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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 www.cmanet.org/ces.



Medical-Legal Library (Formally CMA On-Call)

In this publication, you will find references to "medical-legal" documents. This is an online library that 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.

Tell us what you think

The California Medical Association (CMA) is interested in your feedback. Let us know which topics you would like to see addressed in future issues. Contact CMA's Center for Economic Services at 916/551-2061 or economicsservices@cmanet.org.

CMA Center for Economic Services

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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/news-and-events/publications.

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

Know Your Rights: Managed care contractual protections

Legislation sponsored by the California Medical Association (CMA), AB 1455 and SB 324, require that all health plan contracts with physicians be fair, reasonable, and consistent with California law and regulations. Contractual clauses that are specifically prohibited cover the following:

- Claims filing deadlines that are inconsistent with the law (See "Unfair Payment Practice: Timely filing denials" at www.cmanet.org)
- Financial incentives to deny, reduce, limit or delay care;
- Gag clauses;
- Hold harmless/exculpatory clauses;
- Clauses imposing undue financial risk;
- Clauses allowing for unilateral amendments by health plans (See CMA's "Contract Amendments: An Action Guide for Physicians," and medical-legal On-Call document #1070, "Managed Care Contractual Protections.")
- Clauses requiring physicians to comply with undisclosed QI or UM programs; (See medical-legal On-Call document #1020, "Disclosure by Managed Care Plans and their contracting Medical Groups/IPAs")
- Clauses requiring submission of medical records that are not reasonably relevant for the adjudication of the claim. (See September 2010 issue of CPR and medical-legal On-Call document #1170, "Health Plan Access to Medical Records.")

Physicians who believe their contracts violate any of these laws are urged to contact CMA's Center for Economic Services (CES) at (888) 501-4911 or economicsservices@cmanet.org.

Managed Care Contracting Resources

Payor contract negotiations can be difficult. CMA offers a number of free resources and services to help members and their staff to simplify the contract review and negotiation process.

CMA's Center for Economic Services provides one-on-one education and coaching on managed care contracting issues. Contact CMA's reimbursement help line at (888) 401-5911 or economicsservices@cmanet.org.

"Taking Charge: Steps to Evaluating Relationships and Preparing for Negotiations – A Focus on Payor Contracting." This toolkit provides physicians and their office staff with practical tips and tools to assist with the negotiation, implementation and ongoing management of complex managed care contracts. The toolkit includes sample forms and letters that may be customized for each medical practice.

Contract Analyses. CMA provides objective analyses of several health plan participating provider contracts. While these analyses are not intended to be exhaustive, they are designed to draw a physician's attention to issues which may warrant further inquiry or clarification.

“Contract Amendments: An Action Guide for Physicians.”

This guide is designed to help physicians understand their rights and options when a health plan notifies them of a material modification to a contract, manual, policy or procedure.

Financial Impact Calculator. It is important that physicians understand how a fee schedule can affect their practice's bottom line so that they can make informed decisions about participation in a health plan before contracts are signed. CMA has developed a simple worksheet to help physicians analyze proposed fee schedules and assess the impact fee schedule changes may have on physician practices based on commonly billed CPT codes.

Payor Profiles. CMA's payor profiles include information for each of the major payors in California, including important contact numbers, addresses, and links for quick reference for payor interactions.

“Best Practices: A guide for improving the efficiency and quality of your practice.” This toolkit offers a series of proven steps that solo and small group practices can take to improve many facets of their practice. Chapter IX, “Surviving Out of Network: One Physician's Experience,” offers practical advice, including tips on developing an out-of-network strategic plan.

To access these resources mentioned above, visit the CES page at www.cmanet.org/ces.

