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2016 Third Quarter Newsletter

Proper Use of the -JW Modifier

Effective January 2017, Medicare contractors will require all providers who bill for certain biologicals or drugs, to report an additional modifier to indicate any wasted product. The -JW modifier will be appended to claims for items, such as bioengineered skin substitutes, to indicate a portion of the item that was not used and cannot be reused on another patient. The informational modifier was used at one time as a conditional requirement, optional, depending on the Medicare contractor. In order to report this modifier properly when it becomes mandatory, a drug will have to be reported twice on a claim - see the following example:

A patient with a diabetic foot ulcer of approximately 20 square centimeters comes to the office for an application of a bioengineered skin substitute:

- The first 20 square centimeters would be on one line item-indicating the amount used in units
- The remainder of the skin substitute would be on a separate line item with the -JW modifier appended to indicate that the product was wasted and the units not used.

No matter how much of the product is wasted, providers will still be reimbursed for all units of the product used or wasted as long as the claim is coded properly. As with any service, be sure that all pertinent information, such as the details of the drug/product, dosage, amount used, and amount disposed are documented in the case of an audit. Also be sure to include the NDC number that corresponds to the product.

Updates to ADR Request Protocols

Depending on the types of services rendered in your office, you may occasionally receive a letter from Medicare requesting additional information and stating that a claim has been pended because additional information is needed to determine if the service is medically necessary. Examples of services or items that are selected for complex review are diabetic shoes and inserts, high level evaluation and management codes, unlisted services, and prolonged time codes. Providers have 45 days to respond to a letter that is generated from the local Medicare contractor or third party auditing company (ZPIC) - failure to provide the necessary information will cause a claim to be denied. Last month, some clarification was given in the Medicare claims processing manual on how to address these documentation requests - the key points for the changes are:

- Providers will receive an EOB with claim adjustment code CO-50 / remittance code M127, stating that these are non-covered services because this is not deemed a "medical necessity" // Missing patient medical record for this service.
- The same code combination will be used in an event that a claim is denied with the review of supporting documentation, or if the provider fails to submit the requested information to the MAC or ZPIC for review.

As a reminder, if any claims are pended for a pre or post payment review, address these requests as soon as possible to attempt to receive payment for the services. If the request is not sent timely to the requested entity, the claims may require additional effort in order for a final determination to be made with all of the available documentation.

National Health Insurance Mergers

Late last year, two mergers have gained national attention that will affect New York State providers - the potential combination of Aetna with Humana, and Anthem with Cigna. Mergers, in many areas of the healthcare industry, are becoming increasingly common, between software, analytics, logistics, and healthcare systems to name a few. However, with the potential of these two monumental mergers involving four of the five largest health insurance carriers in the country (United Healthcare being the fifth), the government is attempting to do whatever it can within its power to stop these mergers from being finalized. From the perspective of the health insurance carriers, combining forces will help reduce costs, especially with the loss of profits with exchange policies in certain markets. The concern of the U.S. Department of Justice and the Obama Administration is that there will be a reduction in competition for the entire American population. This includes limited options for employer sponsored plans, exchange policies, and Medicare advantage plans. Although nothing is certain at this point about the success or failure of these mergers, it is causing an uproar for the insurance carriers, their shareholders, health plan members, participating providers.

CORE Code Combinations

Over the past few years, more insurances are opting to provide remittance information electronically as the preferred method of giving providers payment or denial information for claims. Medicare, Medicaid, and almost all commercial payers of any size have used codes that have been published by the Washington Publishing Company to help providers interpret the information to post their payments and perform effective denial management. However, in the past, there has been inconsistencies in the way the codes were used, prompting unnecessary calls to the insurance carriers because of insufficient information given to figure out why a claim was denied, causing some healthcare providers to be weary of these electronic transactions compared to receiving paperwork in the mail. Part of the Accountable Care Act mandates a streamlined, standardized system for EDI transactions, such as claim submission, eligibility inquiries, claim status, and remittances. Starting in 2014, the coding combinations started to be updated and cross-walked more often to assist healthcare providers in easily interpreting electronic EOBs. Whether remittances are received as part of a billing module associated with CEHRT, a clearinghouse, or through software like Medicare Easy Remit, receiving data from any of these sources should provide you with an easier way to review processed claims and outline precise denial management. All healthcare entities are encouraged to become familiar with these code sets since there is a very strong emphasis for all transactions to be electronic, whether a doctor's office, hospital, or an insurance company (since they are required to use these code sets in order to be HIPAA compliant). Current and past lists can be found through the following link, along with prior code lists and implementation dates:

http://www.caqh.org/core/ongoing-maintenance-core-code-combinations-caqh-core-360-rule

Revalidations and Provider Information Updates with Medicare

For the past several years, all Medicare contractors around the country have been requesting providers to verify their information even if there are no changes. This process is known as a revalidation, and applies to all part B providers and DME suppliers in order for their billing privileges to stay active. Failure to submit a revalidation when requested by a part B MAC or the NSC will result in a suspension of billing privileges until the requested information is provided. Typically, a letter is mailed out to doctors with a deadline for the appropriate CMS-855 forms to be completed in order for billing to continue. To preempt a letter being received- if you think you may be due for a revalidation, visit the following website to see if you are pending an update:

http://go.cms.gov/MedicareRevalidation

If there is a due date for a practice to submit paperwork, it should not be submitted for processing until six months before the due date at the earliest, or your paperwork will be returned. As a reminder, if there are any changes to your practice, such as location, change in ownership, adding associate providers, etc., make sure that the updates are made with the local carrier within 90 days (some exceptions apply).