



New York J13

Medicare and
LICENSED CLINICAL SOCIAL
WORKERS

February 28, 2011



2011 Medicare Fee Schedule

- **Single fee schedule for 2011.**
- **Fees are posted to www.ngsmedicare.com**
- **Verify current allowances – some changes since 2010**
- **Awaiting CMS direction for final issues for allowance changes during 2010.**
- **SGR still in the formula!**

The 2011 fees schedules will be posted to this Web site as soon as they are finalized. If you would like to be notified when the fee schedules are posted, sign up for our E-mail Updates by selecting the link under Publications on the left-hand side of this Web page.

[Expand All](#) | [Collapse All](#)

▼ **Publications**

- E-mail Updates
- Manuals
- Medicare Monthly Review
- News Articles

▼ **Claims**

- Administrative Simplification Compliance Act
- Coordination of Benefits
- Electronic Submissions (EDI)
- Fee Schedules**
- HCPSC Codes
- Medicare Secondary Payer
- Top Claims Submission Errors

▼ **Coverage Determinations**

- Medical Policy Center (LCDs)

▼ **Education and Training**

- Clinical Education
- Medicare University
- POE Advisory Group
- Training Events Calendar
- Training Summaries
- Welcome New Providers

▼ **Review Process**

- Appeals
- Comprehensive Error Rate Testing
- Fraud & Abuse
- Medical Review




Fee Schedule Assistance

The [fee schedule assistance page](#) provides access to information about fee schedule definitions and acronyms, instructions for locating and downloading fee schedule pricing, the CMS Physician Fee Schedule Search tool, and area and county information for New York providers.

Locate Fee Schedule Pricing

Timeframe Region


00 Medicare Physician Fee Schedule Pricing

Title/Description	Effective Date	PDF	XLS	TXT	CSV	HTML
CT: Medicare Physician Fee Schedule [FULL SCHEDULE]	01/01/2011 - 12/31/2011			 800 KB		
IN: Medicare Physician Fee Schedule [FULL SCHEDULE]	01/01/2011 - 12/31/2011			 789 KB		
KY: Medicare Physician Fee Schedule [FULL SCHEDULE]	01/01/2011 - 12/31/2011			 789 KB		

01 Medicare Physician Fee Schedule Pricing - Area 01

Title/Description	Effective Date	PDF	XLS	TXT	CSV	HTML
NY: Medicare Physician Fee Schedule [FULL SCHEDULE]	01/01/2011 - 12/31/2011			 798 KB		

02 Medicare Physician Fee Schedule Pricing - Area 02

Title/Description	Effective Date	PDF	XLS	TXT	CSV	HTML
NY: Medicare Physician Fee Schedule [FULL SCHEDULE]	01/01/2011 - 12/31/2011			 798 KB		

03 Medicare Physician Fee Schedule Pricing - Area 03

Title/Description	Effective Date	PDF	XLS	TXT	CSV	HTML

	A	B	C	D	E	F	G	H	I	J	K	L	M	N
4		90472		13.62	12.94	14.88								
5		90473		28.23	26.82	30.84								
6		90474		13.62	12.94	14.88								
7		90801		175.22	166.46	191.43								
8 #		90801		136.14	129.33	148.73								
9		90802		190.55	181.02	208.17								
0 #		90802		149.30	141.84	163.12								
1		90804		75.04	71.29	81.98								
2 #		90804		58.63	55.70	64.06								
3		90805		85.62	81.34	93.54								
4 #		90805		68.29	64.88	74.61								
5		90806		98.99	94.04	108.15								
6 #		90806		89.88	85.39	98.20								
7		90807		117.78	111.89	128.67								
8 #		90807		100.91	95.86	110.24								
9		90808		145.29	138.03	158.73								
0 #		90808		136.17	129.36	148.76								
1 #		90809		148.59	141.16	162.33								
2		90809		164.55	156.32	179.77								
3		90810		76.90	73.06	84.02								
4 #		90810		64.13	60.92	70.06								
5		90811		97.07	92.22	106.05								
6 #		90811		75.19	71.43	82.14								
7		90812		109.04	103.59	119.13								
8 #		90812		94.91	90.16	103.68								
9		90813		128.28	121.87	140.15								
0 #		90813		106.40	101.08	116.24								
1		90814		156.72	148.88	171.21								
2 #		90814		142.14	135.03	155.28								

Medicare Part B Premiums and Deductibles 2010 / 2011

2010

- **Monthly Part B Premium for Beneficiary \$110.50**
 - Higher Part B Premium– \$85,000/\$170,000
- **Part A IH Deductible \$1100.**
- **Part B Deductible \$155**
- **Part B Coinsurance 20%**

2011

- **Monthly Part B Premium for Beneficiary \$115.40**
 - Higher Part B Premium– \$85,000/\$170,000
- **Part A IH Deductible \$1132.**
- **Part B Deductible \$162**
- **Part B Coinsurance 20%**

New Claim Filing Time Limits

Effective 01/01/2010

- **Regulations changed by Patient Protection and Affordable Care Act (PPACA)**
 - New one-year timely filing rule, based on date of service
 - Medicare Part A & Part B Fee-For-Service claims
 - Permission in law to allow exceptions to one-year filing deadline
 - Limited exceptions established at this time
- **Claims not submitted by time limit are provider-liable.**
- **Beneficiary cannot be charged for provider-liable charges.**

New Claim Filing Time Limits

Services Rendered:	Claim Filing Date
10/01/08 – 09/30/09	12/31/10
10/01/09 – 12/31/09	12/31/10
01/01/10 and after	1 calendar year from date of service

Annual Update of the International Classification of Diseases, Ninth Revision, Clinical Modification ICD-9-CM

- **The 2011 Update Applies for Claims with Service Dates On or After October 1, 2010.**
- **ICD-9-CM Codes Must be Date of Service Compliant.**
- **CPT changes are effective January 1, 2011.**
- **New, Revised and Discontinued Codes are available at:**

http://www.cms.gov/ICD9ProviderDiagnosticCodes/07_summarytable.asp#TopOfPage

<http://www.cdc.gov/nchs/icd9.htm>

Mental Health parity is now law!

