

October/November 2011

In this issue:

Review and appeal claims that have been inappropriately denied, underpaid or partially paid	1
ACS took over as new Medi-Cal contractor on October 3	3
Payor updates	3
Medicare to require revalidation of provider enrollment information	4
Did you know?	4
CMA advocacy at work	4
Problems getting paid?	4
Tips for avoiding 5 common causes of Medicare claim denials	4
Anthem Blue Cross fee schedule changes took effect Sept. 1	5
Save the date: Upcoming CMA webinars	5
Medical board urges State Fund to reconsider restrictions on prescription of opioids	6
Health plan provider newsletters	6
We need your suggestions! Take our reader survey now	6

Medical-legal library

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, www.cmanet.org/resource-library. Non-members can purchase medical-legal documents for \$2 per page.

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 www.cmanet.org/ces.



CMA Center for Economic Services

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

CMA Practice Resources 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.

Review and appeal claims that have been inappropriately denied, underpaid or partially paid

California law requires health plans and insurers to provide physicians with an accurate and clear written explanation of the specific reasons why a claim was denied, adjusted or contested. Physician practices are advised to carefully review all Explanations of Benefits (EOBs) to identify why a claim was not paid as expected and, if necessary, appeal accordingly.

Step 1: Review all EOBs carefully.

Determine the name of the third-party payor making the payment (e.g. health plan, insurer, medical group/IPA, self-insured ERISA plan, workers' compensation carrier). Is your practice contracted with the payor?

- **YES:** Check your contracted fee schedule to ensure that you have been paid correctly. If not, appeal for the correct payment.
- **NO:** As a non-contracting provider you are under no obligation to accept a reduced payment. Appeal for additional payment or collect the amount owed directly from the patient.

Step 2: Determine the reason why the claim was denied, underpaid or partially paid.

Step 3: Appeal as appropriate.

The chart on the following page describes some of the more common types of denials and how to investigate and respond to them.

continued on page 2

Last year, CMA recouped over \$2.7 million from insurance carriers on behalf of physician members. CMA provides one-on-one assistance to identify, prevent and fight unfair payment practices.

Payor problems? CMA can help!

(888) 401-5911 or economicservices@cmanet.org

Denial Reason	Next Step
Incorrect coding or documentation doesn’t support billing	Compare coding with chart notes. Verify appropriate use of modifier. If billing was appropriate, appeal with all necessary supporting documentation.
Not medically necessary/investigational	Verify correct usage of ICD-9 codes. Review the payment rules to ensure payor is following its own guidelines.* If an appeal is warranted, physician should justify medical necessity of procedure performed and provide supporting documentation. If you’ve exhausted the appeals process, get the patient involved by assisting with the Independent Medical Review (IMR) process through the regulator. (See CMA medical-legal documents #1025, “Denials of necessary medical services,” and #1007, “Independent external medical review.”)
Timely filing	Determine whether the claim was filed within the allowed time frame. If claim was filed on time, appeal with all necessary supporting documentation, including proof that claim was submitted in a timely fashion (certified mail receipt, computer records, electronic batch report, clearinghouse report).
No prior authorization	Verify whether service required prior authorization. If authorization was required, attempt to obtain retroactive authorization by demonstrating medical necessity. If you obtained authorization, appeal with a copy of the authorization. (See CMA medical-legal document #0145, “Payment denial after authorization/verification of eligibility.”)
Underpayment Reason	Next Step
Bundled services	Check CPT coding guidelines, modifier usage CCI edits, and review the payor’s payment rules to ensure it is following its own guidelines.* If billing was appropriate, appeal with all necessary supporting documentation.
Down coding	Compare coding with chart notes, check CPT coding guidelines and modifier usage, and review the payor’s payment rules to ensure it is following its own guidelines.* If billing was appropriate, appeal with all necessary supporting documentation.
Incorrect payment amount	Verify contracted rates and appeal if appropriate.
Multiple surgery reduction	Check CPT coding guidelines and modifier usage, and review the payor’s payment rules to ensure it is following its own guidelines* and appeal if appropriate.
Service provided during global period	Verify global days. If service is unrelated and provided during post-op period, append modifier 79 and appeal with a corrected claim.
Application of a PPO discount when you do not have a contract with the payor (e.g., rental network PPO)	Review the EOB for any reference to a “PPO discount,” and refer to the EOB remark section, usually located at the bottom of the EOB. If the payor accessed a PPO discount inappropriately (e.g. you are not contracted with the PPO or the payor does not have authorization to access the PPO discount), file a formal appeal. If you are not contracted with the PPO, you can either appeal to the payor or bill the patient for the amount not paid. (See CMA medical-legal documents #1907, “Silent PPO Action Guide” and #0130, “Non-contracting physicians/implied contract.”)
Non-Payment Reason	Next Step
No claim on file	Provide proof of submission (certified mail receipt, computer records, electronic batch report) and appeal.
Service is non-covered under the patient’s benefit plan	Review the payor’s payment policies, typically found on the plan’s website, to determine if the payor processed the claim according to its own policies. Verify that the patient’s benefit plan specifies the services are not covered. If the payor did not process the claim correctly, file a formal appeal. If the service is not covered under the patient’s benefit plan, bill the patient.

