The newly formed JH region encompasses the states of Arkansas, Louisiana, Mississippi, Colorado, New Mexico, Oklahoma, and Texas. Novitas (formerly Highmark Medicare Services) has stated that their mission is to ensure a smooth transition of services from:

Pinnacle Business Solutions, Inc. (PBSI):
- AR and LA Part B providers are scheduled for **August 13, 2012**

Cahaba Government Benefit Administrators, LLC (Cahaba GBA):
- MS Part B providers are scheduled for **October 22, 2012**

Novitas has developed a JH Transition web site [https://www.novitas-solutions.com/transition/jh/index.html](https://www.novitas-solutions.com/transition/jh/index.html) dedicated to providing the most up-to-date information regarding the transition, which includes new claims and appeal addresses.

**Action is REQUIRED:**
Review the 051512 News Blast: Medicare New MAC – Providers Enrolled for EFT.

If your practice is currently enrolled for Electronic Funds Transfer (EFT) with:
- **Pinnacle Business Solutions, Inc. (PBSI):** you should have received a letter dated May 15, 2012, from Novitas Solutions, Inc. (Novitas) requesting a CMS-588 EFT Authorization Agreement (Agreement).
- **Cahaba GBA:** expect a letter by mid August from Novitas Solutions, Inc. (Novitas) requesting a CMS-588 EFT Authorization Agreement (Agreement).

Please read this letter carefully for instructions to complete and return the Agreement.

**Novitas is required to obtain a new Agreement** in conjunction with the MAC JH transition to continue issuing EFT payments post-cutover. **Failure to complete and submit the Agreement may result in a delay or interruption of Medicare payments for your practice.**
**User Guide (UG) Listing is available!!**

Access all available UGs for MEDTRON’s Suite of products from one location. Each UG is sorted by screen options and is linked to the most current published version, simply click on the name of the UG to access. If the UG presents in black (no link) the guide is in the process of being created or updated.

Save the link below to your Internet favorites or desktop for easy reference.

่า To request the assigned User ID and Password or speedier UG publishing, please email our Software Support Dept via support@medtronsoftware.com.

Save the location:


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**UNDERSTANDING 5010**

As a healthcare provider using the Health Insurance Portability and Accountability Act (HIPAA) electronic administrative transactions, such as checking a patient's eligibility, filing an EMC (claim), or receiving an ERA (remittance advice), your practice management (PM) system is required by federal regulation to update from the 4010 version to the updated 5010 version of these transactions; official deadline is January 1, 2012. However, CMS decided it would not initiate enforcement until June 30, 2012. This additional time was to allow health plans and clearinghouses to correct the numerous issues resulting from massive system changes/updates. LA Medicaid and LA BlueCross were among those delaying until June 2012.

Please review the 040912 News Blast: UPDATED Understanding 5010.

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**MEDTRON’s MEDPM and MEDEHR software has already been certified 5010 compliant.**

One of the significant purposes for the 5010 update was to accommodate the ICD-10 code size...

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**HHS Announced Intent to Delay ICD-10 Compliance Date**

All HIPAA-covered entities have until June 30, 2012 to complete the upgrade to version 5010 electronic standards. On April 17, 2012, Dept of Health and Human Services (HHS) published a proposed rule that would delay, by one year, the date by which certain health care entities have to comply with International Classification of Diseases, 10th Edition diagnosis and procedure codes (ICD-10) to October 1, 2014. This delay is largely due to the feedback that provider groups have reported regarding concerns about their ability to meet the October 1, 2013, ICD-10 compliance date, based in part on implementation issues they have experienced meeting HHS’ compliance deadline for version 5010 transactions.

ICD-10 codes provide more robust and specific data that will help improve patient care and enable the exchange of our health care data with that of the rest of the world that has long been using ICD-10.
AVOID COMMON VERSION 5010 CLAIMS REJECTIONS

The version 5010 transaction standards have different requirements than those of version 4010 and 4010A. Here are a few things to keep in mind for processing version 5010 claims to help avoid unnecessary rejections:

~ ZIP Code: Include a complete 9-digit ZIP code for the billing provider and service facility location.
~ Billing Provider Address: Use a physical address for the Billing Provider address. Version 5010 does not allow for use of a ‘PO Box’ address for either professional or institutional claim formats. A ‘PO Box’ can still be used as the address for payments and correspondence from payers as long as the ‘PO Box’ is only reported as a ‘Pay To’ address.
~ National Provider Identifier (NPI): Previously an Employer’s Identification Number (Tax ID) or Social Security Number (SSN) was allowed as a ‘primary identifier’ for the billing provider; for version 5010 claims, only the NPI is allowed as a ‘primary identifier’.