Calendar Year	Percentage Paid by Medicare
2009	50%
2010	55%
2011	55%
2012	60%
2013	65%
2014	80%

Mandatory Participation

- **It is Mandatory that Licensed Clinical Social Workers Participate in the Medicare Program.**
- **Claims Must be Submitted on an Assigned Basis.**

Provider Enrollment

- **Many new CMS requirements in place
Published in the Federal Register.**
- **They are key to protecting the Medicare trust funds and assuring payment accuracy!**
- **Providers have an obligation to keep their contractor up-to-date on changes!**

Enrollment Revalidation for Providers not in PECOS System

- Providers who have not made changes to enrollment record since 2003 will not be in PECOS
 - May need to revalidate enrollment
- NGS is currently sending out revalidation letters starting in Aug.
- Providers who receive a letter must respond or billing privileges will be revoked
- List of Providers in PECOS

<http://www.cms.hhs.gov/MedicareProviderSupEnroll/Downloads/OrderingReferringReport.pdf>

Medicare Provider-Supplier Enrollment

- » [Overview](#)
- » [Enrollment Applications](#)
- » [Advanced Diagnostic Imaging Accreditation](#)
- » [Internet-based PECOS](#)
- » [DMEPOS Surety Bond](#)
- ▶ **[OrderingReferringReport](#)**
- » [DMEPOS Accreditation](#)
- » [Taxonomy](#)
- » [Provider Enrollment Regulation](#)

OrderingReferringReport

CMS continues to urge physicians and non-physician practitioners who are enrolled in Medicare but who have not updated their Medicare enrollment record since November 2003 to update their enrollment record now. If these physicians and non-physician practitioners have no changes to their enrollment data, they need to submit an initial enrollment application which will establish a current enrollment record in PECOS.

The download below contains the National Provider Identifier (NPI) and the legal name (last name, first name) of all physicians and non-physician practitioners who are of a type/specialty that is legally eligible to order and refer in the Medicare program and who have current enrollment records in Medicare (i.e., they have enrollment records in PECOS).

A new file will be made available periodically that will replace the posted file; at any given time, only one file (the most recent) will be available. The file can be downloaded by users with technical expertise and further sorted or manipulated. It can also be used to search for a particular physician or non-physician practitioner by NPI or by name. Please note the following: (1) Records are in alphabetical order based on the surname of the physician or non-physician practitioner. (2) Name suffixes (e.g., Jr.), if they exist, are not displayed. (3) There are no "duplicates" in the file. Many physicians or non-physician practitioners share the same first and last name; their corresponding NPIs are the assurance of uniqueness. (4) Deceased physicians and non-physician practitioners are not included in the file.

There are two file formats for the Medicare Ordering and Referring File below. The first is a PDF format. This file will allow a user to verify that an individual physician or eligible professional has an approved enrollment record in PECOS using Adobe Acrobat Reader. The second file is a ZIP file. The ZIP file contains the same information as the PDF, however, the file is a CSV format. The CSV file will allow users to open the Ordering and Referring data in Excel, Notepad and other software formats that could be easier for users to search/sort.

In order to use the CSV file, please left-click on the "Medicare Ordering and Referring File [ZIP, 64400KB]" and save the CSV document contained in the zipped download. Right-click on the saved CSV file, select "Open With" on the task bar and select the program through which you would like open the Medicare Ordering and Referring File.

Deactivation of Medicare Provider Numbers

- Medicare PTAN becomes inactive if no valid Medicare claim submitted in 12-month period
- To reactivate, provider must:
 - Be ready to submit valid claim
 - Submit appropriate CMS-855 form online or on paper
- Upon reactivation, new PTAN is assigned and new effective date applied
- Providers who received paper checks prior to deactivation are required to complete CMS-588 (EFT Authorization Agreement) to reactivate

Medicare Enrollment Timeframes

- **Effective date of enrollment is later of:**
 - Date of filing (receipt date)
 - Date began furnishing services at practice location (if within 30 days)
- **Date of filing for online applications based on contractor receipt of Certification Statement**
- **30-day retrospective** billing guideline as of April 1, 2009
- **No rights of appeal are available only if enrollment is denied or revoked.**
- **Reactivation application treated as initial enrollment application**

What is Internet-Based PECOS?

Easy - Fast - Secure

- **Better way for physicians, non-physician practitioners, and third-party staff who are authorized to:**
 - Submit new initial enrollment record
 - Make changes to existing enrollment record
 - Add or change reassignment of benefits
 - Reactivate enrollment
 - Voluntarily withdraw enrollment
 - Revalidate enrollment

The Top Reasons for the Return of Enrollment/PECOS in Ranking Order

- **855I Not Needed**
- **2008 Version of the Application**
- **No signature & No date**
- **Authorized Official is Not Correct**
- **Tracking I.D. not found in PECOS**
- **Signature with No date**
- **Wrong Contractor**
- **Individual Rendering Provider & Authorized Official Signatures do not Match**
- **Dates are more than 6 Months Apart**

Completing Online Enrollment

Three Basic Steps

1. **Must have active NPPES User ID and Password**
 - **Additional security clearances needed for groups**
 - PECOS Identification and Authentication system (PECOS I&A) clearances for Authorized Official
2. **Complete online enrollment and submit**
3. **Print, sign and date, and mail Certification Statement to National Government Services along with all supporting paper documentation within seven (7) days of electronic submission**
 - **Signed by AO for groups**