Medical-Legal Library (formerly CMA On-Call). CMA's Medical-Legal Library includes several documents that address managed care contracting, including but not limited to the following documents:

- #1070, “Managed Care Contractual Protections”
- #1055, “Contract Termination by Physicians and Continuity of Care Provisions”
- #1099, “Contract Termination or Exclusion: Action Plan for Physicians”
- #1040, “Exclusivity Provisions and Membership Requirements in Contracts”
- #1020, “Disclosure by Managed Care Plans (and their Contracting Medical Groups/IPAs)”

CMA Contract Analysis Service. Physicians who are interested in personal legal advice and representation with respect to a specific contract or other physician business matters should contact their personal attorneys, or may contact the law firm that provides CMA's contract analysis service. For more information on CMA's contract analysis service and the discounts available to CMA members, see medical-legal On-Call document #1705, “CMA Contract Analysis Service.”



TIP: Physicians do not have to accept substandard health plan contracts. You can and should negotiate your contracts.

Medi-Cal processing claims using NCCI edits

As required by the Affordable Care Act signed into law in March 2010, all state Medicaid programs, including Medi-Cal, began applying National Correct Coding Initiative (NCCI) edits for claims processed on or after March 28, 2011, with dates of service on or after October 1, 2010.

The Centers for Medicare & Medicaid Services (CMS) developed NCCI edits in 1996 to promote national correct coding methodologies and to control improper coding leading to inappropriate payment in Medicare Part B claims. NCCI code pair edits are developed based on coding guidelines defined in the American Medical Association's CPT book, current standards of medical and surgical coding practice, input from specialty societies, and analysis of current coding practice.

NCCI edits are pairs of CPT codes that are not separately payable except under certain circumstances. The edits apply to services billed by the same physician for the same patient on the same date of service.

While the vast majority of billing and payment policies listed in the Medi-Cal Provider Manual follow AMA CPT coding guidelines and, by default, NCCI code pair logic, it is advisable for physicians to familiarize themselves with these rules to ensure accurate coding and avoid denials, costly rework, and appeals.

NCCI edits consist of two types:

1. Procedure-to-procedure (Column1/Column2) edits that define pairs of HCPCS/ CPT codes that should not be reported together for a variety of reasons; and
2. Mutually Exclusive Edits/Medically Unlikely Edits, which are units of service edits, that define for each HCPCS/CPT code identified, the allowable number of units of service; units of service in excess of this value are not feasible for the procedure under normal conditions (e.g., claims for excision of more than one gall bladder or more than one appendix).

More information about Medi-Cal's policy on NCCI code pair edits can be found at the Medi-Cal website, <http://medi-cal.ca.gov> or on the CMS website, www.cms.gov.

Know Your Rights: Filing a formal complaint with the regulator

Legislation sponsored by the California Medical Association (CMA), AB 1455 and SB 324, prohibit health plans, their contracting medical groups/IPAs, and insurers from engaging in various unfair payment practices. See “Know Your Rights: Identify and Report Unfair Payment Practices” for a summary of unfair payment practices.

The effectiveness of these regulations depends upon physicians and their office staff taking the time to report any unfair payment practices to the appropriate regulator and to CMA. To help physicians and their staff identify the appropriate regulator, CMA has developed a new resource sheet, “Know Your Rights: Filing a Formal Complaint with the Regulator,” which can be downloaded at www.cmanet.org/ces. For step-by-step instructions for filing a formal complaint with the regulator, see the May 2010 issue of CPR.



CMA RESOURCES: “Know Your Rights: Identify and Report Unfair Payment Practices,” medical-legal On-Call documents #1051, “Physician Complaints about Managed Care Plans,” and #1049, “Patient Complaints about Managed Care Plans.”

Resources to help physicians transition to the new HIPAA 5010 transaction standards

A new version of Health Insurance Portability and Accountability Act (HIPAA) transaction and code sets standards become effective on January 2, 2012. On that date, all covered electronic health care transactions will have to comply with the new 5010 standards. It is critical that physicians start preparing for the transition to the new 5010 transaction standards to avoid rejected claims and cash flow interruptions.

