



New York J13

Medicare and
LICENSED CLINICAL SOCIAL
WORKERS

July 14, 2010



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Important Updates

- **2010 Fee Schedule – expires November 30, 2010**
Fees are posted on www.ngsmedicare.com
- **Major changes in provider enrollment**
- **The future calls for increased use of EDI**
- **Keep you up-to-date on all Medicare changes**

Current Fee schedule June 1, 2010– Nov 30, 2010 Fee Schedule

On view at: www.ngsmedicare.com

- **Fourth time this year!**
- **The Health Care Reform Act signed on March 23, 2010 enacted Corrections to the 2010 Medicare Physician Fee schedule.**
- **Conversion changed from \$36.0846 to \$36.0791 (.5 cent) retroactive to January 1, 2010. (due to PE-GPCI updates)**
- **Current conversion factor + 2.2% June 1, 2010 - \$36.8729**
- **Remember payment floors apply. (13 days – EDI claims 29 days for paper claims)**

Fee Schedule Update

- Through 5/31/10
- Full Fee schedule allowance - Locality 1
- 90801 \$175.03
- 90804 \$ 75.48
- 90806 \$102.94

- June 1 – Nov 30 2010

- 90801 \$178.88
- 90804 \$ 77.51
- 90806 \$105.21

- LSCW are approved at 75% of the full fee schedule

Mental Health parity is now law!

Calendar Year	Percentage Paid by Medicare
2009	50%
2010	55%
2011	55%
2012	60%
2013	65%
2014	80%

Mandatory Participation

- **It is Mandatory that Licensed Clinical Social Workers Participate in the Medicare Program.**
- **Claims Must be Submitted on an Assigned Basis.**

Claim Filing Limitations

Claims not submitted by time limit are provider-liable /
Beneficiaries cannot be charged for provider-liable charges

Services Rendered:	Claim Filing Date
10/01/07 – 09/30/08	12/31/09
10/01/08 – 09/30/09	12/31/10
10/01/09 -12/31/09	12/31/10
01/01/10 and forward	365 days/ 1 calendar year from the date of service

Provider Enrollment

- **Many new CMS requirements in place
Published in the Federal Register.**
- **They are key to protecting the Medicare trust funds and assuring payment accuracy!**
- **Providers have an obligation to keep their contractor up-to-date on changes!**

Enrollment Revalidation for Providers not in PECOS System

- Providers who have not made changes to enrollment record since 2003 will not be in PECOS
 - May need to revalidate enrollment
- NGS is currently sending out revalidation letters starting in Aug.
- Providers who receive a letter must respond or billing privileges will be revoked
- List of Providers in PECOS

<http://www.cms.hhs.gov/MedicareProviderSupEnroll/Downloads/OrderingReferringReport.pdf>

Medicare Provider-Supplier Enrollment

- » [Overview](#)
- » [Enrollment Applications](#)
- » [Advanced Diagnostic Imaging Accreditation](#)
- » [Internet-based PECOS](#)
- » [DMEPOS Surety Bond](#)
- » **OrderingReferringReport**
- » [DMEPOS Accreditation](#)
- » [Taxonomy](#)
- » [Provider Enrollment Regulation](#)

OrderingReferringReport

CMS continues to urge physicians and non-physician practitioners who are enrolled in Medicare but who have not updated their Medicare enrollment record since November 2003 to update their enrollment record now. If these physicians and non-physician practitioners have no changes to their enrollment data, they need to submit an initial enrollment application which will establish a current enrollment record in PECOS.

The download below contains the National Provider Identifier (NPI) and the legal name (last name, first name) of all physicians and non-physician practitioners who are of a type/specialty that is legally eligible to order and refer in the Medicare program and who have current enrollment records in Medicare (i.e., they have enrollment records in PECOS).

A new file will be made available periodically that will replace the posted file; at any given time, only one file (the most recent) will be available. The file can be downloaded by users with technical expertise and further sorted or manipulated. It can also be used to search for a particular physician or non-physician practitioner by NPI or by name. Please note the following: (1) Records are in alphabetical order based on the surname of the physician or non-physician practitioner. (2) Name suffixes (e.g., Jr.), if they exist, are not displayed. (3) There are no "duplicates" in the file. Many physicians or non-physician practitioners share the same first and last name; their corresponding NPIs are the assurance of uniqueness. (4) Deceased physicians and non-physician practitioners are not included in the file.

