

July 2010

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CMA resources

When you see this icon, that means there are additional resources available free to CMA members at the CMA website. To access any of these resources, visit www.cmanet.org/ces.



CMA On-Call

Throughout this publication, you will find references to "CMA On-Call" documents. On-Call is an online library that contains over 4,500 pages of medical-legal, regulatory, and reimbursement information.

On-Call documents are available free to CMA members at www.cmanet.org/member. Non-members can purchase On-Call documents for \$2 per page in the CMA bookstore, www.cmanet.org/bookstore.

CMA Center for Economic Services

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CMA Practice Resources (CPR) is a free monthly bulletin from CMA'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 NOW: Sign up for a free subscription at www.cmanet.org/news/cpr.

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

BREAKING NEWS: President Obama signs bill halting Medicare physician payment cut. Visit www.cmanet.org for more information. For breaking news, subscribe to CMA Alert at www.cmanet.org/news.

Identify and fight unfair payment practices

In 2000, CMA sponsored legislation in response to thousands of complaints CMA received from physicians regarding unfair health plan payment practices. The law (AB 1455 – the Health Care Providers' Bill of Rights) prohibits health plans and their contracting medical groups/IPAs from engaging in various unfair payment practices. For a list of prohibited unfair payment practices, see "Know Your Rights: Unfair Payment Practices," at www.cmanet.org/ces.

The effectiveness of the unfair payment practices regulations depends upon physicians and their office staff. CMA urges physicians to closely monitor their accounts receivables to ensure that they have been paid properly and to report any violations to the appropriate regulator and to CMA. For more information, see "Report unfair payment practices," in the May 2010 issue of CPR.

Beginning this month, "Unfair payment practice" will become a regular feature in CPR. (See the first installment, below). Our goal is to help physician offices understand which unfair payment practices are prohibited by law and how to determine if violations have occurred, and to provide physicians and their office staff with tips and tools for fighting and reporting unfair payment practices.

Unfair Payment Practice: Failure to disclose complete fee schedule and payment rules

California's unfair payment practices regulations require health plans and their contracting medical groups/IPAs to disclose to contracting physicians the amount of payment for each and every service to be provided under the contract. Plans are required to disclose this information initially upon contracting, annually, and upon the physician's written request.

For any proprietary fee schedule, the physician must be given sufficient detail so that payment amounts can be accurately predicted. Thus, if the plan does not disclose specific fee amounts, it must disclose the methodology used to calculate reimbursement (i.e. RVUs and conversion factors) so that the physician's office can determine the exact amount to be paid under the contract. To the extent that reimbursement is made pursuant to a specified fee schedule (for example, the Medicare fee schedule), the plan must specify the year of the schedule.

In addition to disclosing fee schedules, plans must disclose the detailed payment policies and other rules used to adjudicate claims. Payment rules can have a

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significant impact on physician reimbursement. Thus, physicians are advised to carefully review all payment rules, including but not limited to those related to:

- Bundling edits;
- Reimbursement for multiple procedures;
- Reimbursement for assistant surgeons;
- Recognition of CPT modifiers; and
- Global payment provisions.

Prevent Unfair Payment Practices in 5 easy steps

1. Obtain a copy of all signed and executed payor contracts.
2. Obtain and review complete fee schedules for each contracted plan.
3. Obtain and review complete payment policies and rules for each contracted plan.
4. Review all EOBs to ensure that payment is consistent with your fee schedule and that the plan has followed its own payment policies.
5. Appeal all claims that have not been paid correctly. (For more information, see “Appeal, Appeal, Appeal” in the June 2010 issue of CPR.)



TIP: Fee schedule and payment rule details can generally be found on the plan’s provider website. To request the information in writing, see CMA’s sample letter, “Request complete fee schedule and detailed payment rules,” at www.cmanet.org/ces.

RESOURCES: CMA On-call documents #1020, “Disclosure by Managed Care Plans (and their Contracting Medical Groups/IPAs),” #1070, “Managed Care Contractual Protections,” #1051, “Complaints About Managed Care Plans.”



Also see CMA’s contracting toolkit, “Taking Charge: Steps to Evaluating Relationships and Preparing for Negotiations: A Focus on Payor Contracting.” The toolkit is available as a free download for members-only at www.cmanet.org/ces. Nonmembers can purchase the toolkit for \$100 in the CMA bookstore.

Blue Cross announces changes to Prudent Buyer contract

Anthem Blue Cross recently notified contracting physicians of impending changes to its Prudent Buyer Participating Physician Agreement. According to a notice mailed to physicians in late May, the new contract includes several changes to the insurer’s reimbursement policies, including but not limited to global surgery, anesthesia, modifier -59, sleep studies, multiple surgery reduction, and bundled services and supplies.

