

February 2012

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CMA resources

When you see this icon, that means there are additional resources available free to California Medical Association (CMA) members at the CMA website. To access any of these resources, visit <http://www.cmanet.org/ces>.



Medical-Legal Library (Formerly CMA On-Call)

In this publication, you will find references to "medical-legal" documents. The California Medical Association's (CMA) online medical-legal library contains over 4,500 pages of medical-legal, regulatory, and reimbursement information.

Medical-legal documents are free to members and can be found in CMA's online resource library, <http://www.cmanet.org/resource-library>. Nonmembers can purchase medical-legal documents for \$2 per page.

CMA Center for Economic Services

1201 J Street, #200, Sacramento, CA 95814
economicsservices@cmanet.org • 916/551-2061

CMA Practice Resources (CPR) is a free monthly bulletin from the California Medical Association's Center for Economic Services. This bulletin is full of tips and tools to help physicians and their office staff improve practice efficiency and viability.

SUBSCRIBE TO CPR OR ANY OTHER CMA NEWSLETTERS: To stay up to date, sign up for free subscriptions at www.cmanet.org/newsletters.

SPREAD THE WORD: Please forward this bulletin to your coworkers and colleagues.

Meet Your CMA Center for Economic Services Advocates

Founded in 1999, the California Medical Association's (CMA) Center for Economic Services (CES) provides one-on-one assistance to physician members and their staff on reimbursement, practice operations and contract related issues.

The center is staffed by practice management experts with a combined experience of over 125 years in medical practice operations. Our goal is to empower practices by providing the educational tools to be an effective advocate. But, when the process fails, CMA will intervene with the payor or regulator on the member's behalf. These services are only available to CMA members and their staff.

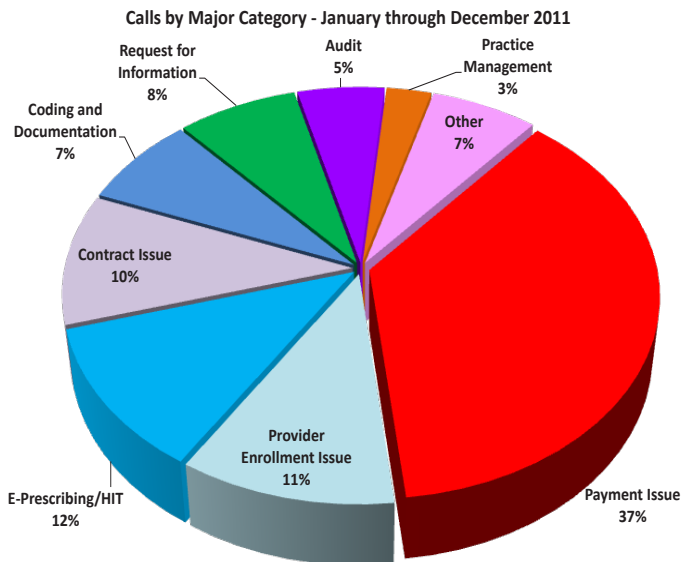
In upcoming issues of CPR, you will get an opportunity to meet the people who are part of the CES team and learn about their backgrounds, health care experiences and unique talents that help make this group of individuals strong physician advocates and educators.



CMA's team of practice management experts stands ready to assist you on a variety of issues. The economic services team includes (left to right) Jodi Black, Mark Lane, Jennifer Williams, Kris Marck, Francisco Silva, Frank Navarro and Michelle Kelly.

2011 CES Advocacy Highlights

For the second year in a row, CES successfully recouped more than \$2.7 million in 2011 from payors on behalf of our physician members. CES staff handled over 2,600 calls from almost 1,300 different physician practices with complaints concerning payment issues remaining the largest percentage of member calls to CES. Of these calls, 30 percent were complaints about denials in payment, 22 percent were about refund request issues and 27 percent were regarding delays and underpayment issues.



Calls related to audit issues increased by over 350 percent in 2011. This significant increase was the result of several Medicare audits as well as audits conducted by the Special Investigations Unit of Anthem Blue Cross.

In addition to payment related issues, CES successfully advocated on behalf of physicians regarding payor policy and contracting issues. Examples include:

- **Upcoming Improvements to Blue Cross's overpayment letters and process**

Complaints about the Blue Cross overpayment process have steadily risen over the past few years. The overpayment letters sent to physicians are confusing, some listing four different addresses in which to direct four different types of correspondence.