Refer to User Guide: Setup/Maintain Setup & Support Files

******AUDITS ABOUND******

Centers for Medicare and Medicaid Services (CMS):
  Prepay Medical Review – letter received from CMS
  Recovery Audit Contractors (RAC) – letter received from Medicare Administrative Contractor (MAC)
  Comprehensive Error Rate Testing (CERT) – letter received from CMS
Department of Health and Hospitals (DHH):
  Surveillance and Utilization Review Subsystem (SURS) – letter received from the Medicaid Carrier
  Office of Inspector General (OIG) – letter received from DHH/OIG
Part C Carriers – Healthcare Effectiveness Data and Information Set (HEDIS)

DO NOT IGNORE LETTERS FROM ANY CARRIER!

LA WORKERS’ COMPENSATION AUTHORIZATION > $750

In summary, the currently approved treating Healthcare Provider (HCP) must complete and submit the 1010 form for approval of the following medical treatment, care, and services:
- Any service performed in the office of the currently approved treating HCP that will exceed $750.00.
- Any referral to another HCP.
- All PT/OT/DME requests.

The only services that will not require completion of the 1010 form are:
- Office visits with the current approved treating HCP.
- Prescription medications that will be handled through LWCC’s Pharmacy Benefits Manager (PBM) in conjunction with the medical treatment.

DO NOT submit the 1010 form to the adjuster.

All completed 1010 forms must be submitted to the centralized UR fax number and email address:
  Fax #: 225-231-8415   Email: lwccur@lwcc.com

LWCC has 5 business days to render a decision or to request additional information from the HCP. LWCC recognizes that this will require more paperwork/work from the HCP.

For more information, please visit the website at: www.laworks.net.

CODING TRENDS OF MEDICARE EVALUATION AND MANAGEMENT (E&M) SERVICES

OIG’s audit of E&M services for the period of 2001 thru 2010 (Medicare payments for Part B goods and services increased by 43 percent, from $77 billion to $110 billion.) During this same time, Medicare payments for E&M services increased by 48 percent, from $22.7 billion to $33.5 billion. E&M services are vulnerable to fraud and abuse. The Centers for Medicare & Medicaid Services (CMS) also found that E&M codes 99214 and 99215 had the highest change in utilization. With this data the OIG has identified 1700 providers with higher than their peer group utilization of these higher level E&M codes. Many of these providers are being asked to supply documentation and support for a sampling of their patient records.

To minimize your chances for an audit take care to bill and document for the correct level of service; review the 060310 News Blast: Consultation Refresher and the E&M Information Packet (available via MEDTRON User Guides) CAUTION: Medical Necessity has become a driving force for level of care appropriateness.
**MEANINGFUL USE**

The Medicare and Medicaid EHR Incentive Programs employ different time lines for implementation but both provide a financial incentive for the "meaningful use" of certified EHR technology to achieve health and efficiency goals. By putting into action and meaningfully using MEDEHR, providers could receive financial incentives; or receive a penalty if not compliant by specified deadlines.

Below we have outlined key information regarding Meaningful Use and what you can be doing now to achieve these financial incentives using MEDEHR.

**What is "Meaningful Use" (MU)?**

Meaningful Use is described as the use of a certified EHR technology:

- in a meaningful manner, such as e-prescribing.
- for electronic exchange of health information to improve quality of health care.
- to submit clinical quality and other measures.

The criteria for meaningful use will be staged in three steps over the course of the next five years.

Stage 1 (2011 and 2012) sets the baseline for electronic data capture and information sharing. Stage 2 (expected/proposed to be implemented in 2014, rather than original date of 2013) and Stage 3 (expected to be implemented in 2015) will continue to expand on this baseline and be developed through future rule making.


