

THE EMPIRE PROMED NEWSLETTER

MAY 2008

Empire Medicare/M2 Migration – Deadline Has Arrived

The 4/30/2008 deadline for the M2 migration for electronic claims submission to Empire Medicare (now National Government Services) has arrived. Previously scheduled for February, the deadline has had to be extended through April to give providers a chance to update to the new system. The first requirement is to obtain new software from IVANS. If you have not downloaded this software, make sure to go to IVANS website, <http://empire.ivans.com>, to download the new Bluezone software. This software must be purchased for a one time fee. Submitters will be charged an annual fee in addition to the monthly IVANS usage fee. All submitters should also have received letters with their new submitter ID numbers. If you have not received this letter, contact National Government Services at 877-273-4334 in order to find out your new submitter ID number.

After the April 30th deadline, E-link can no longer be used to submit Medicare claims, although the software will still be used for Empire BCBS claim submissions. National Government Services has also begun to offer new alternatives to the traditional dialup which IVANS users have been forced to use. One of these options is VisionShare, which is a high-speed web-based application used to submit claims for a slightly higher monthly charge than IVANS dialup service. To contact VisionShare, call 888-895-2649. You can also check out their website at www.visionshareinc.com. IVANS also offers a high speed connection which is good for heavy usage as the fee is significantly higher for this service. For further information, contact IVANS at 800-548-2675 ext. 3750 or email health.services@ivans.com.

NPI Only – No More Legacy Provider Numbers

After 5/23/2008, CMS (Medicare) and most commercial insurances will accept only NPI numbers. Legacy ID numbers will no longer be accepted after this date, even if submitted with the NPI number. Providers /submitters are now being urged to test their systems to ensure claims are accepted with the NPI only. Providers who do not comply after the 5/23/2008 deadline will experience significant cash flow reductions.

Problems will arise if Medicare does not have a provider's correct information according to the NPI crosswalk (tax ID and/or provider ID numbers). Claims will then reject when submitted with the NPI only. In this event, you must contact your Medicare carrier/fiscal intermediary's provider enrollment department and it may be necessary to submit a CMS 855 form to update any incorrect information.

The other major change related to the NPI number requirement is for claims which have a referring provider. Currently, Medicare accepts these claims with a referring provider UPIN number and they do not require the NPI number for that provider. The NPI requirements now pertain only to rendering and billing providers. However, as of the May deadline, Medicare will only accept NPI numbers for referring providers. To comply with this requirement, providers should make sure they have all their referring provider NPI numbers entered into their database. Incorrect/invalid NPI numbers submitted on any claim will result in denials.

Medicare Fee Schedule – 10.6% July 2008 Reduction Looms Large

As of now, it appears that on July 1, 2008 Medicare will implement the 10.6% reduction to the payment update. Will Congress intervene again before this drastic reduction goes into effect? Nothing is guaranteed, so the best advice is to be prepared and plan accordingly for your practice.

The July reduction is just the beginning, as Congress is proposing large cuts in Medicare reimbursement for each of the next 8 years. By 2014, there could be a reduction of more than 41% from today's fee schedule.

Reductions in reimbursement make it extremely important for providers to maximize their collections and reduce their overhead. Obviously this involves examining staffing levels and operating more efficiently in terms of both administrative and clinical costs.

However, providers can fight these proposed cuts by contacting their local Congressional representatives (both the Senate and House). The more complaints from providers (including physicians and hospitals), the more likely that Congress will step in with last minute legislation to reverse the reimbursement cuts. The best method of contacting your representative is via telephone. To contact the Senate, call 800-210-7193 and ask them to co-sponsor S. 2785, the "Save Medicare Act of 2008".

Modifiers for Maximizing Revenue

Are you constantly seeing bundling denials for services which you rendered? Often, you will receive payment from some payers such as Medicare, while other payers deny these same services. When your staff inquires with the insurance company, they may even say they are following CCI (National Correct Coding Initiative) edits, but this is often not the case. The payers interpret these edits using their own computer systems which may have other edits built in. When you ask for documentation, the insurance company can often be vague and you may never get any written documentation regarding their basis for denying the claim.

Here are some tips to follow in order to decide when to use a modifier:

1. Check the CCI edits (both Column1/Column2 and Mutually Exclusive)
2. If there is a CCI edit for a particular CPT code combination, the procedures still may be separately reimbursable if submitted with a modifier. If you have documentation that separate services were rendered and the edit allows a modifier (delineated with the number 1), then you can bill the claim using modifier 59.
3. Use modifiers to denote bilateral procedures or multiple procedures when billing for biopsies or surgical excisions of multiple nodules.
4. E/M services performed with surgical services can be cause for numerous insurance denials. Modifiers are very important for getting these claims paid. If documentation exists that the E/M service resulted in the decision to perform surgery, the E/M service can be paid with a 25 modifier. E/M services rendered during the post-op period should also be payable if the service is unrelated to the actual surgery.
5. The 76 modifier is used to denote a repeat procedure or service by the same physician, while the 77 modifier is for a repeat procedure by another physician.

There are many other cases when modifiers are overlooked resulting in reduced reimbursement, and this is one of the items administrators should examine in determining how to maximize reimbursement for their practice.

New Services Offered by Empire Promed

Empire Promed Billing is planning to offer access to online CPT/ICD-9 coding tools through our website in the near future. Please check back with our website for further updates. Want more information on any of these topics? Email us at info@empirepromed.com or call our office at 866-910-8588. We will be happy to provide any assistance we can to your practice.