MEDICAL BILLING EXPERTS

CLUB NEWS

COMPLIANCE & LEGISLATIVE UPDATES FOR BILLING

ISSUE 7 — OCTOBER 2015

Aetna – Humana Merger

On Monday, October 19th, shareholders for Aetna and Humana unanimously voted to approve the pending merger of the two insurers. Federal regulators are still examining potential anti-trust concerns, and Aetna and Humana must await their approval.

According to a Forbes article, hospitals and doctors are none too pleased over Aetna's acquisition of Humana as it could threaten competition in the health benefits for seniors market. The Forbes article states, "UnitedHealth Group, which is currently the nation's largest health plan, would fall to No. 2 with the larger Aetna becoming the third-largest publicly traded health plan."

Medicare Quarterly Provider Compliance Newsletter Released

The Medicare Learning Network has released it's latest Quarterly Provider Compliance Newsletter (Volume 6, Issue 1). This educational tool can be accessed here (see link address below*):

Topics include:

- **Recovery Audit Finding: Exact Duplicate Professional Claims**
  - RAs identify duplicate professional services billed on separate claims that include the following criteria: same Health Insurance Claim number, same provider number, same date of service, same type of service, same place of service, same billed amount and same procedure code.

cont'd on page 3

* https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MQCN-October-2015.pdf

IN THIS ISSUE

For more information or if you would like to submit possible topics for future newsletters, please contact our coordinator Karen Schepler by email: **kschepler@mbxperts.com**. Thank you for your readership. If you would like more information on how MBX can assist you with your Revenue Cycle Management goals or to schedule a consult, please contact Ian Farmer by visiting **mbxperts.com/contact-us**.

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MEDICAL BILLING EXPERTS

Medicare Part B Premium Increases

House and Senate Democrats are uniting to stop a severe increase in 2016 Medicare Part B premiums, which would affect more than 15 billion beneficiaries. Roughly 30% of Medicare beneficiaries could face a 52% increase in their monthly premiums based on current proposals. Most Medicare beneficiaries are protected from increases by a "hold harmless" provision that guarantees Part B premiums cannot exceed the increase in the beneficiary's monthly Social Security benefit. There will not be a cost-of-living increase for Social Security Recipients in 2016, so those beneficiaries who have their premiums deducted from their Social Security benefits will not see an increase. However, this leaves the remaining beneficiaries to bear the entire cost increase of the 2016 Medicare program. State governments will face a hardship because they pay the Medicare Part B premiums for Medicare/Medicaid dual eligibles with incomes above 120% of the federal poverty level. Companion bills have been introduced in both houses to freeze the Medicare premiums at 2015 levels.

Roughly 30% of Medicare beneficiaries could face a 52% increase in their monthly premiums based on current proposals.

RBMA
Radiology Business Management Association

Revised CMS Instructions Clarify ICD-10 Orders Issue (from the RBMA)

The Centers for Medicare & Medicaid Services has modified its instructions on how to handle imaging orders written before but fulfilled after the October 1, 2015, ICD-10 implementation date. In response to a request from the Radiology Business Management Association (RBMA), the American College of Radiology (ACR), and the Association for Medical Imaging Management (AHRA), CMS now notes in its ICD-10 FAQ section that it is not requiring the ordering provider to rewrite the original order with the appropriate ICD-10 code for lab, radiology services or any other services or device including durable medical equipment, prosthetics, orthotics, and supplies after the October 1st ICD-10 implementation date. Products and services that require a diagnosis code on the order will use ICD-9-CM codes if written prior to October 1st.

Payers and First-Year ICD-10 Coding Mistakes Leniency (from the RBMA)

When the Centers for Medicare and Medicaid Services announced a one-year grace period starting on October 1st for errors in ICD-10 coding on part B Medicare claims, many breathed a sigh of relief. However, not all payers are following the grace period. RBMA researched how major private insuers and state Medicaid offices responded to CMS's July 6th announcement that Medicare review contractors will not deny physician or other practitioner claims billed under the Part B physician fee schedule based solely on the specificity of the ICD-10 diagnosis code, as long as the physician/practitioner used a valid code from the right family. Not all payers addressed this issue, but information from those that did follows:

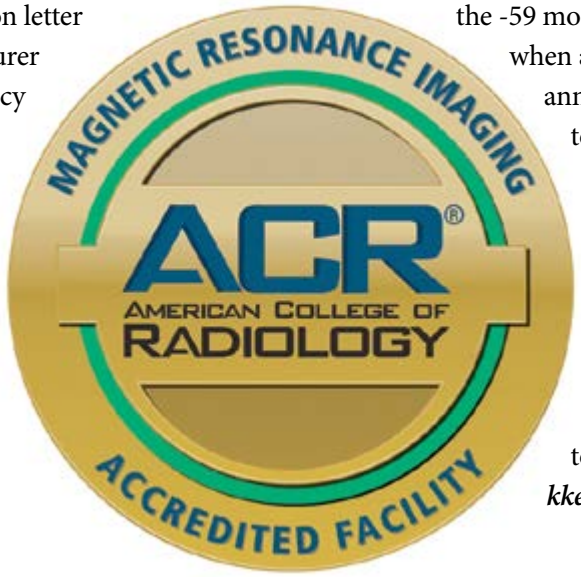
Wellmark, the parent company for Blue Cross and Blue Shield, stated on its website that it "will not deny provider claims based solely on the specificity of the ICD-10 diagnosis code as long as the provider uses a valid code." However, it also warned that a claim could be chosen for review (and possible denial) for other reasons.