Claim pending additional information from treating physician	All reasonable requests for documentation should be complied with ASAP. (See CMA medical-legal document #1170, "Health plan access to medical records.")
Claim pending additional information from patient	Get the patient involved. Send a demand letter to payor to pay or deny claim.
Pre-existing condition	If you have an authorization, you are entitled to payment. If not, bill the patient. Either way, get patient involved.

**California law requires health plans and insurers to fully disclose complete fee schedules as well as medical and payment policies. This information can generally be found on the payor's website. For more information see CMA medical-legal document #1020, "Disclosure by Managed Care Plans."*



CMA RESOURCES: Know Your Rights: Quick Guide to Appeals; CMA medical-legal documents #0146, "Payment denials by managed care plans and IPAs," #1025, "Denials of necessary medical services," #1007, "Independent external medical review," #0145, "Payment denial after authorization/verification of eligibility," #1907, "Silent PPO Action Plan," #0130, "Non-contracting physicians/implied contract," #1170, "Health plan access to medical records," and #1020, "Disclosure by Managed Care Plans," Appeal, Appeal, Appeal (June 2010 issue of CPR).



TIP: Practice revenue is lost when claims are underpaid, delayed or inappropriately denied. For a summary of the timeframes to appeal by plan type, see "Know Your Rights: Timeframes to Appeal," available free to members in CMA's online resource library at <http://www.cmanet.org/resource-library>.

ACS took over as new Medi-Cal contractor on October 3

The Department of Health Care Services (DHCS) recently awarded a 10-year contract to Affiliated Computer Services (ACS), which will serve as the new fiscal intermediary for Medi-Cal. ACS will manage claims processing for health care providers in the Medi-Cal fee-for-service program, including physicians, pharmacies, hospitals and others. ACS assumed full responsibility for Medi-Cal claims processing and related services on October 3, 2011. Until then, the current intermediary, Hewlett-Packard Enterprise Services (formerly Electronic Data Systems), will continue to process all claims.

DHCS expects the transition to be seamless and that there will be minimal or no impact on the provider community. Medi-Cal providers will not be required to enter into new agreements with DHCS for submission of claims, electronic funds transfer, or point-of-service/Internet usage. Claims submission, processing, and payment will continue without interruption during this transition. Medi-Cal contact information also remains unchanged, including phone numbers, addresses and websites.

All claim forms and submission processes will remain the same. Physicians should continue to submit claims as usual. Medi-Cal communications to providers will continue to be issued through the existing channels: provider bulletins, website

Payor Updates

BLUE SHIELD: Blue Shield of California recently notified physicians of changes to its claim processing system that will take effect September 1, 2011. In a July 19 letter to physicians, Blue Shield informed physicians that it will transition from the current National Correct Coding Initiative (NCCI) editing methodology to the McKesson based ClaimCheck editing software. With this change, physicians may notice a difference in how certain codes and code pairs are adjudicated. Physicians are encouraged to review the editing rationale via Blue Shield's "Clear Claim Connection" portal to determine if and how the claim auditing rules will impact their claims. For more information, log into the Blue Shield's provider portal (<http://www.blueshieldca.com/provider>).