There are two file formats for the Medicare Ordering and Referring File below. The first is a PDF format. This file will allow a user to verify that an individual physician or eligible professional has an approved enrollment record in PECOS using Adobe Acrobat Reader. The second file is a ZIP file. The ZIP file contains the same information as the PDF, however, the file is a CSV format. The CSV file will allow users to open the Ordering and Referring data in Excel, Notepad and other software formats that could be easier for users to search/sort.

In order to use the CSV file, please left-click on the "Medicare Ordering and Referring File [ZIP, 64400KB]" and save the CSV document contained in the zipped download. Right-click on the saved CSV file, select "Open With" on the task bar and select the program through which you would like open the Medicare Ordering and Referring File.

Medicare Enrollment Timeframes

- **Effective date of enrollment is later of:**
 - Date of filing (receipt date)
 - Date began furnishing services at practice location (if within 30 days)
- **Date of filing for online applications based on contractor receipt of Certification Statement**
- **30-day retrospective** billing guideline as of April 1, 2009
- **No rights of appeal are available only if enrollment is denied or revoked.**
- **Reactivation application treated as initial enrollment application**

Deactivation of Medicare Provider Numbers

- Medicare PTAN becomes inactive if no valid Medicare claim submitted in 12-month period
- To reactivate, provider must:
 - Be ready to submit valid claim
 - Submit appropriate CMS-855 form online or on paper
- Upon reactivation, new PTAN is assigned and new effective date applied
- Providers who received paper checks prior to deactivation are required to complete CMS-588 (EFT Authorization Agreement) to reactivate

What is Internet-Based PECOS?

Easy - Fast - Secure

- **Better way for physicians, non-physician practitioners, and third-party staff who are authorized to:**
 - Submit new initial enrollment record
 - Make changes to existing enrollment record
 - Add or change reassignment of benefits
 - Reactivate enrollment
 - Voluntarily withdraw enrollment
 - Revalidate enrollment

Completing Online Enrollment

Three Basic Steps

1. **Must have active NPPES User ID and Password**
 - **Additional security clearances needed for groups**
 - PECOS Identification and Authentication system (PECOS I&A) clearances for Authorized Official
2. **Complete online enrollment and submit**
3. **Print, sign and date, and mail Certification Statement to National Government Services along with all supporting paper documentation within seven (7) days of electronic submission**
 - **Signed by AO for groups**

Wait at least 15 days before checking status of online application

Electronic Funds Transfer (EFT)

- **Required as part of enrollment process**
 - New providers
 - Providers making any change to enrollment record
- **Any provider can receive Medicare payments via direct deposit**
 - Funds are available immediately
- **New form CMS-588 form available under “Enrollment” tab on www.ngsmedicare.com**

National Provider Identifier (NPI) Reminders

- **Apply for NPI online**
 - <https://nppes.cms.hhs.gov>
- **Contact NPI Enumerator for assistance with applying for NPI or updating data in NPPES records**
 - 1-800-465-3203
 - CustomerService@NPIEnumerator.com
- **FREE NPI Registry**
 - <https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do>
- **CMS' dedicated NPI web page**
 - www.cms.hhs.gov/NationalProvIdentStand

General Principles of Medical Record Documentation- LCSW

- **Medical records should be complete and legible;**
- **Documentation of each patient encounter should include:**
 - **Reason for encounter and relevant history,**
 - **Physical examination findings and prior diagnostic test results,**
 - **Assessment, clinical impression, and diagnosis,**
 - **Plan for care,**

Medical Record Documentation- LCSW

- **Date and legible identity of observer;**
- **If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred;**
- **Documentation must denote start/stop time or total face-to-face time with the patient, if the code has a time frame indicated;**
- **Past and present diagnoses should be accessible for the treating and/or consulting physician;**
- **Appropriate health risk factors should be identified;**

Medical Record Documentation- CSW

- **The patient's progress, response to changes in treatment, and revision of diagnosis should be documented; and**
- **The CPT and International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes reported on the health insurance should be supported by documentation in the medical record.**
- **Set a format for meeting each of these requirements!**

Psychiatric Diagnostic Interview Examination

90801

- Includes assessment of the patient's history, mental status, establishment of initial diagnosis, evaluation of patients ability/capacity to respond to treatment and initial plan of treatment
- May include communication with family members or other sources, ordering & medical interpretation of lab tests & other medical diagnostic studies

Documentation

- **The medical record must reflect the elements of 90801 as previously described and must be rendered by a qualified provider.**

Comments

- **May be covered once, at the outset of an illness or suspected illness.**
- **May be utilized again for the same patient if a new episode of illness occurs after a hiatus or on admission or readmission to an inpatient status due to complications of the underlying condition.**
- **Certain patients, especially children, may require more than one visit for the completion of the initial diagnostic evaluation. The medical record must support the reason for more than one diagnostic interview.**