Wait at least 15 days before checking status of online application

Electronic Funds Transfer (EFT)

- **Required as part of enrollment process**
 - New providers
 - Providers making any change to enrollment record
- **Any provider can receive Medicare payments via direct deposit**
 - Funds are available immediately
- **New form CMS-588 form available under “Enrollment” tab on www.ngsmedicare.com**

National Provider Identifier (NPI) Reminders

- **Apply for NPI online**
 - <https://nppes.cms.hhs.gov>
- **Contact NPI Enumerator for assistance with applying for NPI or updating data in NPPES records**
 - 1-800-465-3203
 - CustomerService@NPIEnumerator.com
- **FREE NPI Registry**
 - <https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do>
- **CMS' dedicated NPI web page**
 - www.cms.hhs.gov/NationalProvIdentStand

- » Medicare Monthly Review
- » News Articles

[Expand All](#) | [Collapse All](#)

▼ Publications

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Now Available! **New**

- » New Site Crosswalk Tools and Communications **New**
- » Provider Enrollment Clinics Scheduled **New**
- » Welcome New Providers!

Technology for a Clean Environment

Learn more about our available electronic products.

[READ MORE](#)



Latest Production Alerts

[View All Production Alerts](#)

--RESOLVED-- Providers/Suppliers Experiencing Intermittent Issues When Calling the Contact Center | 12/02/2010 12:00 AM

National Government Services is currently experiencing technical issues with Contact Center phone lines.

Reported Missing ERAs for IN/KY Providers Have Been Located and Are Being Sent | 11/19/2010 12:00 AM

Medicare Part B Indiana and Kentucky trading partners are reporting that 835 electronic remittance advices (ERAs) were not received for the dates of 10/22, 10/25, 10/26, and 10/27/2010.

Roster Bill Problem with CPT 90662 (Fluzone) | 11/12/2010 12:00 AM

A problem has been identified with current procedural terminology (CPT) code 90662 when submitting this CPT code on a roster bill. Providers can bill this code on a separate claim but this code cannot be submitted on a roster bill.

Providers/Suppliers Experiencing Intermittent Issues When Calling the Contact Center |

National Government Services is currently experiencing technical issues with Contact Center phone lines.

Latest Part B News Articles

[View All News Articles](#)

- » [Provider Contact Center Extended Hours for Provider Enrollment Will End Friday, December 10, 2010](#)
- » [\(PE201012-08\) Updates from the Medicare Learning Network](#)
- » [\(PE201012-07\) National Provider Call 2010 Physician Quality Reporting System](#)
- » [\(MM7120 Revised\) Influenza Vaccine Payment Allowances - Annual Update for 2010-2011 Season](#)
- » [\(SE1011 Revised\) Edits on the Ordering/Referring Providers in Medicare Part B Claims \(Change Requests 6417, 6421, and 6696\)](#)

Top 5 Pages Requested by Part B Providers

1. Enrollment Tools
2. Electronic Submissions (EDI)
3. Contact Us
4. Manuals
5. Medicare University



[Viewing Application-Based Content](#)

Medical Policy Center

Business type: Part A | **Region:** New York

Step 1: Is your business type and region above correct?

- If yes proceed to step 2
- If no please establish your [business type and region now](#)

Step 2: Begin your search by using one of the features below.

Note: The official Local Coverage Determination (LCD) is the version on the Medicare Coverage Database at www.cms.gov/MCD. [EXT](#)

SEARCH FOR LOCAL MEDICAL POLICY INFORMATION

NEED HELP [?](#)

Search

> Go

Search for local coverage determinations and related articles by CMS Identifier (L number or A number), title, keyword, as well as HCPCS, CPT, or ICD-9 codes.

- [Instructional Guide for Using the Medical Policy Center Search Feature](#) [PDF](#)
- [Search the CMS Medicare Coverage Database for CPT, HCPCS or ICD-9 codes](#) [EXT](#)

VIEW INDEXES OF LOCAL COVERAGE DETERMINATION POLICIES

NEED HELP [?](#)

- [View a list of Active LCDs for your region](#) [EXT](#)
- [View a list of Draft LCDs for your region](#) [EXT](#)
- [View a list of In Notice LCDs for your region](#) [EXT](#)
- [View a list of Retired LCDs for your region](#) [EXT](#)
- [View a list of LCDs retired prior to 01/01/2009 for all regions](#) [XLS](#)
- [View a list of Contractor Numbers for all regions](#) [PDF](#)

VIEW INDEXES OF SIAS, COVERAGE, AND LCD-RELATED ARTICLES

NEED HELP [?](#)

- [View a list of Active SIAs for your region](#) [EXT](#)
- [Search instructions for accessing retired SIAs using the Medicare Coverage Database](#)
- [View a list of Coverage Articles for your region \(not related to a specific LCD\)](#)
- [View a list of Contractor Numbers for all regions](#) [PDF](#)

Medical Policy Center Search Results

Search again:



Need help? [Search Tips](#)

[Return to Medical Policy Center](#)

You searched for: **L26895** in **All LCD and Article** content

Results **1 - 2** of about **2**

Sort by: [Date](#) / [Relevance](#)

Articles [\(View all results for this category\)](#)

[Outpatient Psychiatry and Psychology Services - Supplemental ...](#)
... the Part A/Part B MAC contractor in these states. Related Documents. LCD(s) **L26895**
- [Outpatient Psychiatry and Psychology Services.](#)
> 2010-05-01

Local Coverage Determination [\(View all results for this category\)](#)

