

OIG 2010 Work Plan Published

By: Catherine Sicker, Corporate Compliance Officer

On October 1, 2009, the Department of Health and Human Services' (HHS) Office of Inspector General (OIG) issued its annual Work Plan for fiscal year 2010 that addresses the reviews and projects that the agency wants to undertake in the coming year. New this year is a separate section that includes reviews related to the American Recovery and Reinvestment Act of 2009 (ARRA). Here are some excerpts:

CENTERS FOR MEDICARE & MEDICAID SERVICES

Hospitals

Hospital Admissions With Conditions Coded Present-on-Admission (POA)-The OIG will review Medicare claims to determine the number of inpatient hospital admissions for which certain diagnoses were coded as being present when patients were admitted to the hospitals and will determine which of the diagnoses were most frequently coded as POA. They will also determine which types of facilities are

most frequently transferring patients with a POA diagnosis specified by CMS to hospitals and whether specific providers transferred a high number of patients to hospitals with POA diagnoses.

Hospital Readmissions-

They will review Medicare claims to determine trends in the number of hospital

readmission cases. Based on prior OIG work, CMS implemented an edit in 2004 to reject subsequent claims on behalf of beneficiaries who were readmitted to the same hospital on the same day.

Adverse Events: Various Reviews- The term "adverse event" describes harm to a patient as a result of medical care. The terms "never events," or "serious reportable events," refer to a subcategory of

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CMS expands editing for ordering/referring providers

By: Christy Leonard, Technical Communication Specialist

CMS is expanding claim editing to meet the Social Security Act requirements for ordering and referring providers. The new claim edits will verify that the ordering/referring provider on a claim is eligible to order/refer and is enrolled in Medicare. The claim editing expansion will be divided into two phases.

Claims that are the result of an order or a referral must contain the National Provider Identifier (NPI) and the name of the ordering/referring provider. All ordering/referring providers must be enrolled in the Medicare Provider Enrollment, Chain and Ownership System

(PECOS) or in the Medicare carrier's or Part B MAC's claim system, and must be identified as a specialty that can order/refer.

Phase 1 (October 5, 2009-January 3, 2010):

PECOS will send the Multi-Carrier System (MCS) a national file of physicians who are of the specialty eligible to order or refer under the Medicare program. Nightly, MCS will receive a national PECOS file of the newly added or updated physician and non-physician practitioners.



When a claim is received, MCS will determine if the ordering/referring provider is required for the billed service.

- If the billed service requires an ordering/referring provider and the ordering/referring provider **is not on the claim**, the claim will not be paid.

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Quadax Transition to ANSI 5010

By: Tom Klemens, EDI Edits & Documentation Group Manager

For the past few months, the Quadax EDI Service Department has been in dialogue with many of our clients regarding the upcoming transition to the ANSI 5010 format. The common sentiment from clients was that this issue is still too far in the future to worry about, yet there are several “big picture” questions they are looking to us to answer.

In an effort to proactively address these client concerns/questions, Quadax has identified some of the more important frequently asked questions regarding the transition to the ANSI 5010:

1) What basic information should I know about the new ANSI 5010 electronic claims specs?

The government published two final rules to adopt updated HIPAA standards on January 16, 2009. The final rule names nine 5010 counterparts to the 4010A1 Implementation Guides currently mandated under HIPAA. All nine 5010 Technical Reports are available on the Washington Publishing Company’s Web site. *The current official implementation date of the new ANSI 5010 requirements is January 1, 2012.*

2) When does Quadax intend to switch to the ANSI 5010?

In short, as soon as payers are ready. Since the publication of the final two 5010 rules at the beginning of this year, Quadax has been actively preparing for the switchover to the ANSI 5010 format. However, much like the transition to the 4010A1 format, several steps need to be in place before Quadax can “go live” with it.

3) What specifications are needed to make the conversion to ANSI 5010?

The first piece of the 5010 “puzzle” is already available: the ANSI 5010 Implementation Guide, published by the government. Although this Guide should establish a single standard for all payers to follow, our experience dealing with the transition to the current ANSI 4010 format indicates otherwise. The reality is payers often have different interpretations of the Implementation Guide as well as unique claim requirements that may contradict and/or supersede the Implementation Guide, as was the case with the switch to ANSI 4010. These provisions and alterations are contained in individual payer Companion Guides. As a result, Quadax must wait until payers publish their ANSI 5010 Companion Guides before any changes are made and testing begins by us. As of October 2009, no payer has published an ANSI 5010 Companion Guide.

4) What kind of software changes are required to accommodate ANSI 5010?