Frequently, the reason for the overpayment listed in the letter is either unclear or incorrect; leaving physicians unsure whether the refund is truly due. At other times, physician disputes of the overpayment requests are never received and logged by the correct department at Blue Cross so they are never addressed.

CMA met with Blue Cross in October and outlined the issues, provided feedback for improvement and is working closely with a team at Blue Cross to revamp the overpayment process. Stay tuned for updates.

- **Reversal of inappropriate payment rule on wound closure**

CMA began receiving complaints regarding an Anthem Blue Cross denial of intermediate wound closure procedures when billed in conjunction with surgical lesion removal. In researching the issue, CMA learned that a Blue Cross payment policy implemented in August 2010 denied payment of the closure considering it an integral part of the surgery. However, this

rule was not in alignment with CPT guidelines, which clearly state that intermediate and complex repairs can be billed separately. With CMA's urging, Blue Cross reconsidered their methodology, the guideline was removed and claims previously denied were readjudicated for payment.

- **Participation on UHC Administrative Advisory Committee**

Through a liaison process established with United Healthcare in 2007, CES staff has participated on United Healthcare's California (UHC) Administrative Advisory Committee (AAC), which provides input and feedback on existing and proposed UHC programs, initiatives or proposals. The committee is comprised of United Healthcare "Physician Advocates," network management and contracting personnel, as well as CMA and select CMA-member practice administrators/managers.

Through participation on this committee, CMA has worked to establish a pilot program to educate UHC provider relations staff on various issues impacting physician practices in California with the goal of improving health plan representatives' interactions with physician practices while lessening the administrative burden frequently placed on physician practices.

- **Facilitated fix of Health Net's pricing of radiopharmaceuticals**

In 2011, CES successfully advocated for a change in the way Health Net prices their radiopharmaceuticals. Previously, Health Net priced certain radiopharmaceuticals based on outpatient prospective payment system and drugs were bundled with the radiology study. After significant push back on the various payment methodologies Health Net advised they were utilizing, CMA's persistence paid off and Health Net agreed that they were paying the claims in question (CPT 78452 billed with A9502) incorrectly. Health Net is in the process of updating their system to pay these claims at invoice price if there is no average sales price data. CMA is working with the team at Health Net to ensure prior claims are re-adjudicated.



Are you taking advantage of the tools CES has created for your practice?

In 2011, CES published the following resources to assist physician practices:

1. Medicare Part B 2012 Important Changes: What They Mean to Your Practice
2. 5010 Quick Reference Guide
3. Preparing for the New HIPAA 5010 Standards: A Guide for Physicians
4. Are you ready for the transition to HIPAA Version 5010?
5. Medicare Enrollment Guide for Individual Physicians
6. Special Investigations Unit Audit Guide
7. LaSalle Medical Associates: Important Changes
8. Know Your Rights: Filing a formal complaint with the regulator
9. Medicare Electronic Prescribing Overview: Payment Incentives and Payment Reductions

For a comprehensive list of tools and resources available for physician members and their staff, visit our website at www.cmanet.org/ces.

Blue Shield launches recontracting initiative

The CMA has learned that Blue Shield is in the process of recontracting with physicians across the state. Notices to physicians are scheduled to be mailed on January 27. Blue Shield states the reason for the recontracting initiative is twofold: 1) Blue Shield has not done a large scale recontracting with physicians in over a decade, so the new contracts will allow Blue Shield to ensure consistency and compliance with new laws and regulations; and 2) Blue Shield will be offering various tiered networks based on price point in anticipation of California's health insurance exchange, a key feature of the federal health reform law.

Physicians are under no obligation to participate in any of these products. There are no fee schedule changes at this time, other than for Medicare lines of business.

While the new contract will eventually be rolled out statewide, the first phase focuses on the following counties:

Alameda	Alpine	Amador
Calaveras	Colusa	Contra Costa
El Dorado	Lake	Lassen
Marin	Mariposa	Mono
Monterey	Napa	Placer
Plumas	Riverside	San Benito
San Bernardino	San Francisco	San Joaquin
San Mateo	Santa Barbara	Santa Clara
Santa Cruz	Solano	Sutter
Tehama	Tulare	Yuba

Physicians in Fresno County received the new contract in July 2011.