CIGNA: In March 2011, CIGNA notified physicians via its newsletter that effective September 2, 2011, it will no longer mail paper copies of Direct Deposit Activity Reports (DDARs) or Explanations of Payment (EOP) to physicians who receive payment via Electronic Funds Transfer (EFT). Instead, physicians will be required to access this information on CIGNA's website at <https://cignaforhcp.cigna.com/wps/portal>. Physicians who are not enrolled in EFT will not be affected and will continue to receive paper EOBs and checks by mail. This change does not apply to Great West lines of business. Physicians can continue to receive paper EOPs by submitting an opt-out request every 180 days. For more information or to opt-out, visit CIGNA's secured website at <http://www.cignaforhcp.com>.

MEDICARE: Palmetto GBA will hold its third annual MACToberfest symposium in San Diego October 18-20, 2011, at the San Diego Marriott Marquis and Marina hotel. This year's symposium will focus on quality, partnerships and compliance with program highlights including: OIG-conducted sessions on establishing compliance programs; joint CMS/Palmetto GBA provider enrollment sessions; sessions based on claim payment errors, documentation and more. To register for this year's event, visit <http://www.palmettogba.com/dev/eventweb.nsf/home.xsp>.

UNITED HEALTHCARE: United Healthcare has sent, to randomly sampled practices, the plan's Annual Physician and Practice Manager Satisfaction Survey. The survey provides physicians and practice managers the opportunity to provide feedback on United's services. If you did not receive a survey and would like to provide feedback, you can complete the survey on United's website at <http://www.unitedhealthcareonline.com>.

updates, interactive voice response (IVR) messages, etc. In addition, the telephone service center will be augmented with extra resources to ensure providers have immediate access to assistance should the need arise.

If you have any questions regarding this transition, please contact Medi-Cal at (800) 541-5555.

Medicare to require revalidation of provider enrollment information

Physicians who enrolled in the Medicare program prior to March 25, 2011, will be required to revalidate their enrollment by March 25, 2013, under new risk screening criteria required by the federal health reform legislation.

The revalidation requirement is necessitated by new screening criteria that were implemented this past March. Newly-enrolling and revalidating providers and suppliers will be placed in one of three screening categories representing the level of risk to the Medicare program. The level of risk will determine the degree of screening to be performed when processing the enrollment application.

California's Medicare contractor, Palmetto GBA will begin notifying physicians via mail of this requirement in September. Suppliers and other providers will also be required to revalidate their enrollment. The notices will contain instructions for the revalidation process.

Palmetto's plan is to first notify physicians and other organizations that are enrolled in Medicare, but do not yet have complete profiles in Medicare's online enrollment system, PECOS (Provider Enrollment, Chain and Ownership System). Other physicians and providers will receive notices over the next 19 months, in an order still to be determined. Upon receipt of the revalidation notice, physicians and organizations will have 60 days to respond. Failure to respond may result in deactivation of your Medicare billing number.

Do not do anything until you get a letter instructing you to revalidate. (This is very important in order to ensure an orderly enrollment process.) Physicians who are making changes (moving, closing practice, etc.) should continue to submit their changes as usual.

Institutional providers will be required to pay an application fee of \$505 to enroll or revalidate. This does not apply to physicians or physician groups. Note, however, that physicians or other providers enrolling as suppliers of durable medical equipment, prosthetics, orthotics and supplies must submit the required application fee.

For more information, see <http://cms.hhs.gov/MLN MattersArticles/downloads/SE1126.pdf>.

Tips for avoiding 5 common causes of Medicare claim denials

California's Medicare contractor, Palmetto GBA, recently conducted a review of claims denied by Palmetto and other Medicare contractors. The review found that 54 percent of the denied claims were due to provider documentation related technical errors that can be easily avoided. Below are the top 5 errors and how to avoid them:

Did you know?

Practices can view information on Blue Card (out-of-state Blue Cross Blue Shield) member eligibility, medical policies and pre-certification/prior authorization requirements via the Anthem Blue Cross and Blue Shield of California websites.

