

CLIENT ALERT



MEDICAL MANAGEMENT
STRATEGIES

Medical Management Strategies, 3000 Broad Street, Suite B217, San Luis Obispo, CA 93401

March 17, 2010

MEDICARE DELAYS DEADLINE FOR PECOS ENROLLMENT

The April 5, 2010 deadline to enroll in the new PECOS database has been pushed back to January 3, 2011. This delay will give physicians and non-physician providers who order items or services for Medicare beneficiaries or who refer them to other Medicare providers sufficient time to enroll in or establish a current record in the PECOS system. CMS urges physicians and non-physician practitioners to be sure they have a current enrollment record. A current enrollment record is one that is in the Medicare PECOS system and contains an NPI number.

CenCal announcement about Consult Codes

CenCal follows Medicare B fee schedule for non-Medi-Cal programs (Health Families, Healthy Kids, Prenatal Plus 2 and In-Home Supportive Services). For these plans they will delete consult codes beginning July 1, 2010. CenCal recommends providers begin using the appropriate alternate E/M codes right away to ease the transition. Providers can continue to bill the consultation codes 99241-99245 and 99251-99255 for the Medi-Cal program until further notice.

AETNA – NEW FEE SCHEDULE

Beginning March 1, 2010 Aetna will begin using their new standard commercial fee schedule. If you are interested in how the new rates will affect your reimbursements please contact MMS for assistance. You may also request specific rates directly from Aetna by faxing a request and list of CPT codes to (859) 455-8650.

FRAUD, WASTE & ABUSE TRAINING UPDATE

Aetna, Humana and HealthNet have recently announced encouragement of compliance with the CMS Fraud, Waste & Abuse Training. CMS does not require providers to submit an attestation of training completion, but you should maintain a copy of the course certificate. CMS and the health plans may perform an audit to confirm compliance with the training requirement. Most health plans now have FWT Training available at their websites.

TRICARE Provider Seminars

These seminars provide basic TRICARE information and are a great opportunity to learn about the program. They are also a good refresher for those who have previously attended a seminar. Each attendee will receive the Fall 2009 Provider Handbook and Quick Reference Guides. They will also receive training on the enhanced secure provider portal and tools to streamline the processes in your office for TriCare members. The meeting in this area is at the Radisson Hotel in Santa Maria on May 6, 2010 from 9 am to 11:30 a.m. Only 80 seats are still available for this meeting. Register online at www.triwest.com/provider - you will receive immediate confirmation of your registration.

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Interplan / MultiPlan Wraparound Relationship

Interplan sent participating providers an announcement that effective February 1, 2010 they have entered into an agreement with MultiPlan to allow MultiPlan clients (TPAs) to use providers in the Interplan network for out-of-network claims. This means when a provider is non-participating with MultiPlan and they see a MultiPlan member, they will be reimbursed at Interplan rates as though they are in-network.

The ABC's of the Comprehensive Error Rate Testing Program (CERT)

The **CERT** Program is a federally mandated program designed to monitor & improve accuracy of Medicare payments. Created by CMS to examine the paid claim error rate & provider compliance for all Medicare Administrative Contractors (MAC) – Palmetto GBA for California. **CERT** randomly selects claims, requests copies of medical records and performs review to determine accuracy of payment & reports to CMS.

CERT requests are mailed in a dark tan envelope written with "**Immediate Response Required**" in red; "**Medicare Response Required**" in black. Providers have 75 days to respond with the requested information. Non-compliance will result in a reduction or denial of payment.

CERT notifies the MAC only when there is a change in the original claim decision. The MAC will adjust the claim. An "H" will appear on the RA and represent a CMS denial decision. Appeals/Re-determinations of denials made by CERT may be submitted to the MAC using the normal process. For additional questions, please contact CERT Customer Service Call Center: (301) 957-2380.

EXAMPLE: CERT Part B Evaluation & Management Services Checklist:

This claim was selected for review by the CERT Contractor. You have 75 days to submit the requested information from the date of the request.

Documentation should include:

Beneficiary Name

Date of Service

Test Results (if applicable)

Documentation based upon counseling or coordination of care including total time, % time spent counseling or coordination of care

Description of the discussion

Signed Physician Progress Notes (if applicable) including: History, Physical Exam, and Decision making for the dates of service in question

If Consultation, include copy of request for consult and written report of consultation findings.

If using EMR- signatures include documentation validating the process

CHARGING FOR "AFTER HOURS" SERVICES

Some Health Plans have indicated that new CPT codes 99050 and 99051 may be used for services provided after regular business hours. These codes will be allowed only if billed with place of service (11) office and in conjunction with code(s) for basic services.

99050 – Services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed (e.g., holidays, Saturday or Sunday), in addition to basic service.

99051 – Service(s) provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic services.

Provider would appropriate office visit codes and the Code 99050 or 99051 to indicate "after hours". Referral Authorizations are waived for "after hours" office visits. Reimbursement is based on the health plan's fee schedule.

It is recommended that the doctor check the time when he enters a room with a patient after 5:00 p.m. (even if the pt appt was scheduled at an earlier time, like 4:30 pm). He marks the chart or super bill "**AH**" so his staff knows to add the appropriate code for claims submission.