For more detailed information and to review the requirements to demonstrate Meaningful Use, see the 051412 News Blast: E-Prescribing (eRx) and Meaningful Use Updates.

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**EHR WORKFLOW CONSIDERATIONS**

Going live with an EHR system requires many changes in the practice’s workflow. Mapping out how your practice documents information on paper charts to EHR ‘virtual charts’ will assist in a successful EHR implementation.

**WARNING: Be prepared for CHANGE**

**Consistent entry of patient data into the EHR system:**

Have a uniform plan for capturing data/information related to clinical visits to prevent missing a logical opportunity to capture patient data and save the additional cost and frustration of adding the data after the fact. Each provider has his/her own way of adding salient data into an EHR. Providers and staff should take the time to create templates within the EHR for the practice’s top disease diagnoses, i.e., hypertension, diabetes, heart disease, etc. as well as templates to assist in consistent Medical Records information/documentation. Include the fields necessary for the patient’s lab work and any screenings to be completed. The key is to have the templates prompt questions for the provider/staff to ask the patient. For instance, each template must include fields to indicate reason for the visit, what the patient wants addressed, review of systems and medical history to support the ‘History’ requirements of an encounter. Create the template in a way that makes it nearly impossible for the provider/staff to forget to ask the patient pertinent questions. Then proceed with Exam and Medical Decision Making template prompts, as well as prompts to document and capture other services provided to the patient.

**Develop a Process for EHR Messages:**

Develop a process to relay messages from the Front Desk to the Provider to replace the paper-based process for communication. EHR messages are separate from secure emails and operate more like computerized “sticky notes”. Some providers have staff direct any messages that require a medical decision to the provider and the practice support staff may handle the rest, including prescription refills, i.e., a nurse may procure information when a patient calls and send a Medical Decision ‘task’ to the provider via EHR.

Address the ‘Work Flow’ issues as part of implementation to avoid costly delays or frustrations once live. Contact MEDTRON’s EHR Team at 985-893-2550 for other tips to make the transition to EHR seamless for your practice.
Use MEDEHR to Achieve Meaningful Use (MU) (see Meaningful Use article page 4)

MEDEHR practices can meet the Meaningful Use measures related to ePrescribing (examples below) and all of the other MU measures. Refer to published User Guides regarding MU and how to meet each measure via MEDTRON’s EHR Resources website: http://www.medtronsoftware.com/MEDEHR_Resources/EHR_Resources.html.

Some examples of MEDEHR’s ability to meet MU measures includes those related to medications and/or ePrescribing: The objective of **MU Core Set Measure #1** is to use Computerized Provider Order Entry (CPOE) for medication orders. The objective of **MU Core Set Measure #4** is to generate and transmit permissible prescriptions electronically (eRx). The objective of **MU Core Set Measure #5** is to maintain an active medication list.

Eligible Providers (EPs) using MEDEHR to send permissible prescriptions electronically (eRx), are meeting MU Core set measures #1, #4, and #5. Prescriptions sent via eRx are CPOE coded medications and will automatically list under the ‘Medications’ section of the Facesheet tab thus updating patient’s ‘Medication List’. EPs can eRx via the Encounter Mgmt tab, ePrescribe tab, and/or via the Facesheet tab, ‘Medications’ section, ‘ePrescribe’ option.

Providers can add coded medications that are not sent electronically to the ‘Medication’ section via the Facesheet tab, ‘Add Coded Medication’ for paper prescribed medications and/or to add those prescribed by another provider to the ‘Medication List’.

If you are interested in signing up for MEDEHR to achieve Meaningful Use and possibly receive the incentive payments, contact MSI Sales Department via phone (985.893.2550) or email (sales@medtronsoftware.com).
LA MEDICAID AUDITS

Has your provider/practice received a notice for a Molina/DHH/SURS audit?

Don’t ignore these (or other) audit letters!

These letters are time sensitive and should be addressed upon receipt. Many times during the processing of Medicaid claims, requests are received requiring additional information from the health care provider. These requests could come from the carrier, Molina, or the Department of Health and Hospitals’ (DHH) Surveillance Utilization Review System (SURS); most letters are typically sent via certified mail.