Psychiatric Therapeutic Procedures

- **90804 – 90829** Insight Oriented, Behavior Modifying, Supportive, and/or Interactive Psychotherapy
- **90845-90857** Psychoanalysis, Group Psychotherapy, Family Psychotherapy, Interactive Group Psychotherapy
- **90865** Narcosynthesis for Psychiatric Diagnostic and/or Therapeutic Purposes

Documentation

- **Medical records must indicate the time spent in the psychotherapy encounter and the therapeutic maneuvers.**
- **Behavior modification is not a separate service, but is an adjunctive measure in psychotherapy.**
- **A periodic summary of goals, progress toward goals, and an updated treatment plan must be included in the medical record.**
- **Prolonged periods of psychotherapy must be well-supported in the medical record describing the necessity for ongoing treatment.**

Psychotherapy in a Group Setting

90853, 90857

- **90853** and **90857** represent Psychotherapy administered in a Group Setting, involving no more than 12 participants.
- Facilitated by a trained therapist simultaneously providing therapy to these multiple patients.
- The group session typically lasts 45 to 60 minutes.

Documentation

- The record must indicate that the guidelines under the "Description" and "Comments" sections were followed.

Comments

- Since Group Therapy involves psychotherapy it must be led by a person who is licensed or otherwise authorized by the state in which he or she practices to perform this service.
- This will usually mean a psychiatrist, psychologist, clinical social worker, clinical nurse specialist, or other person authorized by the state to perform this service.
- For Medicare coverage, group therapy does not include: socialization, music therapy, recreational activities, art classes, excursions, sensory stimulation or eating together, cognitive stimulation, or motion therapy.

ACTION CODE "M80" or "B15"

Does not pay for this service because it is part of another service performed at the same time

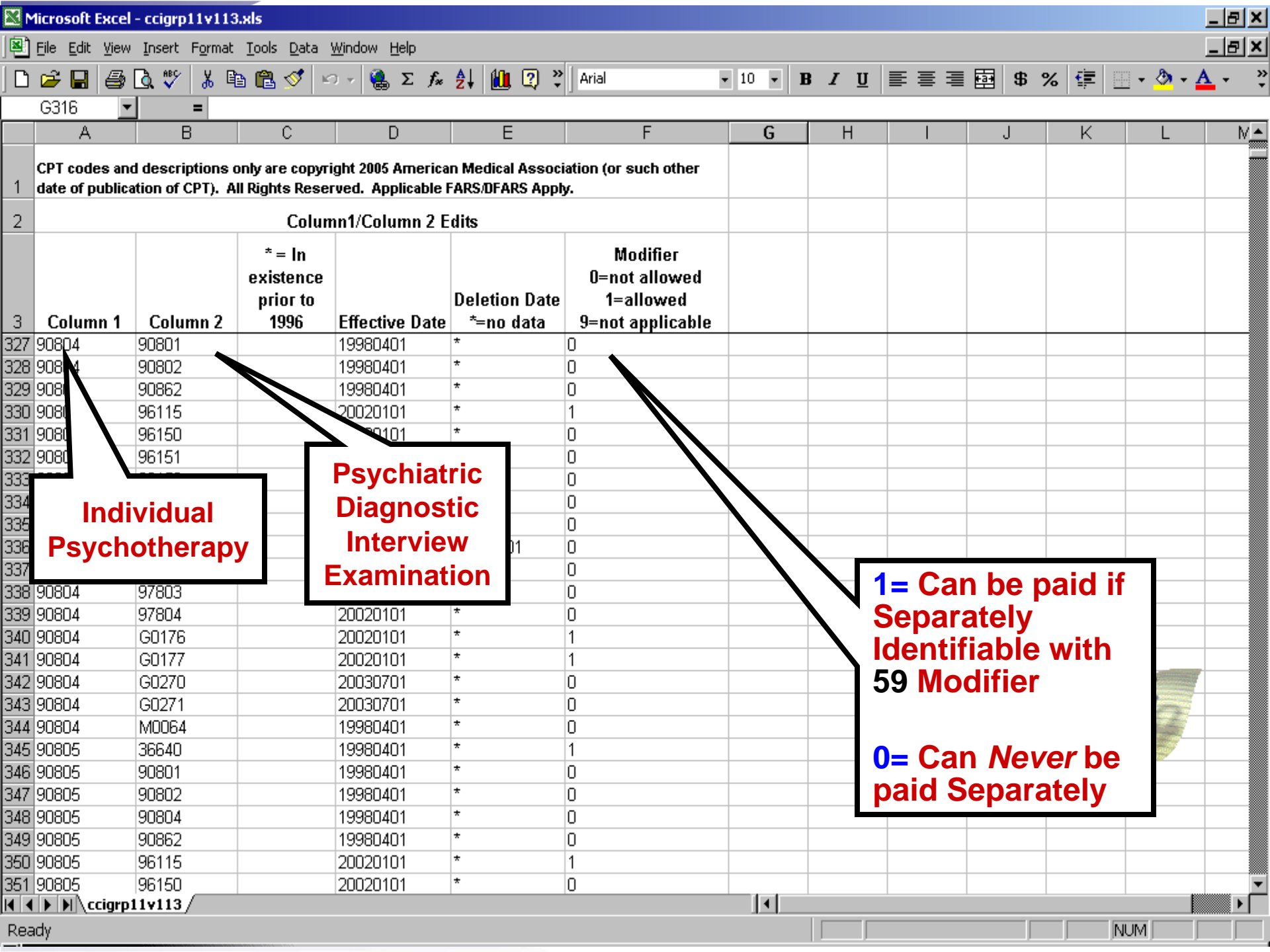
- * *Cannot Bill the Patient*
- * *ABN is Not Valid*