[Outpatient Psychiatry and Psychology Services \(**L26895**\)](#)
LCD for Outpatient Psychiatry and Psychology Services (**L26895**). Contractor Information.
Contractor Name. ... LCD Information. LCD ID Number, **L26895**. LCD Title. ...
> 2010-10-01

Powered by Google

[Close](#)

LCD - Coverage Document

SIA - Supplemental Instructions Article

- **LCD - Specific information need to bill**
 - Indications of Treatment
 - Limitations of Treatment
 - Primary/Secondary ICD-9 Codes Supporting MN
 - Documentation Requirements
 - Utilization Guidelines / Frequency

- **SIA - Coding Guidelines**

General Principles of Medical Record Documentation- LCSW

- **Medical records should be complete and legible;**
- **Documentation of each patient encounter should include:**
 - **Reason for encounter and relevant history,**
 - **Physical examination findings and prior diagnostic test results,**
 - **Assessment, clinical impression, and diagnosis,**
 - **Plan for care,**

Medical Record Documentation- LCSW

- **Date and legible identity of observer;**
- **If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred;**
- **Documentation must denote start/stop time or total face-to-face time with the patient, if the code has a time frame indicated;**
- **Past and present diagnoses should be accessible for the treating and/or consulting physician;**
- **Appropriate health risk factors should be identified;**

Medical Record Documentation- CSW

- **The patient's progress, response to changes in treatment, and revision of diagnosis should be documented; and**
- **The CPT and International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes reported on the health insurance should be supported by documentation in the medical record.**
- **Set a format for meeting each of these requirements!**

Mental Health Services Policy

- I. General Clinical Psychiatric Diagnostic or Evaluative Interview Procedure **90801** *Can be Billed by All*
- II. Special Clinical Psychiatric Diagnostic or Evaluative Procedures **90802** *Can be Billed by All*
- III. Psychiatric Therapeutic Services **90804, 06, 08, 10, 12, 14, 16, 18, 21, 23, 26, 28, 90845 - 47, 90853, 90857, 90865** *Can be Billed by All*
90805, 07, 09, 11, 13, 15, 17, 19, 22, 24, 27, 29, 90849 *Limited to Physicians*
- IV. Psychiatric Somatotherapy **90862, 90870, M0064**
Cannot be billed by CP or LCSW
- V. Other Psychiatric Services or Procedures
90880, 90885, 90887 *Can be Billed by All*
90889 *Limited to Physicians* **90875-76, 90882** *Not Covered by Medicare*
- VI. Central Nervous System Assessments/Tests **96101-3, 96105, 96110-11, 96116, 96118-20** *Limited to Physicians and CP's*

Psychiatric Diagnostic Interview Examination

90801

- Includes assessment of the patient's history, mental status, establishment of initial diagnosis, evaluation of patients ability/capacity to respond to treatment and initial plan of treatment
- May include communication with family members or other sources, ordering & medical interpretation of lab tests & other medical diagnostic studies

Documentation

- **The medical record must reflect the elements of 90801 as previously described and must be rendered by a qualified provider.**

Comments

- **May be covered once, at the outset of an illness or suspected illness.**
- **May be utilized again for the same patient if a new episode of illness occurs after a hiatus or on admission or readmission to an inpatient status due to complications of the underlying condition.**
- **Certain patients, especially children, may require more than one visit for the completion of the initial diagnostic evaluation. The medical record must support the reason for more than one diagnostic interview.**

Psychiatric Therapeutic Procedures

- **90804 – 90829** Insight Oriented, Behavior Modifying, Supportive, and/or Interactive Psychotherapy
- **90845-90857** Psychoanalysis, Group Psychotherapy, Family Psychotherapy, Interactive Group Psychotherapy
- **90865** Narcosynthesis for Psychiatric Diagnostic and/or Therapeutic Purposes

Documentation

- **Medical records must indicate the time spent in the psychotherapy encounter and the therapeutic maneuvers.**
- **Behavior modification is not a separate service, but is an adjunctive measure in psychotherapy.**
- **A periodic summary of goals, progress toward goals, and an updated treatment plan must be included in the medical record.**
- **Prolonged periods of psychotherapy must be well-supported in the medical record describing the necessity for ongoing treatment.**

Psychotherapy in a Group Setting

90853, 90857

- **90853** and **90857** represent Psychotherapy administered in a Group Setting, involving no more than 12 participants.
- Facilitated by a trained therapist simultaneously providing therapy to these multiple patients.
- The group session typically lasts 45 to 60 minutes.

Documentation

- The record must indicate that the guidelines under the "Description" and "Comments" sections were followed.

Comments

- Since Group Therapy involves psychotherapy it must be led by a person who is licensed or otherwise authorized by the state in which he or she practices to perform this service.
- This will usually mean a psychiatrist, psychologist, clinical social worker, clinical nurse specialist, or other person authorized by the state to perform this service.
- For Medicare coverage, group therapy does not include: socialization, music therapy, recreational activities, art classes, excursions, sensory stimulation or eating together, cognitive stimulation, or motion therapy.

