

IMS Advocate

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Medicaid implements CCI edits

Iowa Medicaid will implement Correct Coding Initiative (CCI) edits January 1, 2010. Additionally, Iowa Medicaid will perform a retrospective review of claims from the previous two years, re-process those claims through CCI, and recoup anything paid inappropriately.

IMS has been told Medicaid is looking only for "gross errors" – items that were obviously paid in error and were not caught previously. Medicaid also indicated they are not looking to recoup money for claims that should or should not have had modifiers attached.

MA fraud and abuse training

Federal rules in effect since January 2009 direct Medicare Advantage (MA) plans to provide fraud and abuse training to their employees and "downstream entities" such as their network physicians by December 31, 2009. Some MA plans have asked physicians to certify receipt of such training.

New rules proposed by CMS state that these training requirements do not apply to physicians already enrolled in Medicare. CMS deems all Medicare-enrolled providers as having met these requirements.

The AMA and other organizations, including IMS, joined in support of this clarification and asked CMS to advise MA plans that this exception applies immediately and physicians do not need to meet the December 31 deadline.

Health reform discussions continue

Health system reform continues to dominate Congress, as the Senate debates various proposals before it will offer legislation in coming weeks. Meanwhile, if Congress does not act soon, Medicare physician payments will be cut by 21.2 percent in January. Legislation in previous years has prevented annual cuts but has not solved the larger problem of a fundamentally broken system. This year, the House passed legislation to permanently fix the problem, but similar legislation has failed to pass the Senate. While a fix for the 21.2 percent cut is hopefully imminent, IMS, the AMA, and others want it to be permanent rather than pushing back the problem for another year.

In Iowa, the Legislative Health Care Coverage Commission will hold its final meeting in January. The Commission will recommend health reform changes that may become effective prior to national reforms. The state's budget crisis could hamper immediate implementation of suggested reforms, which will likely include regionalization of the IowaCare program and may include the creation of a state pool for health care coverage.

IMS is participating in the dynamic national and statewide reform discussions in order to ensure improved health care for Iowans. IMS regularly communicates with Iowa's Congressional Delegation, and IMS members are serving on all statewide commissions that are examining reform.

Iowa Medicaid provider cuts began December 1

In October, Governor Culver mandated a ten percent across-the-board cut in state expenditures for the current fiscal year. In response, the Iowa Department of Human Services (DHS) indicated plans to cut Medicaid provider reimbursement by five percent effective December 1, 2009. While IMS had several conversations with DHS regarding the process and timing of the proposed cuts, DHS indicated there was precedent for proceeding with the cut. DHS published Informational Letter No. 863 to this effect.

Medicaid will not be changing the fee schedule; instead, providers will continue to submit current charges and Medicaid will apply a 95 percent calculation on the back end. IMS has received confirmation that remittance advices (RAs) will show **actual** reimbursement (95 percent of current fee schedule) by line and total.

IID examines health plan denials due to "medical necessity"

The Iowa Insurance Division (IID) has begun an examination of Iowa's law and regulations allowing patients and their physicians to file for an external review of a health plan's final decision to deny payment for a medical service deemed to be medically unnecessary. The Iowa external review law was passed in 1999 as part of a patient protection bill. However, the process is seldom used, in part because physicians and their patients are not aware of it. To obtain information from the IID on how to file a request for an external review, go to http://insuranceca.iowa.gov/health/external_review.html or call the Division at (877) 955-1212 and ask for external review.



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Medicare – DME suppliers and PECOS

Phase 2 of Change Requests (CR) 6417 and 6421 require that DMEPOS suppliers bill for items or services only when ordered or referred by eligible practitioners. Practitioners **must be enrolled in the Medicare Provider Enrollment, Chain and Ownership System (PECOS)** and be of the eligible type/specialty to order/refer services for Medicare beneficiaries. The PECOS enrollment deadline was January 1, 2010, but is now delayed until April 5, 2010. **Providers who enrolled in Medicare before PECOS went into effect in 2003 and who have not submitted any enrollment updates or changes since then most likely do not have an enrollment record in PECOS.** To verify current PECOS enrollment, contact WPS enrollment at (866) 503-7664.

To continue ordering or referring items or services for Medicare beneficiaries, providers not enrolled in PECOS will have to submit an initial enrollment application. Providers may do so either by: 1) using Internet-based PECOS, which transmits an enrollment application to the Medicare A/B MAC (WPS for Iowa) – be sure to mail the signed and dated Certification Statement to the A/B MAC immediately after submitting the application; or (2) completing the appropriate paper Medicare provider enrollment application(s) (CMS-855I and CMS-855R, if appropriate) and mailing along with any required supplemental documentation, to WPS, which will enter a provider's information into PECOS and process the enrollment application. Information on how to enroll in Medicare is found on the Medicare provider/supplier enrollment Web site at www.cms.hhs.gov/MedicareProviderSupEnroll.

Note: For providers not in PECOS, re-enrollment will require future payments from Medicare to be received electronically. To report any PECOS enrollment problems, e-mail Jim Bossenmeyer, director of Medicare enrollment, at james.bossenmeyer@cms.hhs.gov.

Wellmark PAC meets

Wellmark's Physician Advisory Committee (PAC) met by teleconference and discussed Wellmark's current policy on nonpayment for Propofol administration for endoscopic procedures except under certain criteria. The PAC voted to recommend that Wellmark examine a coding and payment mechanism that would better recognize Propofol administration for these procedures. The PAC will meet again in February and will discuss Wellmark's cardiology and oncology pre-certification programs. Visit the PAC Web site at www.wellmark.com/Provider/CommunicationAndResources/PACs.aspx for information. Read an IMS summary of the PAC, its purposes, and its processes at www.iowamedical.org.

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