The Prudent Buyer contract has also been amended to include automatic participation in the Blue Cross Medicare Advantage PPO. Although not specified in the notice, you can opt out of the Medicare Advantage PPO. If you do not want to participate in this product, you can opt out by notifying the

Ask the Expert: Fee schedule disclosure

QUESTION: I requested a copy of my complete fee schedule from a payor with which I contract. I was given the fees for the plan’s top 25 CPT codes and was told that is all that I am entitled to receive. Can they limit pricing to only a few codes?

ANSWER: No. California law requires that health plans, insurers, and their contracting medical groups/IPAs disclose the **complete** fee schedule for each and every service to be provided under the contract (28 C.C.R. §1300.71(o), Business & Professions Code §511.4, Insurance Code §10133.6.). The plan can meet this requirement by posting the fee schedule on its website. However, the plan cannot arbitrarily limit its disclosure to just a few select codes. Failure to disclose a complete fee schedule upon physician request is a violation of California’s unfair payment practices laws and you should immediately file a formal complaint with the appropriate regulator and notify CMA. For more information, see “Report Unfair Payment Practices,” in the May 2010 issue of CPR.



RESOURCES: CMA On-call documents #1020, “Disclosure by Managed Care Plans (and their Contracting Medical Groups/IPAs,)” #0129, “Fee Schedules,” #1051, “Physician Complaints About Managed Care Plans,” and #1070, “Managed Care Contractual Protections.”

To submit a question to “Ask the Expert” for possible publication in a future issue of this bulletin, e-mail your inquiry to economicservices@cmanet.org.

insurer in writing by July 30.

Additionally, the revised contract clarifies that if you opt out of Blue Cross’s workers’ compensation provider network and later change your mind, you may not be automatically reinstated. Reinstatement is at the discretion of the insurer.

You should also be aware that Blue Cross is changing the way it notifies you of future contract changes. Whereas the insurer previously notified physicians of changes via certified mail, future changes will be noticed via regular mail, fax, or e-mail.

You should also be aware that you have the right to terminate an agreement if a material change is not beneficial to your practice. If you object to the proposed amendments and wish to terminate your contract, you can do so by notifying Blue Cross in writing within 45 business days of receipt of the notice (or no later than July 30). If you have questions about the Prudent Buyer contract amendments, call Blue Cross’ provider care department at 800/677-6669.

As previously discussed in CPR (see “Know your rights: Fee schedule changes,” in the April 2010 issue), physicians are urged to carefully assess the impact contract changes will have on their practices. To help physicians understand their options when a plan has sent notice of a material change to a contract, CMA has developed a toolkit, “Contract Amendments: An Action

Guide for Physicians.” The toolkit is available free to members at www.cmanet.org/ces.

TIP: Use CMA’s “Financial Impact Worksheet” to determine the impact a proposed fee schedule or reimbursement policy will have on your practice.



RESOURCES: CMA On-Call documents #1055, “Contract Termination by Physicians and Continuity of Care Provisions,” and #1070, “Managed Care Contractual Protections.”



Also see CMA’s contracting toolkit, “Taking Charge: Steps to Evaluating Relationships and Preparing for Negotiations: A Focus on Payor Contracting.” The toolkit is available as a free download for members-only at www.cmanet.org/ces. Nonmembers can purchase the toolkit for \$100 in the CMA bookstore.

Deadline to enroll in PECOS is July 6

As previously reported, the Centers for Medicare & Medicaid Services (CMS) recently announced that the PECOS enrollment deadline has been moved up to July 6, 2010. Physicians who have not updated their enrollment information in the past five years may need to fill out another application or risk facing payment problems for ordered or referred services.

CMA has developed a step-by-step guide to walk physicians through the process, from determining if they are already in PECOS to accessing the Internet-based PECOS enrollment system. This guide is available to members only at www.cmanet.org/ces. CMA also hosted a PECOS enrollment webinar with Palmetto, California’s Medicare contractor. The previously recorded webinar is available for on-demand viewing to members only at www.cmanet.org/calendar.

TIP: Need help determining if you’re in PECOS? Call CMA’s member help center at 800/786-4CMA (4262) and we’ll check your status on the spot. This service is for CMA members only.



Federal Medi-Cal audits to begin in August

The Centers for Medicare & Medicaid Services will be conducting audits of Medicaid claims in California. The audit is part of the federal Payment Error Rate Measurement (PERM) Program, mandated by the Improper Payments Information Act of 2002. The purpose of PERM is to estimate the number of payment errors made in the Medicaid programs of all 50 states and report back to Congress with an “improper payment estimate.”