Based on the ANSI 5010 Implementation Guide, the majority of changes will be made “behind the scenes” to payer maps. There will be no format changes to either the UB or 1500 Claim Form Replica windows in Xpeditor. Depending on individual payer ANSI 5010 Companion Guides, fields may need to be added to the “supplementary 837 fields” section at the bottom of the Claim Form Replica windows, along with the accompanying database updates. Additional edits may also be required to accommodate new fields/requirements that do not currently exist as well as changes to our Filter Module.

5) Are there fees associated with the switch to ANSI 5010?

There will be no fees associated with the majority of changes required for the conversion to ANSI 5010. For example, Quadax will not charge for the addition of new fields in Xpeditor, the creation of databases to accommodate new ANSI 5010 data, the creation/modification of existing global Xpeditor edits, updates to the Filter Module, or the conversion of clients’ incoming 837 in the ANSI 4010A1 format to the ANSI 5010 format. However, changes required for client-specific logic are chargeable items. For example, custom converts, custom edits, after-edit converts, and custom posting files, to name a few.

6) How can clients make the transition to ANSI 5010 as smooth as possible?

The best way to ease the transition to ANSI 5010 is to notify Quadax as soon as possible when you are ready to convert so that we can test the new format and make the necessary changes. In addition, clients should review all current custom coding, including XpressBillers, to determine if logic specific to ANSI 4010 is involved. As always, if you have questions or comments regarding the change to ANSI 5010, please contact your Quadax Account Representative. ♦

A PDF of this document can also be found in the “FAQ” portion of the “Quadax Resources” section on the Quadax Portal Forum. If you are not familiar with the Portal Forum or require access to it, please contact your Quadax EDI Account Representative or the Client Support Center at (866) 422-8079 or locally at (440) 979-4090 (M–F 6:00 a.m.–5:00 p.m. ET).

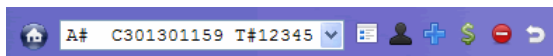
The Next Generation of HARP

By: Candace Wintering, Technical Communication Manager

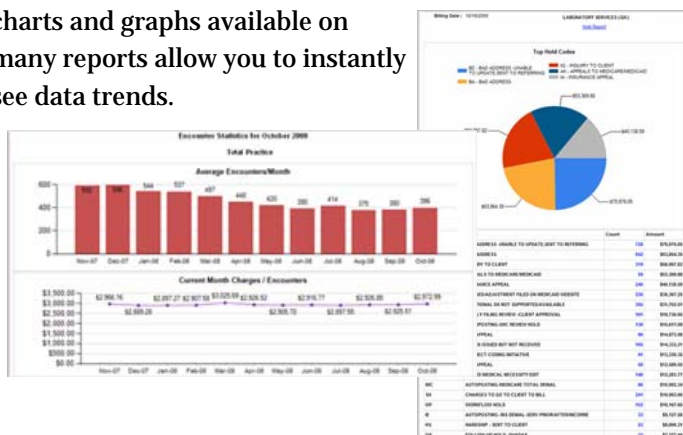
HARP 3, the browser-based version of our tried-and-true A/R software, is now available in limited release. What's exciting is that we were able to build functionality into HARP 3 that is not available in HARP (now referred to as HARP Classic or HARP 2), yet still retain the same proven billing concepts and business logic developed over many years. The browser environment is more flexible than the character-based one of HARP Classic, allowing more information to appear on a page and fewer keystrokes to perform tasks. And since both versions access the same databases, work can be performed in either version with updates appearing in both.

Favorite Features in HARP 3

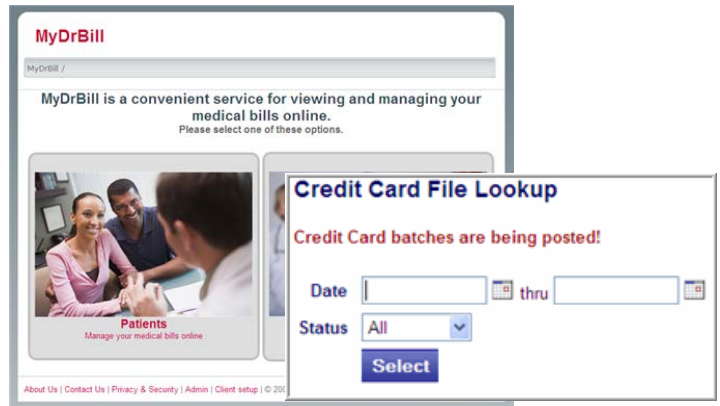
Quick-Access Toolbar. Sometimes the little things make all the difference. The Quick-Access Toolbar is an optional toolbar in the header of the application that provides direct links to patient and A/R data screens for the current patient. Even better, it maintains a history of the last 20 tickets so you can easily access any screen for those patients in a single click.