The cover letter that will accompany the new contract asks that physicians review, sign and return the new agreement to Blue Shield by February 17. However, Blue Shield has assured CMA that failure to return the new agreement will not affect a physician's participation status with Blue Shield.

To assist physicians, CMA has completed an analysis of the new Blue Shield contract, which is available to CMA members at www.cmanet.org/ces. Physicians are encouraged to carefully review and understand the vast range of legal and practical implications associated with the execution of any contract for the delivery of medical services or the associated management and administrative services.

Physicians with concerns about the new contract terms are encouraged to contact Blue Shield Provider Services at (800) 258-3091.



For additional information on evaluating and negotiating complex managed care contracts, see CMA's contracting toolkit, *Taking Charge: Steps to Evaluating Relationships and Preparing for Negotiations – A Focus on Payor Contracting*.

Contact: CMA's reimbursement helpline (888) 401-5911 or economicsservices@cmanet.org

Want more CMA news? "Like" us on Facebook at <http://www.facebook.com/cmaphysicians>

Problems getting paid?

The California Medical Association's Center for Economic Services provides direct reimbursement assistance to CMA physician members and their office staff.

• REIMBURSEMENT HELP LINE (888/401-5911)

- One-on-one educational and reimbursement assistance to physician members and their staff

• PRACTICE EMPOWERMENT

- Tools and resources to empower physician practices
- Seminars and toolkits for physicians and their staff

• EXPERIENCED STAFF

- Staffed by practice management experts with a combined experience of over 125 years in medical practice operations

The Coding Corner: When to use, and not use Modifier-59



CPR's "Coding Corner" focuses on coding, compliance and documentation issues relating specifically to physician billing. This month's tip comes from the **Director of Educational Development for AAPC, John Vehovshek, MA, CPC**.

Before appending Modifier-59 to override a Correct Coding Initiative (CCI) edit, you must be certain that unbundling is allowed for the particular code pair you wish to report as separate/distinct procedures.

Each CCI code pair edit includes a correct coding modifier indicator of "0" or "1," as indicated by a superscript placed to the right of the column 2 code. A "0" indicator means you may not unbundle the edit combination under any circumstances. An indicator of "1" means you may use a modifier to override the edit if the procedures are distinct from one another.

For example, "CPT 11400 Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 0.5 cm or less" is mutually exclusive of "CPT 10060 Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle or paronychia); simple or single)," according to the CCI edit.

Code 11400 is the "column 1" (more extensive) procedure. For incision and drainage and lesion excision at the same location, report only 11400 because 10060 is bundled to the excision. This code pair contains a "1" modifier indicator, however, and you may dismiss the edit if the procedures are distinct from one another. For instance, for incision and drainage and lesion excision at different locations, you would report 11400 and 10060-59. Note the placement of Modifier-59 on the "lesser" procedure.



For additional information on the usage of Modifier-59, please see further articles from AAPC available free to members in CMA's online resource library at <http://www.cmanet.org/resource-library>.

Blue Cross announces changes to Prudent Buyer contract

In December, Anthem Blue Cross notified its contracting physicians of impending changes to its Prudent Buyer Participating Physician Agreement, which will become effective April 1. The amendment includes an expanded confidentiality provision and several modifications to Exhibit F, which pertains to the Blue Cross Medicare Advantage PPO product.

The amendment also modifies the reimbursement rates at which physicians will be paid for providing workers' compensation services. Effective April 1, 2012, physicians will be paid the lesser of the Official Medical Fee Schedule or the Blue Cross fee schedule in Exhibit B.

CMA has several concerns with the changes to Exhibit F. The new language in Exhibit F holding physicians accountable for audits of "first tier, downstream and related entities," is extremely broad and could make physicians responsible for audits of entities over which physicians may have no control.

Another change to Exhibit F would require PCPs and OB-GYNs to provide or make arrangements for services to Blue Cross Medicare Advantage enrollees on a 24-hour, seven-day-a-week basis. Previously, physicians were exempt from this requirement if similar providers didn't typically provide services 24/7.

Additionally, the language in Exhibit F subjects physicians to hefty financial penalties for failure to comply with requests to inspect records in a timely fashion. Blue Cross has also added a 14-day requirement in which to comply with Medicare Advantage Risk Adjustment Audit requests.