ACTION CODE "M80" or "B15"

Does not pay for this service because it is part of another service performed at the same time

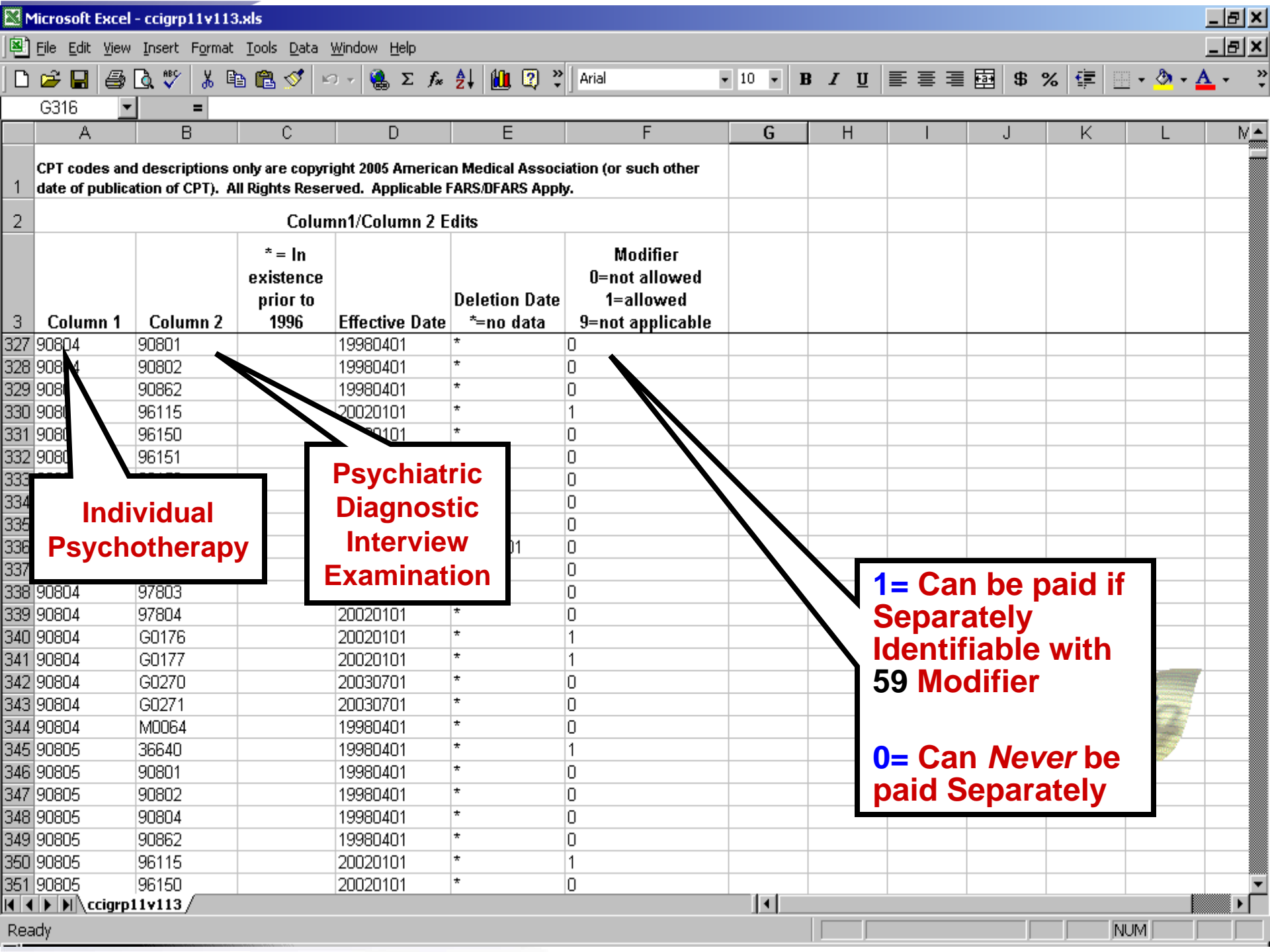
- * *Cannot Bill the Patient*
- * *ABN is Not Valid*

CCI Modifiers

25, 59, 91

Example of Edits

Comprehensive Service	Component Service
90804 Office-Individual Psychotherapy Insight Oriented 45-50 min	90801 Psychiatric Diagnostic Interview Examination



G316 =

CPT codes and descriptions only are copyright 2005 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS Apply.

Column1/Column 2 Edits

	Column 1	Column 2	* = In existence prior to 1996	Effective Date	Deletion Date * = no data	Modifier 0 = not allowed 1 = allowed 9 = not applicable
327	90804	90801		19980401	*	0
328	90804	90802		19980401	*	0
329	90804	90862		19980401	*	0
330	90804	96115		20020101	*	1
331	90804	96150		19980401	*	0
332	90804	96151				0
333						0
334						0
335						0
336						0
337						0
338	90804	97803				0
339	90804	97804		20020101	*	0
340	90804	G0176		20020101	*	1
341	90804	G0177		20020101	*	1
342	90804	G0270		20030701	*	0
343	90804	G0271		20030701	*	0
344	90804	M0064		19980401	*	0
345	90805	36640		19980401	*	1
346	90805	90801		19980401	*	0
347	90805	90802		19980401	*	0
348	90805	90804		19980401	*	0
349	90805	90862		19980401	*	0
350	90805	96115		20020101	*	1
351	90805	96150		20020101	*	0

Individual Psychotherapy

Psychiatric Diagnostic Interview Examination

1 = Can be paid if Separately Identifiable with 59 Modifier
0 = Can Never be paid Separately

Always Code ICD-9 Codes to the Greatest Degree of Specificity

Claims Lacking the Most Specific Diagnosis will be Rejected as a Truncated DX

EXAMPLE :

300.00 Anxiety state, unspecified / 300.02 Generalized anxiety disorder

Invalid Diagnosis Code Editing Second Phase

- Edits have been added to the Medicare Claims Processing System to prevent acceptance of claims with invalid Diagnosis Codes.
- This applies to all Diagnosis Codes Listed in Item 21 - Even Those **NOT** Linked to the Line of Coding.
- Medicare systems will reject claims with diagnosis codes that were not valid on the date of service

e.g. 300.00-.29 Anxiety disorder valid code - 300.0 not valid!