Web Based Reports. These reports provide a quick, efficient method to view important data. The reports are generated almost immediately because they access information in static databases created after significant processes, such as the last Close or Monthend. Taking advantage of options for the Web, the reports have links that allow you to “drill down” to details, such as tickets in an aging bucket or charges in a particular month. Colorful charts and graphs available on many reports allow you to instantly see data trends.



Credit Card Processing. Credit card payments can be made by a patient through the Quadax-hosted MyDrBill or MyLabBill Web sites, or by telephone to one of our call center representatives. All credit card data is transmitted directly to the payment gateway, which reduces the risk of processing and storing credit card information locally. The gateway service returns an electronic payment file that is automatically posted to patient tickets in HARP. A large laboratory client who recently implemented credit card processing saw a significant increase in payments they received on patient balances after just a month. They commented that they absolutely love it and keep thinking they are missing something because it's so easy!



Demographics Repository System (DRS). Like the Charge Repository System, the Demographics Repository is a holding database for data received in electronic files, but it is for patient data rather than for charges. The information can be reviewed for accuracy before it is loaded into HARP's main database. Deficiencies are flagged so users know what information needs to be corrected. The DRS: reducing errors, saving time, increasing productivity – now that's a great enhancement!

Although HARP 3 is still in development, most patient and patient A/R screens are fully functional. Progress continues on reports and setup screens, but in the meantime, HARP Classic fills in. Peek into the future of HARP with HARP 3! ♦

Work plan, continued from page 1

adverse events that the National Quality Forum (NQF) deemed “should never occur in a health care setting,” such as surgery on the wrong patient.

- Hospitals: National Incidence Among Medicare Beneficiaries
- Hospitals: Methods To Identify Events
- Hospitals: Early Implementation of Medicare’s Policy for Hospital-Acquired Conditions
- Hospitals: Responses by Medicare Oversight Entities
- Public Disclosure of Adverse Event Information

Other Part A and Part B Providers Payments

Medicare Incentive Payments for E-Prescribing-The OIG will review Medicare incentive payments made in 2010 to eligible health care professionals for their 2009 electronic prescribing (e-prescribing) activities. The Medicare Improvement for Patients and Providers Act of 2008 (MIPPA) provided for incentive payments to eligible health care professionals for e-prescribing beginning in 2010 and continuing through 2013. They will assess whether, and, if so, the extent to which incentive payments for e-prescribing activities in 2009 were made in error.

Laboratory Test Unbundling by Clinical Laboratories-The agency will examine the extent to which clinical laboratories have inappropriately unbundled laboratory profile or panel tests to maximize Medicare payments. Medicare contractors must group together individual laboratory tests that clinical laboratories can perform at the same time on the same equipment and then consider the price of related profile tests. Payment for individual tests must not exceed the lower of the profile price or the total price of all the individual tests. The OIG will determine whether clinical laboratories have unbundled profile or panel tests by submitting claims for multiple dates of service or by drawing.

Payments for Services Ordered or Referred by Excluded Providers-The OIG will review the nature and extent of Medicare payments for services ordered or referred by excluded providers. Excluded or terminated providers have

engaged in fraud, program abuse, or other conduct that formed the basis for termination from Medicare, Medicaid, and all other Federal health care programs. Pursuant to the Social Security Act, no payment shall be made for any items or services furnished, ordered, or prescribed by an excluded individual or entity. In April 2009, CMS completed its transition to the use of national provider identifiers (NPI) to identify its Medicare providers. It is possible that during the transition period to NPIs, some referring or ordering providers, referred to as “secondary” providers, did not have NPIs. Secondary providers are not required to enroll in Medicare, and no edits currently exist to determine whether secondary providers have been barred, suspended, or excluded by Medicare or Medicaid.

RECOVERY ACT WORK PLAN

Medicare Part A and Part B

Breach Notification and Medical Identity Theft in Medicare-They will review CMS’s compliance with new breach notification requirements for personally identifiable information (PII) in the Recovery Act (ARRA) and the Centers for Medicare &

Medicaid Services (CMS) oversight

measures in cases of medical identity theft within Medicare. Such PII includes health information maintained by Medicare providers and contractors. Breaches of PII can facilitate the theft of health-related PII (medical identity theft). The OIG will examine CMS’s internal procedures and processes related to the Recovery Act’s breach notification requirements.

Medicare Incentive Payments for Electronic Health Records-The agency will examine the Medicare incentive payments made to eligible health care professionals and hospitals for adopting electronic health records (EHR) and CMS’s safeguards against incentive payments made in error. ♦

More information about the complete Work Plan is available at: http://oig.hhs.gov/publications/docs/workplan/2010/Work_Plan_FY_2010.pdf



Quadax Wellness Initiative: Real Results for Valued Employees

By: Candace Wintering, Technical Communication Manager

Over 1000 pounds! That's how much the onsite Weight Watchers group at Quadax lost since its beginning in March. Just over a year ago, Quadax launched a corporate wellness program with a goal of improving the health and well-being of our employees and our community. Quadax made this commitment, realizing that our dedicated, expert staff is the foundation of corporate success.