Five hundred California Medi-Cal claims will be selected for audit over the course of one year, approximately 130 claims per quarter. Audited claims will have dates of service of October 1, 2009, to September 30, 2010. Providers whose medical records have been selected for review will begin receiving written requests for medical records beginning this August.

The California Department of Health Care Services (DHCS) is urging all providers to comply with requests for medical records

CMA Advocacy at Work

“Women’s Healthcare Associates of Redding considers CMA our health care partner. Recently our practice contacted CMA to assist us in getting resolution on a claims issue with Anthem Blue Cross. Our practice had spent months trying to work with Anthem Blue Cross to receive timely payment on urodynamic studies performed in our office and to resolve conflicting payment rules, underpayment, and delayed processing by Anthem Blue Cross. CMA stepped in and went directly to work with Anthem Blue Cross, advocating on our behalf, to assist us in developing a system whereby claims would be directly sent for medical review, processed, and paid in a timely manner. They were a vital part of facilitating communication with Anthem Blue Cross (something we tried in vain to achieve) and vital in the development of a system that resolved our claims payment issues. They were available for us from the beginning to the end of this exhaustive process, staying in close communication with us and arranging telephone conferences with Anthem Blue Cross. We are pleased with the outcome and resolution we were able to achieve with the assistance of CMA. We now have a solid process in place and no longer experience non-payment, underpayment, or delayed payment for our urodynamic claims. We routinely contact CMA and continue to work with them on other health care issues that are affecting our practice. Currently we are working with CMA on another project regarding understanding contract language and understanding our practice rights under California law. Thank you CMA for being our health care partner.”

*Brenda Vance, CMM, Practice Administrator
Women’s Healthcare Associates of Redding
CMA member since 1996*

from the federal contractors or DHCS. If you fail to submit the requested records, an error will be counted against California and you will be required to refund the claim payment amount to DHCS. Your cooperation will help ensure that the audit results are accurate and that California retains its much-needed federal matching monies for the Medi-Cal program.

For more details on the federal audits, see DHCS’s March 2010 Medi-Cal Update newsletter at www.medi-cal.ca.gov.

As reported in the June 2010 issue of CPR, the DHCS Audits and Investigations Unit has also been stepping up anti-fraud efforts, including investigations of physicians and other providers. This year’s budget proposal includes a request for 38 additional DHCS positions to implement an anti-fraud initiative, with an estimated net savings of \$26.4 million resulting from the increased audit efforts.

RESOURCES: CMA On-Call document #0626, “Medi-Cal Audits.”



CMA also recently hosted a webinar on Medi-Cal fraud and abuse. The previously recorded webinar is available for on-demand viewing to members only.

Palmetto releases E/M peer code comparison reports

Palmetto GBA has released E/M Peer Code Comparison Reports for July - December 2009 dates of service. If you want to know how your practice compares to your peers in Northern or Southern California, see the report at www.palmettogba.com/j1b. Click on "articles" in the left sidebar, then on "E/M Help."

Palmetto GBA has also introduced a new Online Provider Services (OPS) tool. OPS enables physicians to view Medicare claim status, remits, eligibility, financial data and more. To access OPS, you must have a signed electronic data interchange (EDI) enrollment agreement on file with Palmetto GBA. Physicians who currently submit claims to Palmetto electronically already have an EDI enrollment agreement. If your office does not bill electronically, you must complete the appropriate EDI applications to access this tool. For more information, visit www.palmettogba.com/j1b and click on "EDI" in the left sidebar.

Coding Corner: Use of modifier -25

CPR's "Coding Corner" focuses on coding, compliance, and documentation issues relating specifically to physician billing.

A modifier is used to indicate that a service or procedure that has been performed has been altered by some specific circumstance, but has not changed in its definition or code. Modifier -25, for example, is used to identify a significant, separately identifiable evaluation and management (E/M) service by the same physician on the same day of the procedure or other service.

CPT guidelines for the use of modifier -25 include:

- Modifier used only on E/M codes (for significant, separately identifiable non-E/M services, see modifier -59);
- Office, hospital, nursing home, emergency room, critical care or consultation indicating services beyond the usual pre- or post-operative services included in the global period;
- Not to be used to report E/M service that resulted in the decision to perform surgery (see modifier -57);
- Patient's condition must warrant a "significant, separately identifiable E/M Service;"
- Diagnosis connected to services must indicate medical necessity, but different diagnoses are not required; and
- Can be used to bill a problem focused E/M visit when performed in conjunction with preventive medicine on the same day.