To access this information, visit the Anthem Blue Cross website and click on "Medical Policy, Clinical UM Guidelines, and Pre-Cert Requirements." Eligibility information is available through Provider Access. Or, visit the Blue Shield of California website and login.

More information on the BlueCard program can be viewed on the Anthem Blue Cross and Blue Shield of California websites.

CMA advocacy at work

"It has become increasingly clear that large payors have the resources to leverage and exploit solo & small group physician practices. Without question, CMA as our partner has become a welcome equalizer and even force-multiplier in our fight to try and ensure equitable treatment by payors. We hope all physicians, (not just Solo/Small Group) recognize the value of CMA as we have...there is strength in numbers."

—Steve Nottoli/Controller for Roxanne Hon, M.D.
(CMA member since 2010)

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

Denial Reason #1: No medical records received after request for records.

Resolution: When medical records are requested, send the records with a copy of the request within the time frame specified on the request to the right contractor address.

Denial Reason #2: No signature (or illegible signature) on documents and illegible medical records.

Resolution: Progress notes and orders must be legible and signed. If the signature appears illegible, you can create a signature page identifying the usual signature of the physician and attach it to the materials sent. If the signature is missing, the physician can send an attestation stating he or she actually saw the patient on the date of service in question.

Denial Reason #3: No time documented on timed codes.

Resolution: When service time is part of a particular code (e.g., for some therapy, mental health claims, infusions, critical care, etc.), the time must be documented on the chart either in the format of “from X to Y” or total time.

Denial Reason #4: No record of medications given when medication billed on claim.

Resolution: When medications or lab tests are billed, there must be some documentation (or order) to show the medication was administered and the test was wanted or needed.

Denial Reason #5: Incorrect place-of- service on claim and incorrect use of “new patient” versus “established patient.”

Resolution: The distinction between a new and an established patient is whether a patient was seen face to face by the provider within the last three years. Since some E/M codes are the same for “office or other outpatient services,” the correct place of service must be on the claim and match the documentation.

Remember, your documentation serves as the basis for the services you bill to Medicare. If your documentation does not support the services on the claim, then a payment error exists.

Physicians are encouraged to take the proactive steps below to help reduce the payment error rate and avoid future claim denials.

- Establish an office process and designate one individual responsible for all record requests.
- The response to a request for records should always be reviewed by an individual with clinical experience before submitting it to a Medicare contractor.
- Use a checklist to verify if the progress notes were signed, legible, had the correct patient name and date, had the correct return address, etc.
- Always keep a record of the company and the contact asking for the record and when it is due.
- If documentation is missing, it can be added by the physician (or other individuals with clinical background) before mailing or faxing the material.

Anthem Blue Cross fee schedule changes took effect Sept. 1

Anthem Blue Cross recently notified physicians of changes to its Prudent Buyer physician fee schedule that took effect September 1, 2011. The new fee schedule increases payment levels for many evaluation and management (E/M), preventive care, ER, after-hours, and chemotherapy administration services. Additionally, although Blue Cross will continue to recognize consultations codes, it will be decreasing payment levels for those codes.

The notice also advises of changes to the number of Payment Areas statewide, reducing the total from eleven to nine,

Save the date

The California Medical Association (CMA) 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

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

10/12: ICD-10: This webinar will cover what you need to do now to prepare for the ICD-10 transition, which will introduce more than 200,000 new diagnosis codes effective in 2013.

10/18: HIPAA 5010 AND ICD-10; ARE YOU READY? This webinar will cover the key requirements for 5010 and ICD-10 for physician practices. Special focus will be given to ensuring your vendors are ready, what you need to do with your key payors and steps you should take to minimize any cash flow impact in January.

10/19: EOB ANALYSIS: SUCCESSFUL CLAIMS APPEAL:

There's a healthy chance that some of your insurance claims will be denied or underpaid. The reasons vary from a simple coding mistake to more complex issues such as medical necessity. This webinar will cover the who, why, what, and when of claim appeals, including getting the patient involved, when needed.