The HIPAA standards govern transactions involving claims and encounter information, payment and remittance advice, claims status, eligibility, enrollment and disenrollment, referrals and authorizations, and premium payment. If a covered entity conducts one of these transactions electronically, they are required to use the adopted standard, including standard code sets to identify diagnoses and procedures. Non-compliance with the HIPAA transaction standards may result in fines, exclusion from Medicare, and non-payment of claims.

To assist physicians in this transition, the California Medical Association (CMA) has published resource sheet, "Are you ready for the Transition to HIPAA Version 5010?" The sheet, which includes practice tips for implementation from the American Medical Association and a list of additional resources for physicians, is available free to members in CMA's resource library at www.cmanet.org/resource-library.



CMA RESOURCES: "Are you ready for the Transition to HIPAA Version 5010?" resource sheet; CMA medical-legal On-Call document #1606, "HIPAA Electronic Transaction Rule."

Contact: *Samantha Pellon, (916) 551-2872 or spellon@cmanet.org.*

Medicare reprocessing claims affected by the Affordable Care Act and 2010 Physician Fee Schedule changes

The Centers for Medicare & Medicaid Services (CMS) has instructed contractors to begin to reprocess claims affected by the Affordable Care Act and corrections to the 2010 Medicare Physician Fee Schedule. These changes were implemented April 1, 2010, with an effective date retroactive to Jan. 1, 2010. Palmetto GBA has identified the impacted claims and began reprocessing claims for California in March 2011.

Due to the retroactive effective dates of these provisions and the fee schedule corrections, a large volume of claims will be reprocessed. It is expected that this reprocessing effort will take some time. Reprocessed claims will be slowly worked into the payment process to ensure that new claims coming into the Medicare program during this time are timely and accurately processed.

Most physicians won't need to take action to receive any applicable adjustment. However, any claim submitted with billed charges lower than the revised 2010 fee schedule amount will need to request a reopening from Palmetto using the Redetermination/Reopening Request form. Include copies of the EOBs, and identify the corrected billed charge. CMS is extending the normal one-year time period to request a reopening of these claims, as necessary. Still, physicians are encouraged to submit their requests quickly.

Payor Updates

ANTHEM BLUE CROSS: Anthem Blue Cross has released their seminar schedule for 2011. These seminars focus on how physicians and their office staff can simplify their interactions with the insurer. For a list of seminars and locations, visit the Anthem website at www.anthem.com.

Anthem has also updated the Network Relations contact information. Effective April 4, 2011, physicians should note that the Network Relations phone number changed from (800) 933-6633 to (855) 238-0095. Visit www.anthem.com for a copy of Anthem's contact information.

CIGNA: CIGNA has notified contracting providers of changes to reimbursement policies, effective July 1, 2011. Specifically, the insurer is modifying its reimbursement policies for Multiple Radiology Reduction-Contiguous Body Parts and for Assistant Surgeon – Modifiers 80 and 82.

- **Contiguous Body Parts:** The highest allowable reimbursement amount will be paid at 100 percent of the fee schedule, maximum reimbursable charge (MRC), or usual and customary (U&C) rate, while all subsequent procedures will be subject to the multiple radiology reduction and will be reimbursed at 50% of the technical component of the fee schedule, MRC or U&C rate. Additional procedure codes were also added to the existing family of codes.
- **Assistant Surgeon:** Physicians rendering services as an Assistant Surgeon (modifiers 80 and 82) will be reimbursed at 16 percent of the surgeon's contracted rate, or U&C, or maximum reimbursable charge rather than the current reimbursement rate of 20 percent.

Physicians are reminded that if you do not agree with a proposed material modification to your contract, you have the right to terminate your contract prior to the change becoming effective. For more information visit the CIGNA for Healthcare Professionals secure website, <http://cignaforhpc.cigna.com/wps/portal>.

UNITED: United Healthcare has notified physicians of a legal entity name change from PacifiCare of California to UnitedHealthcare of California. The transition is expected to be complete by the end of July 2011. New patient ID cards are being issued to reflect the name change. Physicians should note that on June 30, 2011, the PacifiCare website is changing from www.pacificare.com to www.uhcwest.com. Usernames and passwords will remain the same. A copy of the notice can be found at www.cmanet.org.

