

From the CEO

Transitioning to a New Medicare Carrier

By Barbara Baldwin, M.P.H.



In 2008, the California, Nevada, and Hawaii Medicare Part B claims processing contract was awarded to Palmetto GBA, a Part B carrier for Ohio, South Carolina, and West Virginia. The transition, which took place mid-year, happened at a highly inopportune time because, in addition to the expected glitches associated with a massive turnover of data and systems, other CMS requirements were implemented around that time that also caused a perfect storm in claims processing.

One huge complication was due to the implementation of the NPI (National Provider Identifier) requirement in May, and claims submitted without them were rejected. Another was that a backlog of provider enrollment applications carried over from former Part B carrier NHIC's administration could not be processed timely, partly because the NPI file dropped thousands of provider records during the transition.

A December 10, 2008 Alert on the Palmetto GBA Web Site notes that it is in the final stages of processing Part B California provider enrollment applications received prior to September 2, 2008.

Provider Enrollment staff currently are contacting providers by phone to correct errors and obtain missing information. If the information is not obtained from providers, their applications will be rejected or returned and providers will be required to submit new enrollment applications. New applications will be processed in the order in which they are received.

New Local Coverage Decision

When a new contractor takes over Part B claims processing, the contractor must review the Local Coverage Decisions of states under its jurisdiction and, where conflicting policies, or no policy exists in some states but not in others, the carrier must adopt the least restrictive policy and apply it to all states.

A policy of particular concern to anesthesiologists is the new Monitored Anesthesia Care LCD. Before the transition, California did not have a MAC LCD. A MAC policy was in effect in Hawaii, which was then expanded to California and Nevada when the transition to Palmetto GBA took place. As the

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policy was implemented, many anesthesiologists were caught unaware, and, without the proper documentation, claims were rejected. The policy can be viewed in its entirety by going to the Web page at www.palmettogba.com/J1B and clicking on the Anesthesiology link. It states, in part:

MAC provided by qualified anesthesia personnel may be reimbursed for these procedures only when one or more of the following conditions are met:

1. It qualifies for use of HCPCS modifier QS:
 - MAC is appropriate for:
 - Combative patients
 - Patients with low pain thresholds or who experience severe pain
 - Situations where the surgeon anticipates the possible intra-operative expansion of a procedure
 - Any condition in a Medicare-eligible pediatric patient younger than 12 years of age
 - The patient has a physical status grade of P3 or higher noted in the medical record
 - This modifier may be submitted only with anesthesia procedure codes (i.e., CPT codes 00100-01999).
 - Submit HCPCS modifier QS to indicate that the anesthesia service performed was monitored anesthesia care.
 - This modifier is informational only. You must report actual anesthesia time on the claim.
 - Submit the HCPCS modifier indicating that the service was personally performed or involved medical direction or medical supervision first, and submit HCPCS modifier QS second.

The policy applies to Procedure Codes:

00100	00522	01730	99143
00124	00524	01780	99144
00148	00530	01916	99145
00160	00532	01920	99148
00164	00702	01922	99149
00300	00740	01935	99150
00400	00810	01936	
00410	00920		
00520	01420		

2009 Payment Rates

The unfair SGR calculation is an ongoing threat to all physicians. Last year brought a brief reprieve from mandatory reductions in payment rates. On July 15, 2008, the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) was signed into law. Section 131 of this Act provides an update to the Medicare physician fee schedule conversion factor of 1.1 percent (1.0110) for 2009. Absent congressional intervention last year, conversion factors would have been decreased by 10.1 percent. The 2009 California Participating Physician Conversion Factors for California are:

Area		Conversion Factor
26	Anaheim/Santa Ana	21.78
18	Los Angeles	21.80
3	Marin/Napa/Solano	21.22
7	Oakland/Berkeley	21.58
5	San Francisco	21.99
6	San Mateo	22.17
9	Santa Clara	22.05
17	Ventura	21.58
99	Rest of California	20.50

While fair payments are an overriding concern for physicians, other Medicare initiatives may affect physician practice profoundly. CMS is currently beginning development of a Plan to Transition to Medicare Value-Based Purchasing for Physician and Other Health Professional Services. The Plan was mandated by the Medicare Improvements for Patients and Providers Act of 2008. Medicare's quality initiative for physicians, PQRI, is the first step in establishing a value-based purchasing program for physician services. CMS is considering posting physician ratings on its Web site to make quality information available to patients.

An interim study of alternative payment localities under the Medicare Physician Fee Schedule entitled "Review of Alternative GPCI Payment Locality Structures" would, if implemented, adjust geographic adjustment factors for many areas. Conversion factors for California would be adjusted, with as much as a 7 percent increase in the lowest and no more than a 1 percent reduction in others.

The new administration will bring new ideas for health care reform that will affect health care under all systems, including Medicare. With many competing priorities, it remains to be seen when changes will be proposed—the only certainty being that the debate on the best solutions will continue.

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