SUPPLEMENTAL INSURANCE

Any Insurance that Comes After Medicare

- Purchased by the Patient
- Given as a Retirement Benefit
- Provided by the Government
- Covered by a Spouse

Medicare Trading Partners

- *Also Known as CROSSOVERS* *Coordination of Benefits*
- Insurance Plans that have Agreed to have an Automatic Crossover from Medicare.

Medigap

- Insurance that is Purchased directly by the Beneficiary from an Insurance company.

Medicare as Secondary Payer *MSP*

Make Insurance First & Medicare Last

- Working Aged
- Disability
- Workers' Compensation
- Auto No-Fault and Liability
- End Stage Renal Disease
- Black Lung

Can be Submitted Electronically !!!

CERT Process

- AdvanceMed will collect a Random Sample of claims from NGS and then request, Medical Records Information Directly from the Providers
- When the information is received it is evaluated by the CERT professional review staff
- Providers should respond promptly to each request
- 2010 rates have increased in NY

CERT Errors

- **Insufficient Documentation: National 1.9%**
Did you order lab/diagnostic services?
- **Medically Unnecessary Services: National-4.0%**
- **Incorrect Coding: National-1.6%**
- **Physician Signature Missing or Illegible (Handwritten or electronic (stamp signatures are not acceptable))**
- **New CMS directives on signature requirements! (posted: 4/29/2010)**

Common Errors

- **No Documentation – No medical record received**
- **Insufficient Documentation –**
 - **Physical Therapy - Documentation received included the initial evaluation signed by the physical therapist. Missing were the order, and/or plan of care signed by the ordering physician and treatment notes.**
 - **Missing or illegible signatures.**
- **Medically Unnecessary –**
 - **Inpatient Hospital Stay - Payment was made for a one day inpatient hospital stay. The patient was admitted with a diagnosis of abdominal pain and stayed less than 12 hours. The patient failed to meet medical necessity criteria for an inpatient admission. Service could have been provided with the patient in an outpatient observation status.**

New Signature requirements

- The use of stamped signatures is not acceptable on any medical record
- Medicare requires a legible identifier for services provided and ordered. Medicare will accept hand-written, electronic signatures or facsimiles of original written or electronic signatures for medical review purposes
- The Medical Review department will deny claims not meeting the signature requirements on records requested on Additional Development Requests (ADRs)
- Medicare Program Integrity Manual (100-08), Chapter 3, §3.4.1.1

What is the future of Medicare

- **Electronic solutions are the key!**
 - **Electronic Medical Records are coming**
 - **Quality Initiatives are available**
 - **Bonuses will exist**
-
- **ICD-10 is a reality in October 1, 2013**
 - **A platform of x12 HIPAA 5010 version will be implemented. - January 1, 2012**

Electronic Health Records

- **American Recovery and Reinvestment Act of 2009 (ARRA)**
- **Beginning in 2011, eligible professionals (EPs) who implement and report “meaningful use” of electronic health records (EHR) will be eligible for incentive payments**

Incentive Payments

- Equal to 75 percent of Medicare allowable charges for covered services furnished by EP in a year, subject to a maximum payments of: **\$44,000**
- **2011= \$18,000**
- **2012 = \$12,000**
- **2013 = \$8,000**
- **2014 = \$4,000**
- **2015 = \$2,000**

Payment Adjustments

- Medicare fee schedule amount for professional services provided by EP not a meaningful EHR user for year reduced by:
 - 1% in 2015
 - 2% in 2016
 - 3% for 2017
 - Between 3 to 5% in subsequent years

ICD-10 Implementation

- ICD-9-CM codes will not be accepted for services provided on or after October 1, 2013
- ICD-10 codes will not be accepted for services prior to October 1, 2013

ICD-10 Differences

- **ICD-10 codes are different from ICD-9-CM codes**
 - They provide greater detail in describing diagnoses and procedures
 - There are more ICD-10 codes than ICD-9-CM codes
- **ICD-10 codes are longer and use more alpha characters**
- **System changes required to accommodate ICD-10 codes**

ICD-10 Implementation

- **October 1, 2013 – Compliance date for implementation of ICD-10-CM (diagnoses) and ICD-10-PCS (procedures)**
 - No delays
 - No grace period
- **ICD-10-CM (diagnoses) will be used in all settings**
- **ICD-10-PCS (procedures) will be used for only inpatient procedures**

Number of Codes – 2010

- **Diagnoses**

– ICD-9-CM	14,315
– ICD-10-CM	69,099

- **Procedures**

– ICD-9-CM	3,838
– ICD-10-PCS	71,957

ICD-10-CM Structure

ICD-9-CM

3 - 5 characters

- First character is numeric or alpha (E or V)
- Characters 2-5 are numeric
- Always at least 3 characters
- Use of decimal after 3 characters

