A Message
From
IPMS

Robert Wenz
Dermatology
Account Manager

Happy New Year! I hope you and your families had a wonderful holiday season.

It is hard to believe that 2008 is our third year of publishing IPMS Newsletters! We plan to continue to bring you the most up-to-date information to keep you in the know for the year to come.

We look forward to working with you to achieve the goals set forth and wish you all a Happy and Healthy New Year!

DEPARTMENT OF SOCIAL SERVICES AND EDS
CONNECTICUT INTERCHANGE MMIS
SYSTEM CHANGES IN 2008

The Department of Social Services (DSS) and EDS rings in the New Year with changes to the Connecticut interChange MMIS. According to the recent workshop offered by DSS and EDS, the MMIS system was “originally designed to handle paper claims and track eligibility.” Currently MMIS is used to verify client eligibility, process healthcare provider claims and address a variety of DSS Medical Assistance Program business needs. The current MMIS system has become more costly to maintain and the technology is outdated. Due to this, the Connecticut MMIS updates will begin in January 2008.

Take note of the following important dates:

- **1/5/08** – The new website will be available. [www.ctdssmap.com](http://www.ctdssmap.com) will be replacing the current website [www.ctmedicalprogram.com](http://www.ctmedicalprogram.com).
- **1/11/08** – All new enrollment requests and current provider updates received after this date will be processed in the new IC system.
- **1/17/08** – Web User ID letters will be mailed on YELLOW mailer. Be on the lookout for this information. It will be required to create your new secure Provider Web account.
- **1/19/08** – PIN letters mailed on RED mailer. Be on the lookout for this mailer. This will be your password information, needed, in addition to the User ID, to create your new secure Provider Web account.
- **1/24/08** – As of 8pm OMNI devices are no longer supported by the current MMIS. DSS bulletin dated September 2007 offers 2 free alternatives. (1) Submit client eligibility verification via the DSS free Provider Electronic Solutions Software, or (2) through their website. Providers interested in purchasing the new POS device may contact MedData directly at 1-800-233-7768. General information for this device can be found on the MedData website [www.spotcheck.com](http://www.spotcheck.com). EDS is not the contact for MedData product support. Any questions regarding the MedData POS device should be directed to MedData.
- **1/25/08** – First day to set up Provider user accounts in the IC Web portal [www.ctdssmap.com](http://www.ctdssmap.com). This is the time to create your Provider Web User Account and Clerk Accounts, using the ID (received under yellow cover) and PIN (received under red cover).
- **2/2/08** – Last day the current website, [www.ctmedicalprogram.com](http://www.ctmedicalprogram.com), will be available.
- **2/4/07** – Provider Assistance Center Updates Effective: (in-state toll free) 800-842-8440, (NEW - local to Farmington, CT) 860 269-2028, (NEW – fax) 860-269-2033.

For further information regarding the Connecticut interChange MMIS go to [http://www.ctmedicalprogram.com/interChange.html](http://www.ctmedicalprogram.com/interChange.html).

—Michele Krpata, Training Specialist
If your diagnosis coding fails to support medical necessity for the services and procedures provided, carriers can deny the claims outright or may require repayment (along with fines or even fraud investigations) at a later date. Even when a procedure or service is medically necessary and appropriate, faulty ICD-9 coding can derail the claim. Here are some helpful tips to use when diagnosis coding.

- **Think Accuracy First, Medical Necessity Later**
  As always, you should strive to report ICD-9 codes that accurately and completely describe the patient’s condition as supported by the physicians’ documentation. Never assume that a diagnosis applies. Be sure that there is sufficient information in the encounter or operative note to support any ICD-9 codes you assign. If documentation is unclear, ask the reporting physician for guidance.
  
  At the same time, you should always be sure that you report a diagnosis to the highest available and supportable specificity level. Including fourth and fifth digits, when available, to any ICD-9 codes you report is very important for both proper coding and timely payment.

- **Use as Many Codes as Needed and Be Specific**
  With the physician’s documentation as your guide, you should bill as many diagnosis codes as you need to establish medical necessity for the services you are billing. Medicare guidelines now allow up to eight ICD-9 codes on a claim.