CMA has expressed our concerns to Blue Cross and will share updates as they are received.

Physicians are urged to carefully review and assess the impact the contract changes will have on their practices. Questions and concerns about the Prudent Buyer contract amendments should be directed to the Blue Cross provider care department at (800) 677-6669.

Physicians should also be aware that they have the right to opt out of the Blue Cross Medicare Advantage PPO product. If you do not wish to participate in this product, you can opt out by providing 180 days written notice, which should be sent via certified mail with return receipt to Anthem Blue Cross Prudent Buyer Plan Contract Processing, Mail Station 8A, P.O. Box 4330, Woodland Hills, CA 91365-4330.

Additionally, physicians have the ability to opt out of the Workers' Compensation product. Physicians who no longer wish to participate in the workers' compensation product should email their request to opt out to Jacqueline Pederson, Provider Network Manager at Jacqueline.Pedersen@AnthemWC.com.



To help physicians understand their rights when it comes to health plan contract amendments, CMA has published "Payor Contract Amendments: An Action Guide for Physicians." Additional guidance on negotiating and managing complex third-party payor agreements is also available in CMA's contracting toolkit, "Taking Charge: Steps to Evaluating Relationships and Preparing for Negotiations--a Focus on Payor Contracting." Both resources are available free to members in the CMA Resource Library. Non-members can purchase the contracting toolkit for \$100 in the CMA Resource Library.

Contact: *reimbursement helpline* (888) 401-5911 or *economicsservices@cmanet.org*

Save the Date:

The California Medical Association offers our members free programs to educate physicians and staff on a range of practice management issues. Space is limited, so register soon. Most events are PMI CEU Credit Approved.

Upcoming CMA webinars

Webinars are held over the lunch hour, from 12:15 - 1:15 p.m. and are free for CMA members and their staff. See the event calendar at <http://www.cmanet.org/events> for additional details.

February 1: Key Financial Ratios to Increase Profitability

This workshop will teach critical skills in analyzing the practice profit/loss statement for overhead expense, accounts receivable and staffing ratios, and how to access specialty comparison norms for benchmarking.

February 15: Risk Analysis for Meaningful Use

This webinar will provide detailed instruction on the steps needed to complete a HIPAA risk analysis which is vital to qualifying for electronic health record (EHR) incentive funding.

March 7: Managing Difficult Employees and Reducing Conflict in the Practice

This information-packed workshop will teach you the secrets of how to lead, coach and manage difficult employees; set practice values; and reduce conflict in the practice.

March 21: HIPAA Update 2012

This webinar will provide instruction on how to achieve compliance with new 2012 HIPAA rules as well as compliance with the existing HIPAA Privacy and Security rules and relevant California privacy laws.

For more information or to register for any of these events, view the CMA event calendar.

Contact: CMA's member help center, (800) 786-4262 or memberservice@cmanet.org.

Are your visits being down-coded by Medicare?

Help CMA help YOU by completing our short survey!

Claims for which medical records have been requested are now being completed by Palmetto GBA, and CMA is hearing from physicians that many of the services are being down-coded. CMA is surveying practices on the impact of the Medicare audits and we need your feedback by Thursday, February 2nd.

On December 3, 2011, CMA President James T. Hay, M.D., sent a letter to the Centers for Medicare & Medicaid Services (CMS) regarding the multitude of medical review records requested of physicians by Palmetto, the Medicare administrative contractor for California. In the letter, Dr. Hay expressed members' concerns about the volume of requests and the tone of the audit letters. In addition, Palmetto is also delaying payment to physicians for claims associated with the medical records and threatening physicians with further action.

CMA is collecting data to demonstrate the impact the audits have had on physician practices. The results will assist us in our discussion points when we meet with CMS. If your office has received requests for medical records from Palmetto,

please let us know by taking a moment to complete a brief survey at http://www.surveymonkey.com/s/Medicare_Audits. It is critical that we receive your response no later than Thursday, February 2nd.

CMA continues to work with Palmetto and CMS so they understand the burden of locating, copying and mailing off the requested patient records.

Contact: CMA's reimbursement helpline (888) 401-5911 or mkelly@cmanet.org

Changes to United's Medicare Advantage audit program

CMA was alerted to an issue involving misleading and incorrect requests for refund letters for Secure Horizons patients. The overpayment letters were vague and merely stated that a review of medical records indicated the documentation submitted did not support the level billed and paid. The letters requested the practice refund the full amount paid, ignoring the fact that some level of payment was still due for the services provided.