10/26: KEY FINANCIAL RATIOS TO INCREASE PRACTICE

PROFITABILITY: Today's physicians and office managers need business management skills. This workshop will teach critical skills for analyzing profit/loss statement for overhead expense, accounts receivable, and staffing ratios and how to access specialty comparison norms for benchmarking.

11/1: RISK MANAGEMENT AND LONG TERM CARE:

This webinar will not only teach you how to identify the risk and potential of needing long term care, but also will help you understand the options that are available to you through CMA's long term care insurance program.

11/9: EHR MEANINGFUL USE: This webinar will cover the criteria for achieving meaningful use and what physicians and their office staff need to know to qualify for the incentive payments.

11/16: TOP 10 WAYS TO SAVE YOUR PRACTICE MONEY:

Learn how to curb expenditures and improve revenues so that you can help your physicians make wise choices and save your practice thousands of dollars.

For more information or to register for any of these events, visit www.cmanet.org/events.

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

changes to reimbursement methodology for obstetric anesthesia and therapy services, and changes to the multiple procedure payment reduction for the technical component of diagnostic imaging. Additionally as part of the fee schedule update, workers' compensation claims will be reimbursed at the lesser of the Prudent Buyer fee schedule or the Workers' Compensation Official Medical Fee Schedule.

Physicians can obtain a complete copy of the new fee schedule on the Blue Cross website (log in and select the "Prudent Buyer Fee Schedule Update" link under the "What's New" section).

The California Medical Association (CMA) urges physicians to assess the impact this fee schedule update will have on their practices. CMA has created a financial impact worksheet to help physicians assess the impact the fee schedule changes will have on their practices based on their most commonly billed CPT codes. This worksheet is available to members only in CMA's online resource library at <http://www.cmanet.org/resource-library>.

Physicians should also be aware that they have the right to terminate an agreement if a material change is not beneficial to their practice. For more information about your rights, see "Contract Amendments: an Action Guide for Physicians," also available in CMA's online resource library.

If you have questions about the new contract terms, contact Blue Cross Provider Relations at (855) 238-0095 or networkrelations@wellpoint.com.



CMA RESOURCES: Contract Amendments: An Action Guide for Physicians; CMA's Financial Impact Worksheet.

Medical board urges State Fund to reconsider restrictions on prescription of opioids

The California State Compensation Insurance Fund (SCIF), the state's largest workers' compensation insurer, recently notified the physicians in its medical provider network (MPN) that they must agree to refrain from prescribing opioids for a period longer than two months and not prescribe compounded medications without prior authorization from the insurance adjuster or by order of a workers' comp judge. The new rules, detailed in SCIF's "General Provision and Criteria" document, also stipulate that MPN physicians cannot even prescribe certain medications at all, regardless of medical necessity.

The California Medical Association (CMA) believes that these new provisions are an attempt by SCIF to exert control over physicians' practice of medicine and clinical judgment, require physicians to treat injured workers' differently than other patients and violate state law, which allows for prescribing, dispensing, furnishing or administering controlled substances for the treatment of a condition causing pain, including but not limited to intractable pain. The restrictions also violate the Medical Board of California's Guidelines for Prescribing Controlled Substances for Pain.

In addition to the concerns above, SCIF's notice required physicians to agree to the new preauthorization rules within two weeks or be kicked out of the MPN. State law requires insurers to provide physicians with at least 45 business days' notice of a material change to a contract. The law also gives physicians the right to terminate the contract prior to implementation of the change.

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/j1b. 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.

We need your suggestions! Take our reader survey now.

Thank you for subscribing to CMA Practice Resources (CPR). Please take our brief reader survey at <http://cal.md/cpr-reader-survey> and let us know what you think.

At CMA's request, the California Medical Board reviewed SCIF's preauthorization requirements for opioid prescriptions and has informed CMA that it shares the association's concerns. The board recently sent a letter to SCIF, urging the fund to review the board's guidelines for the treatment of intractable pain and to reconsider whether the preauthorization requirements are "a necessary component of effective treatment provided in the workers' compensation arena."

If SCIF doesn't voluntarily withdraw the provisions, the medical board has told CMA that it will take further action. 🚧