TIP: Check with each of your contracting payors to determine if they have specific payment rules related to the use of modifiers.

Updated La Vida Medical Group information guide now available

As reported in June 2010 issue of CPR, the Department of Managed Health Care (DMHC) has ordered its licensed health plans to terminate or modify contractual arrangements with La Vida Medical Group by June 21. Plans were required to terminate or modify their contracts so that La Vida no longer assumes

Problems getting paid?

CMA's Center for Economic Services (CES) 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

To access our reimbursement advocates, your physician must be a CMA member. For membership information, contact CMA Member Services at 800/786-4CMA (4262) or memberservice@cmanet.org.

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: <https://www.unitedhealthcareonline.com>. Click on "Tools & Resources" in the main menu, then on "Network Bulletin."

risk for payment of claims. Plans may, however, continue to contract with La Vida for administrative claims processing. The order results from the medical group's failure to meet several financial solvency standards for risk bearing organizations.

La Vida (aka La Vida Medical Group & IPA, La Vida Multispecialty Medical Group, Prairie Medical Group) currently serves about 54,000 enrollees in the Los Angeles area through risk-bearing contracts with nine different health plans. La Vida previously served 40,000 patients in the Central Valley through a single risk-bearing contract with Blue Cross. Blue Cross terminated its Central Valley arrangement with La Vida on February 1, shortly after DMHC ordered La Vida's contracted health plans to freeze enrollment due to financial solvency concerns.

CMA is working with the health plans, DMHC and La Vida, to facilitate a smooth transition for the patients and physicians affected by this order. For more details, including updated information on each plan's transition plan, see CMA's La Vida Medical Group information guide at www.cmanet.org/ces.



RESOURCES: CMA On-call documents #0223, "Risk Bearing Medical Groups, Including IPAs – Regulation of Solvency," and #0131, "Insolvency of Health Plan, IPA or Other Entities that Contract with Health Plans."

Also see CMA's "Payor Solvency Check List."

Cal-Net Physicians IPA: Important information for physicians

Cal-Net Physicians IPA serves approximately 5,500 enrollees in San Diego County. Cal-Net contracts with Molina Health Plan, Community Health Group and Care 1st to provide services to Medi-Cal and Healthy Families enrollees. CMA recently learned that these health plans have terminated their contracts with Cal-Net, effective June 1, 2010, due to financial solvency concerns.

For more details, including information on transition plans, continuity of care protocol and claims payment, see CMA's Cal-Net Physicians IPA information guide at www.cmanet.org/ces.

RESOURCES: CMA On-call documents #0223, "Risk Bearing Medical Groups, Including IPAs – Regulation of Solvency," and #0131, "Insolvency of Health Plan, IPA or Other Entities that Contract with Health Plans."



Got questions?

If you have questions related to any of the articles in this issue, please contact CMA's reimbursement help line, 888/401-5911 or economicservices@cmanet.org. Questions about membership, including technical website issues, should be directed to CMA's member help center, 800/786-4CMA or memberservice@cmanet.org.

Tell us what you think

CMA is interested in your feedback on this bulletin. 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 awetzel@cmanet.org.

Save the Date:

Upcoming CMA events

CMA offers our members free webinars 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.

August: Certified medical office manager series (Ventura)

Course Classes: August 5, 12, 19, 26 (9 am – 4 pm)

This program is recommended for experienced medical office managers who want to take their skills to the next level. Learn to initiate policies and protocols that will improve, protect and stabilize the financial security of the practice. More physicians need "Certified Office Managers" who understand the newest business and regulatory issues, and help guard against risks and motivate employees to improve productivity and increase revenue.

9/22: Practical steps to ensure HIPAA compliance

Members-only webinar (12:15 - 1:15 pm)

In this member's only webinar, David Ginsberg of Private Plan presents on the practical steps you can take to ensure HIPAA Compliance.

10/13: Successful preparation for and implementation of an electronic health records system

Members-only webinar (12:15 - 1:15 pm)

In this member's only webinar, David Ginsberg of Private Plan Associates presents explains how you can prepare your practice for the successful implementation of an Electronic Health Records System.

11/17: Document, document, document

Members-only webinar (12:15 - 1:15 pm)

In this member's only webinar, Dr. Arthur Lurvey, Medical Director for PalmettoGBA, will illustrate the most common claim denials. It will also provide you with the appropriate information on how to avoid or resolve these common denials.

12/8: ICD-10 update

Members-only webinar (12:15 - 1:15 pm)

In this member's only webinar, Practice Management Institute, Inc. presents on this important issue.

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

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.