This reprocessing of claims may result in underpayments or some overpayments. Physicians who have claims that result in additional payment will receive a payment and EOB showing the correction. Medicare claim corrections that result in an overpaid amount will appear as a corrected claim showing a negative payment amount. Palmetto will issue overpayment letters and will follow the normal process for handling overpayments that occur.

Physicians may choose to collect the additional co-payment that may be due, or waive it. The Office of Inspector General has developed favorable policy related to waiving beneficiary cost-sharing amounts attributable to retroactive increases in payment rates resulting from the operation of new federal statutes or regulations. View the notice released by CMS at www.palmettogba.com.

Palmetto GBA to conduct E&M audit

The Palmetto GBA Medical Review department will be performing a prepayment review of CPT code 99214 billed by physician specialties in cardiology, family practice, and internal medicine. Palmetto identified that California physicians are two to three standard deviations above the norm as compared to other jurisdictions. This is not an audit of individual physicians, but a random sampling of three to four claims for each provider selected.

If you are selected for sampling, requests for medical records will be sent to your practice. Physicians must respond to the requests for medical records or the claims will be denied. The California Medical Association suggests that physicians personally review the records returned to Palmetto in order to assure that there are no clerical errors. Records should include:

- Legible copy of the patient's medical record for the listed date(s) of service
- Physician signature and credentials, or an attestation statement to authenticate if the signature is not legible.
- Medication list
- Patient name and date of service on each office note
- Consultation report or progress notes
- Any diagnostic test results that help substantiate the level of service

Common problems that have accounted for 50 percent of claim denials are the result of missing signatures and illegible records. Lack of response from physicians is also a leading cause of denial. Physicians in the specialties mentioned above should look for letters from Palmetto in the mail in the coming weeks.

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.

Save the Date:

Upcoming CMA events

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. Events marked with an asterisk (*) are PMI CEU Credit Approved.

Upcoming CMA webinars

*5/25: EHR Overview

12:15 - 1:15 pm and 6:15 - 7:15 pm

This webinar will cover the basics of EHRs, the federal incentive programs, and meaningful use.

*6/1: ICD-10

12:15 - 1:15 pm

This webinar will explain the new characteristics of ICD-10 coding and how they differ from ICD-9.

*6/8: E&M Coding - Don't Leave Money on the Table

6:15 - 7:15 pm

Learn tips using the documentation guidelines to identify ways to achieve higher accuracy with bill claims.

*6/15: Best Practices for Working your Account Receivable Reports

12:15 - 1:15 pm

Learn how to receive maximum reimbursement with quick accounts receivable turnaround.

*6/15: Key Account Receivable Indicators Physicians need to know

6:15 - 7:15 pm

Learn how to receive maximum reimbursement with quick accounts receivable turnaround.

*6/29: EHR: Selecting the Right System for Your Practice

12:15 - 1:15 pm and 6:15 - 7:15 pm

This webinar will guide physician practices through the process of selecting an EHR system.

Upcoming CMA conferences and seminars

*6/3-5: 14th Annual California Health Care Leadership Academy

This year's conference has been designed to provide both information and tools to help successfully negotiate the challenges—and opportunities—of the new era.

What Every Physician Needs to Know About Their Practice

This seminar will teach physicians and their staff how to control costs, maintain quality staff and improve patient experiences to help ensure the success of the practice.

6/22: Santa Clara County Medical Association

Call (408) 998-8850, for information and to register.

6/23: Monterey County Medical Society

Call (831) 445-1008, for information and to register.

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

Education and networking opportunities

There are numerous educational and networking opportunities for office managers and administrators throughout California. Many county medical societies host forums for practice managers and are an excellent resource. The California Chapter of the Medical Group Management Association (CAMGMA) also offers a broad range of practice leadership, professional development, educational opportunities, and networking activities. For more information or to register for upcoming CAMGMA events, visit www.camgma.com/calendar.cfm.