Additionally, the practice who first raised the issue with CMA reported United had never sent them a request for medical records. CMA escalated the issue to the national level at UHC and to the American Medical Association (AMA).

As a result of CMA advocacy and collaboration with the AMA Federation, United has agreed to make significant changes to the way in which it conducts its Medicare Advantage audit programs.

United has updated its audit recovery practices. Instead of requiring a full refund of the amount paid on the original claim, beginning in the first quarter of 2012, physicians will be able to submit a corrected claim to United and refund only the difference between the amount originally paid and the amount that would have been paid under the corrected code. Physicians who believe that they coded correctly on the initial claim will continue to have the option of appealing the decision.

United also ended its relationship with MedAssurant, the company that previously conducted United's payment integrity audits. The termination followed months of complaints from the CMA and the AMA Federation about the often confusing and onerous way MedAssurant operated.

Finally, United confirmed that it is making significant changes to its Risk Adjustment Data Validation audit request letters that include clarifying the reason for the audit; identifying the line of business being audited; and providing consistent information on follow-up medical record reviews, audit requests, and post audit claim payment determinations.

Contact: Reimbursement helpline (888) 401-5911 or mlane@cmanet.org.

Blue Cross required to pay health care providers money owed to them, dating back to 2007

On January 12, the DMHC ordered Anthem Blue Cross to pay health care providers money owed to them, with interest, for services provided dating back to 2007. The action is a result of Anthem's refusal to remediate providers following

Payor Updates

BLUE SHIELD: Blue Shield recently announced new and updated medication coverage policies, effective December 15, 2011. For more information, download the Fourth Quarter 2011 Formulary and Medication Policy Update or visit the Blue Shield of California website at www.blueshieldca.com.

MEDICARE: The Medicare fee schedule for January and February 2012 is posted to the Palmetto GBA website. The revised fee schedule is in effect until February 29, 2012. Action must be taken by Congress before the end of February to establish the fees for the remainder of the year. CMA will continue to monitor the progress of Congressional action and provide reports to members.

UNITED: UnitedHealthcare recently announced changes to the procedure code list for the plan's Radiology Notification and Prior Authorization (Medicare Advantage) programs. Claims with dates of service on or after Jan. 1, are subject to these changes. Overall, United added seven additional CPT codes while removing eleven procedure codes from the notification and prior authorization list. The full list of procedure codes requiring notification or prior authorization for 2011 can be found on the United website, www.unitedhealthcareonline.com, by going to "Clinician Resources," then "Radiology," then "Radiology Notification & Authorization," and selecting the "Resources: Reference Materials" section.

a financial claims audit that identified errors in payment of medical claims.

CMA President James T. Hay, M.D., applauded DMHC for their recent announcement.

"We provide necessary care to our patients based on the assumption that the health plans will promptly and accurately reimburse us for services rendered," Dr. Hay said. "Anthem Blue Cross's refusal to pay for a mistake on their end puts an undue burden on those of us who provide care."

In 2008, DMHC launched provider claims audits of the seven largest health plans in California due to a growing pattern of complaints from providers regarding late and inaccurate payments and inappropriate claim denials. These audits found claims payment violations above the threshold allowed under California law at all seven health plans.

In response to the audits, DMHC required the plans to pay providers the money they were owed and to demonstrate improvements to the plans' claims processes to prevent future errors. In addition, each plan entered into settlement agreements to pay administrative fines. To date, six of the seven plans have undertaken provider remediation efforts.

Anthem has refused to pay providers for the claims violations uncovered in the audit. Anthem Blue Cross now has 30 days to submit to DMHC a corrective action plan to identify the claims that were not correctly paid and pay the providers as prescribed by law.

For a full copy of the DMHC press release, please visit their website, at www.dmhc.ca.gov.

Contact: CMA reimbursement helpline, (888) 401-5911 or economicservices@cmanet.org.

Medi-Cal program successfully closes out transition

In October 2011, the California Department of Health Care Services (DHCS) transitioned to Affiliated Computer Services (ACS) as the new fiscal intermediary for the Medi-Cal program. This transition, which will be completed on January 31, 2012, was the largest and one of the most complex in the nation.