UnitedHealthcare stated on its website that it was "in the process of assessing the potential impacts of the remaining guidance as it relates to medical and reimbursement policies."

Aetna did not say that it will not follow CMS guidance but noted in its response to that guidance that "all policies that we apply during the claims payment process won't change, other than a conversion to the ICD-10 code set."

American College of Radiology Seeks Support for Letter Opposing UnitedHealthcare MPPR Expansion (from the RBMA)

The American College of Radiology (ACR) has prepared a sign-on letter urging UnitedHealthcare to abandon plans to expand its multiple procedure payment reduction (MPPR) policy to include the professional component of advanced imaging services. The sign-on letter follows an announcement that the insurer plans to expand its current MPPR policy for imaging services covered by its commercial health insurance plans to the professional component (PC) of imaging services beginning on November 15, 2015. Following implementation, the private insurer's PC reimbursement rates for high-tech imaging services performed by the same physician in the same session will be reimbursed at 100 percent for the first service and 75 percent for the second and subsequent services. They will, however, consider a policy change upon reversal of the Medicare policy by CMS or Congress. They also indicated that practices may use the -59 modifier to indicate separate sessions when appropriate. UnitedHealthcare initially announced expansion of their MPPR policy to the PC of imaging services in Spring 2014, but delayed implementation after being notified about the mandate requiring CMS to produce the data used to justify their PC MPPR policy. The ACR encourages all radiologists, radiology group practices and providers of medical imaging services to sign on by emailing Katie Keysor at *kkeysor@acr.org*.



Medicare Quarterly Provider Compliance Newsletter Released

cont'd from page 1

- **Recovery Audit Finding: Multiple Surgeries**
  - RAs reviewed surgical claims with a multiple procedure indicator value "2" or "3", that were incorrectly reported by the same physician, on the same beneficiary, on the same date of service. When billing for multiple surgeries by the same physician on the same day, the major surgical procedure should be reported without the multiple surgery modifier "-51": Each additional surgical procedure must be reported with modifier "-51".

- **CERT Review: Insufficient Documentation**
  - Providers must provide medical documentation to support claims for Medicare services upon request. The most common cause of improper payments found by the CERT program is failure of the referring providers to provide adequate documentation of their orders/intention to order services, and clinical information to support the medical necessity of the services.

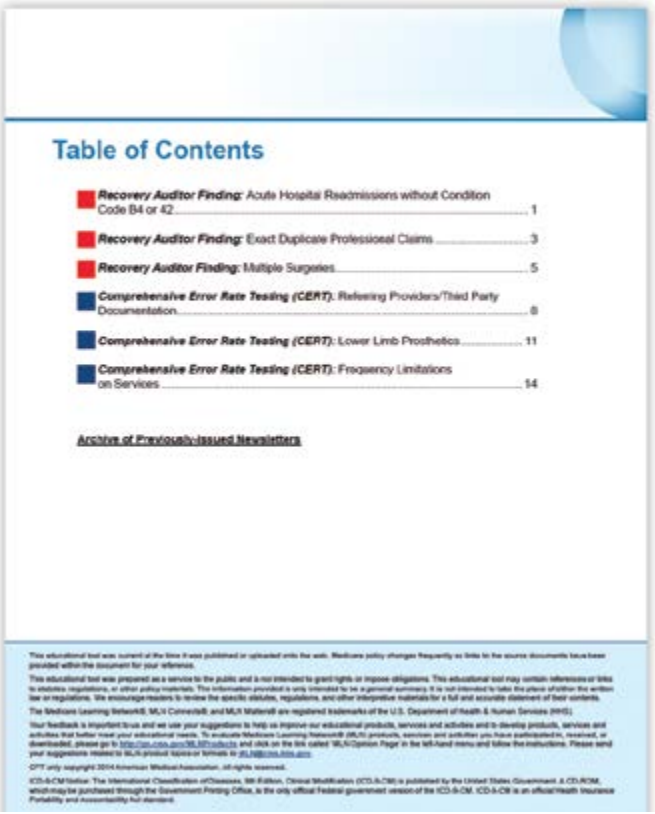


Table of Contents

North Carolina Medicaid Reform Approved
(update from AISHealth)

The North Carolina Medicaid reform plan was approved 33-15 in the state Senate and 65-40 in the House. Governor Pat McCrory (R) is expected to sign the legislation. However, the reforms will not begin for several years. The legislation calls for the State's Department of Health and Human Services to submit its waiver proposal to CMS by June 1, 2016. Once North Carolina receives the go-ahead from CMS, the department then has another 18 months before it opens enrollment in the pre-paid health plans.

According to the reform plan:

- The state's Medicaid agency will contract with three commercial health plans to provide care statewide to Medicaid beneficiaries.
- The Medicaid agency also will contract with up to 10 Provider-Led Entities ("PLEs") to provide care in specific regions. Medicaid beneficiaries can opt into, or will be assigned, to both the commercial insurers and to the regional PLEs.
- Contracts with both commercial insurers and PLEs will be capitated.
- All contracts will include defined measures and goals for risk-adjusted health outcomes, quality of care, patient satisfaction, access and cost.
- In 2016, North Carolina will cut per-member, per-month payments to North Carolina Community Care Networks, Inc., which provides Medicaid primary care case management, by 15%.

Beneficiaries who are dually eligible for Medicare and Medicaid are not included in the reforms. Under the legislation, the state will create a Dual Eligibles Advisory Committee to develop a long-term strategy to cover dual eligibles through the capitated pre-paid health plan contracts. A report is due by Jan. 31, 2017.