CCI Modifiers

25, 59, 91

Example of Edits

Comprehensive Service	Component Service
90804 Office-Individual Psychotherapy Insight Oriented 20-30 min	90801 Psychiatric Diagnostic Interview Examination



CPT codes and descriptions only are copyright 2005 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS Apply.

Column1/Column 2 Edits

	Column 1	Column 2	* = In existence prior to 1996	Effective Date	Deletion Date * = no data	Modifier 0 = not allowed 1 = allowed 9 = not applicable
327	90804	90801		19980401	*	0
328	90804	90802		19980401	*	0
329	90804	90862		19980401	*	0
330	90804	96115		20020101	*	1
331	90804	96150		19980401	*	0
332	90804	96151		19980401	*	0
333						0
334						0
335						0
336						0
337						0
338	90804	97803				0
339	90804	97804		20020101	*	0
340	90804	G0176		20020101	*	1
341	90804	G0177		20020101	*	1
342	90804	G0270		20030701	*	0
343	90804	G0271		20030701	*	0
344	90804	M0064		19980401	*	0
345	90805	36640		19980401	*	1
346	90805	90801		19980401	*	0
347	90805	90802		19980401	*	0
348	90805	90804		19980401	*	0
349	90805	90862		19980401	*	0
350	90805	96115		20020101	*	1
351	90805	96150		20020101	*	0

Individual Psychotherapy

Psychiatric Diagnostic Interview Examination

1 = Can be paid if Separately Identifiable with 59 Modifier
0 = Can Never be paid Separately

Always Code ICD-9 Codes to the Greatest Degree of Specificity

Claims Lacking the Most Specific Diagnosis will be Rejected as a Truncated DX

EXAMPLE :

300.00 Anxiety state, unspecified / 300.02 Generalized anxiety disorder

Invalid Diagnosis Code Editing Second Phase

- Edits have been added to the Medicare Claims Processing System to prevent acceptance of claims with invalid Diagnosis Codes.
- This applies to all Diagnosis Codes Listed in Item 21 - Even Those *NOT* Linked to the Line of Coding.
- Medicare systems will reject claims with diagnosis codes that were not valid on the date of service

e.g. 300.00-.29 Anxiety disorder valid code -
300.0 not valid; needs a 5th digit

SUPPLEMENTAL INSURANCE

Any Insurance that Comes After Medicare

- Purchased by the Patient
- Given as a Retirement Benefit
- Provided by the Government
- Covered by a Spouse

Medicare Trading Partners

- *Also Known as CROSSOVERS* *Coordination of Benefits*
- Insurance Plans that have Agreed to have an Automatic Crossover from Medicare.

Medigap

- Insurance that is Purchased directly by the Beneficiary from an Insurance company.

Medicare as Secondary Payer *MSP*

Make Insurance First & Medicare Last

- Working Aged
- Disability
- Workers' Compensation
- Auto No-Fault and Liability
- End Stage Renal Disease
- Black Lung

Can be Submitted Electronically !!!