ICD-10-CM

3 - 7 characters

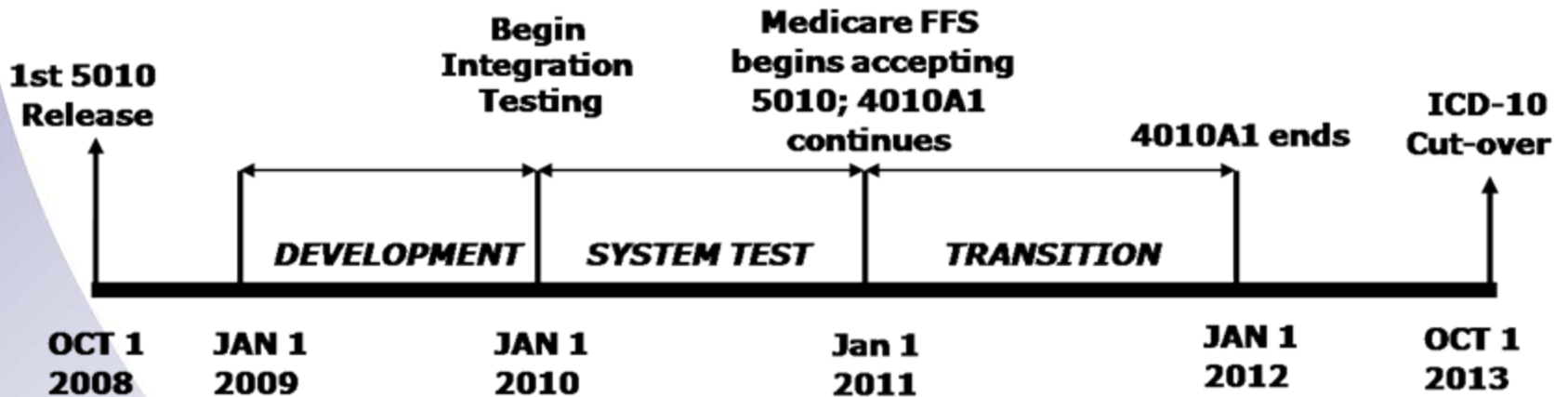
- Character 1 is alpha (all letters except U are used)
- Character 2 is numeric
- Characters 3 - 7 are alpha or numeric
- Use of dummy placeholder "x"
- Alpha characters are not case-sensitive

5010: What You Need to Do to Prepare

Action Steps You Could Take Now for Medicare Changes

- Contact your system vendors:
 - Does your license include regulation updates?
 - Will the upgrade include acknowledgement transactions 277CA & 999?
 - Will the upgrade include a “readable” error report produced from these 277CA and 999 transactions?
- Inquire when your vendor is planning to upgrade your system
- Assess this response to be sure your vendor can assure your transition well before the cutoff, Jan 1 2012
- Evaluate the impact to your routine operations and begin planning for training, transition

Medicare 5010 Implementation Timeline



Electronic Data Interchange (EDI)

Interested in Electronic Billing?

- **Option 1 - Use a software vendor's product**
- **Option 2 - Employ a billing service or clearinghouse**
- **Option 3 - Order National Government Services' free software program, PC-ACE**

Free PC-ACE Pro32 Software

- **Bill Medicare Part A and Part B claims electronically**
- **Easy to use**
- **Ability to bill MSP claims**
- **Must be used with network service**
 - Small charge involved
- **Enrollment form and information on www.ngsmedicare.com under EDI tab**

Administrative Simplification Compliance Act (ASCA)

- **Electronic billing required since October 16, 2003**
- **Paper claims only allowed for providers who meet one of ten ASCA exceptions**
- **Exceptions include:**
 - Medicare tertiary (third) payer claims
 - Providers that submit fewer than 10 claims per month
 - Physician/practitioner/supplier with fewer than 10 full-time equivalent employees (FTEs)

ASCA Enforcement

- **ASCA enforcement began on July 5, 2005**
- **Quarterly analysis conducted - highest volume paper submitters**
 - **Request for Documentation letter mailed**
 - **Must respond within 30 calendar days**
 - **Response will be processed within 30 business days**
 - **Valid response: Approval letter mailed, provider not reviewed again for 2 years**
 - **Invalid or no response: Paper claims denied (91st day)**

ERA and MREP

- **Electronic Remittance Advice (ERA)**
 - “Understanding Remittance Advice Guide” on CMS website
 - To sign up for electronic remittances (835), complete ERA agreement
 - www.ngsmedicare.com under Claims > Electronic Data Interchange > Enrollment
- **Medicare Remittance Easy Print Software (MREP)**
 - Print paper copies of your Medicare Remittances
 - Available as free download
 - www.ngsmedicare.com under Claims > Electronic Data Interchange > Software

EDI Helpdesk

- 877-273-4334
- Monday - Friday
- 8:00 AM - 4:00 PM (Eastern) for all EDI requests
- 4:00 PM - 6:00 PM for password resets only
- [NGS EDI PartB@wellpoint.com](mailto:NGS_EDI_PartB@wellpoint.com)

Dealing with Medicare

- Addresses were changed in 2010
- Sign up for the www.ngsmedicare.com listserv to keep up to date on changes.
- Check our Provider Outreach and Education calendar on www.ngsmedicare.com

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA BLK/LUNG OTHER (Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID) (SSN or ID) (SSN) (ID)		1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE MM DD YY SEX M F	
5. PATIENT'S ADDRESS (No., Street) CITY STATE		6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other	
7. INSURED'S ADDRESS (No., Street) CITY STATE		8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) a. OTHER INSURED'S POLICY OR GROUP NUMBER b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F c. EMPLOYER'S NAME OR SCHOOL NAME d. INSURANCE PLAN NAME OR PROGRAM NAME		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES NO b. AUTO ACCIDENT? PLACE (State) YES NO c. OTHER ACCIDENT? YES NO 10d. RESERVED FOR LOCAL USE	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____		11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY SEX M F b. EMPLOYER'S NAME OR SCHOOL NAME c. INSURANCE PLAN NAME OR PROGRAM NAME d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO # yes, return to and complete item 9 a-d 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____	

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		17a. _____ 17b. NPI _____		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? \$ CHARGES YES NO		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate items 1, 2, 3 or 4 to item 24E by line) 1. _____ 3. _____ 2. _____ 4. _____		23. PRIOR AUTHORIZATION NUMBER			

1	2	3	4	5	6	24. A. DATE(S) OF SERVICE		B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EXPECTED PAYE	I. ID. QUAL.	J. RENDERING PROVIDER ID.#
						From MM DD YY	To MM DD YY									

25. FEDERAL TAX I.D. NUMBER		SSN EIN		26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO		28. TOTAL CHARGE \$		29. AMOUNT PAID \$		30. BALANCE DUE \$	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED _____ DATE _____				32. SERVICE FACILITY LOCATION INFORMATION a. NPI b. _____				33. BILLING PROVIDER INFO & PH # () a. NPI b. _____					

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION



Welcome to National Government Services!