Weight loss has proven health benefits for an individual. For an added bonus, Weight Watchers donated the equivalent of a pound of food to hunger relief for pounds lost during September and October, so our loss was a gain for the needy!

The Weight Watchers at Work program is just one example of the many positive initiatives sponsored by the Wellness Committee this year. ♦

What does 1000 pounds look like?



100 pounds = an adult male polar bear



1000 pounds = three refrigerators



1000 pounds = a 12ft. 9in. shark



1000 pounds = one horse

Qualifying the Qualifiers

By: Chuck Parker, EDI Systems Manager

When the UB-04 was designed and implemented, a new concept was introduced in relation to the Physician fields. On the UB-92, you entered a Physician Name and associated Physician ID. The ID could have been a NPI, UPIN, Tax ID, Payer assigned ID, etc. When the UB-04 was introduced, the Physician fields changed, and Blocks 76 (Attending) and 77 (Operating) were broken up into several fields. Now that it is mandated for nearly all payers, the NPI is the most-used identifier. However, there are still some payers out there that expect to see a legacy Provider Number either in addition to the NPI or as the only ID reported.

When reporting a legacy Provider ID, it is imperative to use the correct associated qualifier. For a legacy Provider ID, enter one of the following qualifiers in both blocks 76B and 77B:

OB - State License Number (Note: The first character is zero, not the letter O.)

1G – Provider UPIN Number

G2 – Provider Commercial Number

Blocks 78 (Other Physician 1) and 79 (Other Physician 2) have been divided even further. Both blocks have **two** qualifiers. The first one is used to define the NPI when it is entered in each block.

CMS expands editing, continued from page 1

- If the ordering/referring provider **is on the claim**, MCS will verify that the ordering/referring provider is on the national PECOS file.
- If the ordering/referring provider **is not on the national PECOS file**, MCS will search the MAC's claims system next for the ordering/referring provider.
- If the ordering/referring provider **is not on the national PECOS file and is not in the claims system**, the claim will continue to process and the Part B provider will receive a warning message on the Remittance Advice.
- If the ordering/referring provider **is in PECOS or the claims system, but is not of the specialty eligible to order or refer**, the claim will continue to process and the Part B provider will receive a warning message on the Remittance Advice.

The appropriate NPI qualifiers are:

DN – Referring Physician

ZZ – Other Operating Physician

82 – Rendering Provider

The second qualifier pertains to the legacy Provider ID (if entered). This is exactly like Blocks 76 and 77, using the same qualifiers listed above.

When a Physician ID is entered in Blocks 76 through 79, whether it is the NPI or a legacy provider number, the Physician First and Last Name **must** also be present. This information is required to complete the appropriate ANSI 837 segments.

Also, to add to the confusion, the Physician fields (Block 79) that were added to the UB-04 are currently not reportable in the ANSI 837 **4010A1** format. Once the ANSI **5010** format has been implemented, there *will be* a loop/segment designated for sending this information.

The current ANSI 837 **4010A1** loops/segments used to report Physician information are: **NM1*71** (Attending – Loop 2310A), **NM1*72** (Operating – Loop 2310B), and **NM1*73** (Other Physician – Loop 2310C).

In the upcoming ANSI 837 **5010** format, they will be: **NM1*71** (Attending – Loop 2310A), **NM1*72** (Operating – Loop 2310B), **NM1*ZZ** (Other Operating – Loop 2310C) and **NM1*82** (Rendering – Loop 2310D). Hopefully, this article qualifies as good information to help clear up the qualifying qualifiers! ♦

Phase 2 (January 4, 2010 and thereafter):

- If the billed service requires an ordering/referring provider and the ordering/referring provider **is not on the claim**, the claim will not be paid.
- If the ordering/referring provider **is on the claim**, MCS will verify that the ordering/referring provider is on the national PECOS file.
- If the ordering/referring provider **is not on the national PECOS file**, MCS will search the MAC's claims system next for the ordering/referring provider.
- If the ordering/referring provider **is not on the national PECOS file and is not in the claims system**, the claim will not be paid and will be rejected.
- If the ordering/referring provider **is in PECOS or the claims system but is not of the specialty to order or refer**, the claim will not be paid and will be rejected. ♦

The full article can be viewed at

<http://www.cms.hhs.gov/Transmittals/downloads/R572OTN.pdf>

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