CERT Process

- **AdvanceMed will collect a Random Sample of claims from NGS and then request, Medical Records Information Directly from the Providers**
- **When the information is received it is evaluated by the CERT professional review staff**
- **Providers should respond promptly to each request**
- **2010 rates have increased in NY**

CERT Errors

- **Insufficient Documentation: National 1.9%**
Did you order lab/diagnostic services?
- **Medically Unnecessary Services: National-4.0%**
- **Incorrect Coding: National-1.6%**
- **Physician Signature Missing or Illegible (Handwritten or electronic (stamp signatures are not acceptable))**
- **New CMS directives on signature requirements! (posted: 4/29/2010)**

New Signature requirements

- The use of stamped signatures is not acceptable on any medical record
- Medicare requires a legible identifier for services provided and ordered. Medicare will accept hand-written, electronic signatures or facsimiles of original written or electronic signatures for medical review purposes
- The Medical Review department will deny claims not meeting the signature requirements on records requested on Additional Development Requests (ADRs)
- Medicare Program Integrity Manual (100-08), Chapter 3, §3.4.1.1

What is the future of Medicare

- **Electronic solutions are the key!**
 - **Electronic Medical Records are coming**
 - **Quality Initiatives are available**
 - **Bonuses will exist**
-
- **ICD-10 is a reality in October 1, 2013**
 - **A platform of x12 HIPAA 5010 version will be implemented. - January 1, 2012**

Electronic Health Records

- **American Recovery and Reinvestment Act of 2009 (ARRA)**
- **Beginning in 2011, eligible professionals (EPs) who implement and report “meaningful use” of electronic health records (EHR) will be eligible for incentive payments**

Incentive Payments

- Equal to 75 percent of Medicare allowable charges for covered services furnished by EP in a year, subject to a maximum payments of: **\$44,000**
 - 2011= **\$18,000**
 - 2012 = **\$12,000**
 - 2013 = **\$8,000**
 - 2014 = **\$4,000**
 - 2015 = **\$2,000**

Payment Adjustments

- Medicare fee schedule amount for professional services provided by EP not a meaningful EHR user for year reduced by:
 - 1% in 2015
 - 2% in 2016
 - 3% for 2017
 - Between 3 to 5% in subsequent years

Dealing with Medicare

- Addresses have changed in 2010
- Sign up for the www.ngsmedicare.com listserv to keep up to date on changes.
- Check our Provider Outreach and Education calendar on www.ngsmedicare.com

Mail Consolidation Effective 4/1/2010

J13 Contact Information

NY

Interactive Voice Response unit (IVR)	1-877-869-6504
Provider Contact Center:	866-837-0241
Fax on Demand:	866-709-1905
EDI:	877-273-4334
Paper Claims:	NGS PO Box 6178 (Downstate) Box 6239 (Queens) Box 6189 (Upstate) Indianapolis, IN 43206-
Provider Enrollment:	NGS NGS P.O Box 6230 Indianapolis, IN 46206-6230

Provider Interactive Voice Recognition *IVR* (877) 869-6504

Easy and Quick Method to Obtain Information

- Monday – Friday *6am - 7pm ET*
- Saturday *7am - 3pm ET*

Information Available:

- Status of Claim
- Eligibility
- Request Duplicate Remittances
- Deductible Information
- Enrollment Application Information
- Pricing
- Seminars
- Appeal Rights

Provider Customer Service Representative *CSR* Toll Free Line (866) 837-0241

- **To be used for Inquiries that Can Not be Handled through the Automated Line.**
- **A CSR will Assist You.**
- **Monday, Tuesday, Wednesday, Friday
8:00 a.m.- 4:00 p.m. ET**
- **Thursday 8:00 a.m. - 2:00 p.m. ET**

Training Hour Closure Time – Thursdays 2:00 - 4:00

Contacting the TRU Line

888-812-8905 for NYS

- **Hours of Availability:**
 - Monday - Friday 8:00 am - 12:00 pm. and 1:00 pm - 4:00 pm ET
- **The Telephone Reopening Representative will assist you with up to Three Claims each time you call.**
- **When requesting a reopening over the phone, you must be prepared to provide the following information:**
 - Beneficiary's Name
 - Medicare Health Insurance Claim Number
 - Your Full Name (first and last name)
 - Your Phone Number
 - Provider's Name
 - Provider's Number
 - Date(s) of Service in Question
 - Reason for Request

Eligibility Status Can Be Obtained Through the IVR Line/Eligibility Option

The Following Information Must Be Given:

This information must match **EXACTLY** or **the information CANNOT be released**

- **Provider's Name and PIN**
- **Beneficiary Last Name and First Initial**
- **Beneficiary Date of Birth**
- **Beneficiary HICN**