NOTE: MEDDATA (MDS) clients should contact MDS immediately upon receipt of any audit letter, see MDS Reminders, Carrier Audits/Correspondence section.

In addition to submitting a rebuttal and possibly reducing the amount due, providers can negotiate a settlement of amounts due from an audit with reasonable payouts. Just be sure to respond timely to requests.

****LA MEDICAID PAYMENT SCHEDULE UPDATE****

LA Medicaid announced that there will be NO CHECKS cut for the week of June 24 – June 30th, 2012.

View the Revised FY 2012 Medicaid Check Write Calendar at: http://www.lamedicaid.com/provweb1/recent_policy/2012_Check.htm
A provider/practice’s first contact with a Recovery Audit Contractor (RAC) is likely to come in the form of a "Demand Letter". Demand letters dated prior to January 1, 2012 were sent from Connolly Healthcare; letters dated January 1st or later are sent directly from the states Medicare Contractor; LA - Pinnacle Business Solutions, Inc (PBSI); MS - Cahaba GBA [the contractor for LA/MS will be Novitas Solutions (formerly Highmark Medicare Services) effective August 13, 2012 for LA and October 22, 2012 for MS].

A complimentary ANSI ERA message code N432 is sent at the same time as the demand letter and introduces a new ICN/FCN. FCN is used for recording the Forward Balance (FB) and the Write Off (WO) per ERA.

NOTE: The new MAC for JH Transition buys the provider a 90 day ‘black out’ period for RAC Requests.

Connolly Healthcare has created a CMS Provider Portal that can be accessed by providers to follow the audit process. The CMS Provider Portal has recently been enhanced to be more user friendly.

To Access The Portal:
The portal is available via:
https://cmsprovider.connollyhealthcare.com/ProviderLogin.aspx

Complete fields:
*Provider State* → choose the state
*NPI/Medicare ID Number/Invoice Number* → Key the Medicare ID number, this information is found on the Insurance Provider Numbers screen.

At Insurance Company Master screen
F11 Provider Numbers
Medicare ID Number = Provider ID + last 4 digits of Clinic ID, i.e., Physician Ronald Regan = 5H645CA32

‘Enter a valid Claim Number/DCN’ → Key the ICN number from the letter received, i.e., the original ICN number

Click ‘Next’

Claims History presents only for the provider to which ‘Medicare ID Number’ was keyed during login process.

PBSI held a Medicare Part B RAC Webinar on June 14, 2012 (click), review the presentation for the latest updates.
**Hurricane Season is here.**

June 1 – November 30

The National Oceanic and Atmospheric Administration (NOAA) is expecting the 2012 Atlantic hurricane season to be a less active season compared to recent years. They are expecting 9 to 15 named storms, 4 to 8 hurricanes and 1 to 3 major hurricanes (top winds of 111 mph or higher).

Regardless of the outlook, MEDTRON/MEDDATA wants to encourage everyone to be prepared. Have a plan in place if your area comes under severe weather. Discuss your plan to stay safe with your family and be ready to implement your plan. Rest assured MEDTRON has an excellent Disaster Recovery Plan in place to provide continuous system connectivity.

Our best defense against a storm is PREPARATION! In an effort to assist your office to prepare for hurricane season, MEDTRON/MEDDATA is providing ‘Suggestions for Storm Preparation’:

IBM iSeries Clients

Timeshare/MEDDATA Clients

Contact our Technical Support Dept at tech@medtronsoftware.com for further assistance.

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**Federal/State Holiday Reminders**

**Upcoming Federal Holidays:**

- Independence Day, Wednesday, July 4th
- Labor Day, Monday, September 3rd

See 033012: News Blast State Holiday Reminder

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**Upcoming Events**

June 27-29th, 2012

MGMA of Mississippi Conference

IP Casino Resort & Spa

Biloxi, MS

[http://www.mgmams.com](http://www.mgmams.com)

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**Mark Your Calendar!**

MEDTRON’s office will be closed:

- July 4, 2012 in observance of Independence Day
- September 3, 2012 in observance of Labor Day

News Blasts will be published for the Statements schedule.