NGSmedicare.com offers valuable Medicare-related content for providers and suppliers of Medicare services and products. To start exploring our Web site, **determine your Medicare contract** – then **select the 'Go to Home Page'** link for your business type and location.

Save selected information on this computer for the next visit

Jurisdiction 13 Providers		Title XVIII Providers			Jurisdiction B Suppliers	
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Connecticut New York	Connecticut New York	Illinois Indiana Kentucky Michigan Ohio Virginia West Virginia Wisconsin	Indiana Kentucky	All Locations	All Locations	All Locations
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		Go to Home Page				

We also provide helpful resources for Medicare beneficiaries and Congressional offices.
[People with Medicare](#) and [Congressional Offices](#)

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- » [New Site Crosswalk Tools and Communications *New*](#)
- » [Provider Enrollment Clinics Scheduled *New*](#)
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We are pleased to introduce Connex.

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--RESOLVED-- Providers/Suppliers Experiencing Intermittent Issues When Calling the Contact Center | 12/02/2010 12:00 AM
National Government Services is currently experiencing technical issues with Contact Center phone lines.

Reported Missing ERAs for IN/KY Providers Have Been Located and Are Being Sent | 11/19/2010 12:00 AM
Medicare Part B Indiana and Kentucky trading partners are reporting that 835 electronic remittance advices (ERAs) were not received for the dates of 10/22, 10/25, 10/26, and 10/27/2010.

Roster Bill Problem with CPT 90662 (Fluzone) | 11/12/2010 12:00 AM
A problem has been identified with current procedural terminology (CPT) code 90662 when submitting this CPT code on a roster bill. Providers can bill this code on a separate claim but this code cannot be submitted on a roster bill.

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- Medical Policy Center (LCDs)

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- POE Advisory Group
- Training Events Calendar
- Training Summaries
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- Comprehensive Error Rate Testing
- Fraud & Abuse

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- » [Provider Contact Center Extended Hours for Provider Enrollment Will End Friday, December 10, 2010](#)
- » [\(PE201011-08\) Updates from the Medicare Learning Network](#)
- » [\(PE201012-07\) National Provider Call 2010 Physician Quality Reporting System](#)
- » [\(MM7120 Revised\) Influenza Vaccine Payment Allowances - Annual Update for 2010-2011 Season](#)
- » [\(SE1011 Revised\) Edits on the Ordering/Referring Providers in Medicare Part B Claims \(Change Requests 6417, 6421, and 6696\)](#)

Top 5 Pages Requested by Part B Providers

1. [Enrollment Tools](#)
2. [Electronic Submissions \(EDI\)](#)
3. [Contact Us](#)
4. [Manuals](#)
5. [Medicare University](#)



Viewing Application-Based Content

J13 Contact Information

Interactive Voice Response (IVR)	877-869-6504
Provider Contact Center	866-837-0241
Fax on Demand	866-709-1905
Electronic Data Interchange (EDI)	877-273-4334
Correspondence	National Government Services Part B Provider General Written Inquiries P.O. Box 7052 Indianapolis, IN 46207-7052
New Direct Telephone line for Provider Enrollment (J13)	888-379-3807

Provider Interactive Voice Recognition *IVR* (877) 869-6504

Easy and Quick Method to Obtain Information

- Monday – Friday *6am - 7pm ET*
- Saturday *7am - 3pm ET*

Information Available:

- Status of Claim
- Eligibility
- Request Duplicate Remittances
- Deductible Information
- Enrollment Application Information
- Pricing
- Seminars
- Appeal Rights

Provider Customer Service Representative *CSR* Toll Free Line (866) 837-0241

- **To be used for Inquiries that Can Not be Handled through the Automated Line.**
- **A CSR will Assist You.**
- **Monday, Tuesday, Wednesday, Friday
8:00 a.m.- 4:00 p.m. ET**
- **Thursday 8:00 a.m. - 2:00 p.m. ET**

Training Hour Closure Time – Thursdays 2:00 - 4:00

Contacting the TRU Line

888-812-8905 for NYS

- **Hours of Availability:**
 - Monday - Friday 8:00 am - 12:00 pm. and 1:00 pm - 4:00 pm ET
- **The Telephone Reopening Representative will assist you with up to Three Claims each time you call.**
- **When requesting a reopening over the phone, you must be prepared to provide the following information:**
 - Beneficiary's Name
 - Medicare Health Insurance Claim Number
 - Your Full Name (first and last name)
 - Your Phone Number
 - Provider's Name
 - Provider's Number
 - Date(s) of Service in Question
 - Reason for Request

Eligibility Status Can Be Obtained Through the IVR Line/Eligibility Option

The Following Information Must Be Given:

This information must match **EXACTLY** or **the information CANNOT be released**

- **Provider's Name and PIN**
- **Beneficiary Last Name and First Initial**
- **Beneficiary Date of Birth**
- **Beneficiary HICN**

Mail Consolidation Effective 4/1/2010

J13 Contact Information

NY

Interactive Voice Response unit (IVR)	1-877-869-6504
Provider Contact Center:	866-837-0241
Fax on Demand:	866-709-1905
EDI:	877-273-4334
Paper Claims:	NGS PO Box 6178 (Downstate) Box 6239 (Queens) Box 6189 (Upstate) Indianapolis, IN 43206-
Provider Enrollment:	NGS NGS P.O Box 6230 Indianapolis, IN 46206-6230