after electronic filing and 45 days after paper filing unless the claim is disputed. The law is not automatic,

there are things each office will have to know and do to take advantage of it.

- ❖ **Submit a clean claim.** Every insurance carrier is required to provide a participating provider with a copy of its filing requirements. This information is usually communicated in a provider manual or bulletin, and the requirements can vary from one insurance carrier to another.
- ❖ **Be sure the claim is one that falls under the state law.** The law applies to fully insured health insurance plans in the state of Colorado. It does not apply to self-insured health plans (such as unions and large employer groups). These plans are subject to federal ERISA laws. If in doubt, call the patient's insurance carrier, they should be able to tell you. The law does not apply to Auto No-Fault, Worker's Compensation, Part B Medicare and the state Medicaid program.
- ❖ **Respond promptly to a request for additional information from the insurance carrier.** If you don't respond within 30 days, the insurance carrier can deny the claim.
- ❖ **Monitor your claims.** Set up a system in your office to track the timeliness of the insurance carrier's processing. If they are outside of the required time limits contact them for an explanation. (Help us monitor the effectiveness of the law by copying us on your correspondence to the insurance carrier.)

The Colorado Division of Insurance (DOI) has published a brochure entitled *Rights and Responsibilities That Impact Providers Under Colorado Health Insurance Law*. It is very informative. It provides short bullet points on many of aspects of the laws and regulations concerning prompt payment of claims, prior authorization and utilization review. It would be a very valuable tool to have in your office. The Division has promised to provide us with copies of the brochure to distribute to our members in the near future. However, you can also obtain a copy directly from DOI by calling them at (303) 894-7499 or 1-800-930-3745, press 0 and tell the operator that you would like to speak to a Consumer Affairs Analyst.

Medicare Audit (continued)

- The *Electronic Claims Submission* audit is done to verify that the claims transmitted by your office actually reflect the services provided. For in office services you will also have to prove that the patient showed up. The records review that is done to prove the electronic claims were valid is not as in depth; for example, they are not scrutinizing the records to be sure that the documentation supports the level of service billed.
- **What's your role?** Don't panic - but do be responsive. Be sure that the requested documentation is returned within the time limit specified in the letter. If there is going to be a problem contact the person named in the letter. Be sure to provide all of the documentation that supports the service billed. If you had a consultant help you with some of these same billing issues in the past contact him/her. They may be able to assist you in identifying what information in the chart will justify the service. Keep copies of everything you send to the Carrier. If you do receive a request for money back check your Remittance Advice to be sure that the service was actually paid in the first place.

Fax-Back Form

In our last newsletter we also mentioned our plans to implement the use of a fax-back form to answer general billing and coding questions. A blank form was mailed to all CMS members with the timely payment survey in October. A number of you have already taken

advantage of this service. If you can't locate the form, let us know and we will send you another copy. Starting with the next newsletter we will publish some of the common questions and answers (*anonymously of course*).



Don't Forget to Check Out the CPT 2000

Compare the codes you use all the time to those in the new CPT. Check to see if any of your old favorites have been deleted or revised, or if there are new codes you should be aware of. Don't panic if you can't find the laparoscopic codes (56300-56399), they've been moved. The code numbers have been changed and they are now included in the appropriate anatomical section of the surgery codes. Examples:

New Code	Old Code
44200 Laparoscopy, surgical; enterolysis	56310
47562 Laparoscopy, surgical; cholecystectomy	56340
58671 Laparoscopy, surgical; w/occlusion of oviducts	56302

Part of the CPT process is to provide additional clarification, through new or revised codes and explanatory notes, for areas where there have been problems with interpretation. A number of such changes have been made in the spinal section of the musculoskeletal codes, throughout the cardiovascular surgery section and the nervous system. There have also been changes in the facet joint and facet nerve injection codes (64622-64627) so they better reflect the current use.

It's important to incorporate the CPT 2000 changes into your billings to avoid delays or denials. However, *timing is everything*. Most insurance carriers, including Medicare, give you a grace period before use of the CPT 2000 codes becomes mandatory. For Medicare that grace period is 90 days. If you're not sure about your other insurers check with them. Using the codes too soon can cause just as many delays as using the old codes too long.

Medicare Coverage Changes for 2000

- Beginning January 1st Medicare will cover annual Prostate Cancer Screening for men over 50. The covered cancer screening tests include a digital rectal exam - new HCPCS code G0102, and screening PSA - new HCPCS code G0103.
- As of January 1st Medicare will bundle the following codes into payment for other services, primarily the E&M visits.