  Remember, also, that you should always report diagnoses to the highest available degree of specificity. You should never report a category (three-digit) or subcategory (four-digit) code when ICD-9 lists more specific codes under those headings.

By just implementing these tips into your diagnosis coding you can be confident that your claims are coded with accuracy and compliant according to CMS guidelines.

—Tina Scavetta

**WILL MEDICARE PAY?**

There’s a way to find out—and in advance too! It’s by way of Fee Schedule Status Indicators—a feature of the Medicare Physician Fee Schedule. When viewing that fee schedule, take note of a very narrow column that lists a one-letter status code. This status indicator provides a great deal of information about how Medicare pays for the particular service. Some are described below:

- **Procedure Status “A”**
  The majority of codes have an “A” status indicator, meaning that the code is active and payable on the Physician Fee Schedule.

- **Procedure Status “C”**
  “C” status means that the service is carrier priced, indicating that Medicare does not provide RVU amounts for the procedure.

- **Procedure Status “E”**
  Status “E” indicates that these are excluded by regulation from the Medicare Physician Fee Schedule. Payment is not made under the fee schedule for these codes.

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YOUR GUIDE TO THE MOST COMMON PLACE OF SERVICE CODES

Choosing the correct place-of-service (POS) code for your claims is essential to avoiding denials. Here is an easy guide to keep handy when choosing your POS codes:

- **11 (Office)** – Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, state or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis and treatment of illness or injury on an ambulatory basis. Fair market value for the office must be paid for this office to qualify for an office and POS 11.
- **21 (Inpatient Hospital)** – A facility, other than psychiatric, that primarily provides diagnostic, therapeutic (both surgical and nonsurgical) and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.
- **22 (Outpatient Hospital)** – A portion of a hospital that provides diagnostic, therapeutic (both surgical and nonsurgical) and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
- **23 (Emergency Room – Hospital)** – A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.
- **31 (Skilled Nursing Facility)** – A facility that primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing or rehabilitative services but does not provide the level of care or treatment available in a hospital.
- **32 (Nursing Facility)** – A facility that primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care services above the level of custodial care to other than mentally retarded individuals.
- **33 (Custodial Care Facility)** – A facility that provides room, board and other personal assistance services, generally on a long-term basis, and does not include a medical component.

Basically, for every CPT code, there is a correct place of service code that corresponds to it. If these medical codes are used incorrectly in billing, it will cost your practice time and money. Insurance companies will deny the claims and your office will have to correct the problem. At IPMS, your claims are checked before they go out the door to ensure the correct billing procedures are used for every medical service performed and we check claims for accuracy before they are submitted to the carriers. Make sure you’re maximizing your reimbursements with the correct POS codes.

—Tina Scavetta

WILL MEDICARE PAY? (continued from page 2)

- **Procedure Status “I”**
  "I" indicates that Medicare does not recognize codes assigned this status. Medicare uses another code for reporting of, and payment for, these services—such as a HCPCS Level II code.
- **Procedure Status “N”**
  “N” indicates that this is a non-covered service. Medicare payment may not be made for these codes.
- **Procedure Status “P”**
  A “P” in this column indicates codes that are considered to be bundled or excluded by Medicare.

You may access the status and PC/TC indicator columns yourself on Medicare’s website at [www.cms.hhs.gov/PFSlookup/](http://www.cms.hhs.gov/PFSlookup/). Select “Physician Fee Schedule Search”, then select “Payment Policy Indicators” from the heading “Type of Information”.

—Sharon Donelli
WHAT OUR HIGHLY VALUED CLIENTS HAVE TO SAY ABOUT IPMS . . .

“I have been outsourcing my medical billing for ten years and have been disappointed with both my A/R as well as the care and treatment given to both my patients and my staff by previous billing companies. The professionalism exhibited, the excellent results obtained, the personal care to my patients and myself is outstanding . . . I could not be more pleased with IPMS.”

~Rand L Werbitt MD
Dermatologist
Stamford, Connecticut