


Iowa Medical Group Management Association

Panel of Payers

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RELATIVE VALUE UNIT CHANGES




- CMS published 6,747 RVU changes due to the health care reform bill and technical corrections
- Wellmark will not implement RVU changes
 - Budget impact of \$1 million would require changing conversion factors and already-published fee schedule
 - Specialty impact was less than 1% for all physicians except cardiology and E/M services were affected negatively

E/M Code	RVU Reduction	Wellmark Volume
99211	N/A	50,963
99212	N/A	434,387
99213	-.01	1,729,331
99214	-.02	465,557
99215	-.02	88,539
Total		2,708,775

- Love settlement does not allow for two fee schedule reductions in one calendar year

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CONSULTATION POLICY



- Wellmark will follow Medicare's policy to eliminate use of consultation codes
- Medicare eliminated consultations by
 - Increasing work RVUs for new and established office visits by 6%
 - Increasing work RVUs for initial hospital and facility visits by 2%
 - Increasing RVUs for interventional and surgical procedures with 10 and 90-day global periods which include E/M services
- Medicare's methodology makes it difficult not to follow their policy, including physician administrative burden for MSP claims
- Wellmark is able to minimize impact by
 - A significant increase to E/M RVUs and small increase to E/M conversion factor
 - Utilizing multiple conversion factors as all physicians perform a significant number of diagnostic tests and procedures. Both of these Wellmark conversion factors were increased significantly for July 2010
- If Medicare reverses its position, Wellmark will also follow that policy

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CONSULTATION POLICY

Office/Outpatient Consultation Crosswalk

Source	Destination	CMS Mapping
99241	99201	50%
	99211	50%
99242	99202	50%
	99212	50%
99243	99203	50%
	99213	50%
99244	99204	50%
	99214	50%
99245	99205	50%
	99215	50%

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CONSULTATION POLICY

Inpatient Consultation Crosswalk

Source	Destination	CMS Mapping	Wellmark Mapping
99251	99221	70%	97%
	99304	30%	3%
99252	99221	35%	21%
	99222	35%	77%
	99304	15%	1%
	99305	15%	1%
99253	99222	70%	98%
	99305	30%	2%
99254	99222	35%	49%
	99223	35%	49%
	99305	15%	1%
	99306	15%	1%
99255	99223	70%	99%
	99306	30%	1%


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- CONSULTATION POLICY**
- But our July 1 implementation was less than successful
 - The edit was not date of service sensitive
 - The denial message assigned member liability
 - We were able to stop the claims from processing with the exception of approximately 100 FEP claims which have been reprocessed
 - The edit to deny consultations has been loaded again successfully. Consult services with date of service July 1 will be reprocessed.
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iCAP CHANGES 


- Effective with claims processed after January 1, 2011, Blue Card claims will now be edited with the iCAP rather than ClaimCheck.
- Edits are typically date of service sensitive. However, in order to be able to process adjustments after turning off ClaimCheck, it is necessary to use process date.
- This change will provide consistent editing for all claims, including consistent modifier processing!

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TOP 10 REASONS FOR NOT USING THE WEB 


1. Easier to call – Prefer to talk to a person
2. Not Registered/No login available/Not logged in
3. Denial Not Specific/iCAP message code detail
4. Required to call – Must document name
5. Claim Adjustment needed
6. Do not know how to use web
7. Physical Medicine Benefits
8. Validate Web
9. Chiropractic Benefits
10. Web too complex

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DEVELOPING NEW ELECTRONIC OPTIONS 

- **Initiate a claim adjustment using a new online service**
 - Finalize claim adjustments within 24–48 hours
 - Attach documentation
 - Track the progress of your inquiry
- **Access one standard form for most Wellmark pre-service requests**
 - Select the service (e.g., the drug, surgical procedure, type of admission) you'll be prescribing or providing to drive your request
 - Receive responses via e-mail
- **View, print, and save a PDF of your Provider Claim Remittances (PCRs)**
 - Eliminate the paper PCR
 - Sort using *your* preferences (such as member name or account number)
- **Receive Wellmark payments via Electronic Funds Transfer (EFT)**
 - Eliminate paper checks
 - Receive payments sooner


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QUESTION 

Do you anticipate credentialing equipment? If so, will there be a minimum standard for CT equipment (i.e. 64 slice, etc.)?

- Yes, Wellmark currently credentials equipment in freestanding radiology centers. We anticipate starting to credential office-based radiology equipment in 2010-2011 to be followed by hospital-based equipment.
- And no, there is not a minimum technology standard. However, regardless of the technology, quality and safety standards must be met.


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QUESTION 

When billing for initial observation care and an observation discharge when the service spans two dates, we are getting denials that state the qualifying service is not on the claim. Our system only bills for one date of service per claim. How should we be billing for these?

- Without a specific example, it is hard to be certain but the most likely scenario is the edit below. The claims could be processing out of sequence.
 - If 99217 (observation discharge) is billed and 99218-99220 (observation admit) has not been billed by any provider in the past 3 days, then deny 99217.

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QUESTION 

Why won't you pay for both a transvaginal and transabdominal ultrasound when done during the same session? The order from the physician states they want both.

- The ACR's *Ultrasound Coding User's Guide* states that the pelvic ultrasound using a full bladder as a window to the pelvis and a transvaginal ultrasound using a vaginal probe as a window to the pelvis are separately coded procedures when necessary.
- This has been a long-standing ACR coding guideline published in the October 1993 *Radiology Business Management Association Bulletin* in an article titled "Transvaginal Sonogram of the Pelvis"
 - "In order to properly evaluate a patient it is often necessary to perform additional studies during one session. These studies are done in order to acquire additional clinical information not evident from the initial study, or to further investigate an area that appears suspicious or problematic. Performing a transabdominal and a transvaginal pelvic sonogram at one sitting is an example of this type of evaluation.

Examples of when both may be appropriate:

If a woman has vaginal bleeding, a transvaginal scan is needed to assess the endometrium at higher resolution than that available with the transabdominal probe. If an adnexal mass is visualized, a transvaginal examination allows for improved characterization of the internal characteristics of the mass. When coding for both transabdominal and transvaginal studies in a single setting, it is important for the report to clearly state the indication for performing the second examination, for example, for better assessment of the endometrium and/or adnexa."

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