The focus was to move operations from the previous contractor to ACS with minimal impact to physicians and patients. One of the greatest challenges was the amount and volume of inherited suspended claims. Over the last few months, ACS, with DHCS oversight, has continued to make significant progress toward resolving this issue. After starting with a volume of 1.8 million suspense claims in October 2011, ACS has lowered that volume by more than 30 percent with the implementation of an aggressive and effective mitigation strategy.

ACS anticipates the claims suspense volume to be lowered by another nearly 30 percent by mid-February 2012, achieving optimal operating status.

CMA worked closely with DHCS and ACS to reduce negative effects of the transition, and appreciates DHCS's recognition of the impacts to Medi-Cal physicians during this transition period, and for its pursuit of every possible remediation of suspended claims.

CMA looks forward to a continued partnership between DHCS and ACS to ensure the perspective and concerns of physicians are considered as we seek to improve the Medi-Cal program. CMA members are encouraged to call the reimbursement helpline with any issues.

Contact: CMA reimbursement helpline, (888) 401-5911 or economicsservices@cmanet.org.

CMS Requires new ABN Form for 2012

Effective January 1, 2012, the Centers for Medicare and Medicaid Services (CMS) has implemented a revised Advanced Beneficiary Notice of Noncoverage (ABN), Form CMS-R-131. This form is used by physicians when they expect Medicare will deny payment and to notify patients of their financial responsibility for those non-covered services.

All ABNs with the release date of 3/2008 that are issued on or after January 1, 2012 will be considered invalid. The latest version of the ABN (with the release date of 3/2011 printed in the lower left hand corner) and further information on the change is available on the CMS website.

CMA Advocacy at Work

"The CMA has been of great benefit to this office, particularly with respect to our various billing and collections issues. In an age where large insurance companies can (and do) largely ignore the issues of smaller practices such as ours, it is of extreme importance to have access to a service such as this that allows us to effectively stand up for our rights."

*David R. Hantke, M.D.
CMA member since 1987*

Health plan provider newsletters

To make sure that you are aware of important news from your contracting health plans, we encourage you to regularly read plans' provider newsletters and bulletins. Follow the links below to access the current issues.

AETNA: www.aetna.com. Click on "Health Care Professionals" in the main menu, then on "News for Providers" in the left sidebar.

CIGNA: www.cigna.com. Click on "Health Professionals" under "Customer Care" in the main menu. Then, scroll down and click on "Newsletters."

ANTHEM BLUE CROSS: www.anthem.com/ca. Click on "Providers" in the main menu, then on "Professional Network Update" under "Spotlight."

BLUE SHIELD: www.blueshieldca.com. Click on "I'm a Provider," then on "Announcements" under "News and Features."

HEALTH NET: www.healthnet.com. Click on "I'm a Provider" and then "California." Enter username and password, and then click "Online News."

MEDI-CAL: www.medi-cal.ca.gov. Click on "Publications" in the main menu, then on "Provider Bulletins."

MEDICARE/PALMETTO GBA: www.palmettogba.com/jlb. Click on "Publications" in the left sidebar, then on "Medicare Advisory."

UNITED HEALTHCARE: www.unitedhealthcareonline.com. Click on "Tools & Resources" in the main menu, then on "Network Bulletin."

CMA RESOURCE: Find up-to-date profiles on each of the major payors in California at www.cmanet.org/ces.

Ask the Expert: Blue Cross Bilateral Billing

Over the past year, CMA has received several calls from practices who have received refund requests from Blue Cross in regards to bi-lateral surgical procedures that were overpaid. What we've learned is that often times the overpayment stems from the way the bi-lateral procedure was billed.

While there are multiple ways practices bill for bi-lateral surgical services, Blue Cross policy requires practices to bill for bilateral surgical services on one line item using moCross system will automatically adjudicate the bi-lateral surgical services at 150% of the contracted rate (excluding any applicable multiple surgery reductions). Claims submitted for bilateral surgical procedures any other way may lead to initial overpayments and subsequent refund requests.

For more information on the Blue Cross policy visit the Blue Cross website (click "login," enter your User ID and password, then under Policies and Procedures, click "Global Pricing & Claim Edits Policy" then see page 21).

Contact: CMA reimbursement help line, (888) 401-5911 or economicsservices@cmanet.org.