No longer reimbursed separately:

- 94760 - Pulse oximetry; single determination
- 94761 - Pulse oximetry; multiple determinations
- 93740 - Temperature gradient studies
- 93770 - Determination of venous pressure

HCFA feels that payment for these services is already included in the overhead expenses.

- Medicare will pay separately for use of the operating microscope (CPT code 69990) as an add-on to these specific codes: 61034-61711, 62010-62010, 63081-63308, 63704-63710, 64831, 64834-64836, 64840-64858, 64861-64870, 64885-64898, and 64905-64907.

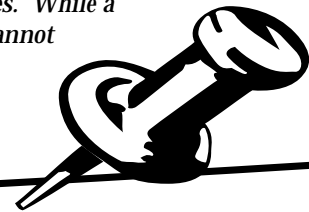
Have You Seen the Medicare 2000 Disclosure Report?

This year the Medicare Carrier for Colorado mailed physicians a copy of the 2000 Disclosure Report and participation information in a *plain white packet*. The booklet, which is almost 1/2" thick, should be in your hands now as it was mailed in mid-November.

Fee Schedule - This year the format of the fee schedule (disclosure report) has been revised to provide you with more detailed information. In addition to the allowable amounts and limiting charge, the report also provides information on the global surgery days and what modifiers apply for each CPT/HCPCS code listed. If you do much lab work in your office, you may want to write the Medicare Carrier and request a copy of the *Clinical Lab Fee Schedule* for 2000.

Medicare Participating Physician or Supplier Agreement - Physicians who want to change their participation status with Medicare must do so by December 31, 1999. **To become participating**, have the doctor sign the participation agreement that was included in front of this year's disclosure report. If the doctor sees patients in another state, a separate participation agreement is needed for that state. A completed form should be mailed to each state's Medicare Carrier. A separate participation agreement is also needed for Railroad Medicare. **To become non-participating**, the doctor must send a letter to the Medicare Carrier requesting the change in participation status. Again, if the doctor is participating in more than one state, a separate letter must be sent to each state's Medicare Carrier.

Don't confuse non-participation with "opting-out". A non-participating physician still sees Medicare patients and bills Medicare for those services. While a physician who opts-out cannot bill Medicare.



note

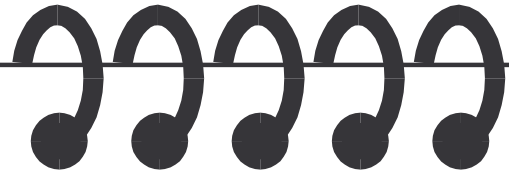
- Medicare will update the physician's fee schedule for dates of service 1/1/2000 and after on January 14, 2000.
- HCFA published the 2000 changes to the RBRVS in the November 2, 1999 issue of the Federal Register. If you want to order a copy of this information you should send a check for \$8.00 to: New Orders, Superintendent of Documents, PO Box 371954, Pittsburgh, PA 15250-7954. Specify that you want the Federal Register dated Tuesday, November 2, 1999 containing the Final Rule on "Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2000."
- Medicare's 2000 conversion factor for surgery and medicine was increased to \$36.6137. The new anesthesia conversion factor is \$17.25.

Checklist for the New Millennium

Following are some reminders from Ginny Roath of Timely Insurance Payment Services to be sure you put your best coding and billing foot forward in the new year.

- 4 **Audit your currently used CPT codes** against the *CPT 2000*. Check for revisions to your codes, potential deletion of codes, and then review the coding additions. You will find a summary of the CPT changes in and appendix at the end of the book.
- 4 **Make certain you have identified current HCPCS codes** for your medicines, supplies and miscellaneous services.
- 4 **Obtain current provider manuals from your contracted payers** and review these for specific claim reporting requirements, specific carrier coding requirements, and situations of benefit limitations based on reporting.
- 4 **Review your Medicare fee schedule for 2000** (non-par physicians make sure you update your fees to the new limiting charges). By checking the Medicare fee schedule you can identify HCPCS and local carrier coding requirements.
- 4 **Audit and assess your common coding and claim reporting problems during 1999**. A review of your explanation of benefits, claim rejection reports, and claim denial correspondence will allow you to summarize these problems and find ways to prevent them in 2000.

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



Resources

- HCFA has provided us with copies of a "Conversion 2000: Y2K Jumpstart Kit" on CD-ROM. The program is designed to walk you through completion of an inventory of your office and equipment that may be susceptible to Y2k problems. You can contact us for a copy. Or, you can also download the information from the HCFA Y2K Help Center web site at <http://y2khelp.nist.gov>.
- The Medicare Carrier for Colorado has their bulletin information available for downloading on their web site at <http://dragon.bcsnd.com/medweb/bulletin.html>. It has both current and prior information.