

The Montana Chiropractor

December 2011

President's Letter

Marcus Nynas, DC



Bah Humbug. Or was that Merry Christmas? Either way I hope your holidays were enjoyable and travel was safe and uneventful for you and yours.

At the board level we had a conference call recently putting finishing touches on next year's convention and starting to prepare for the upcoming elections. Again if you know a legislator or candidate personally please let us know so we may provide some support from the association.

I attended the COCSA convention in Dallas as the MCA president. That's the Congress of Chiropractic State Associations. It's an interesting group think tank where we share ideas, problems and solutions to what's happening in our states and regions on a national level. Trying to whittle down the notes I took I believe the most important thing in your practice is that we all will have to re-enroll in Medicare in 2012. There will be a big envelope mailed to your office that you need to watch for. Otherwise there was a lot of discussion about legislative and legal issues.

As always feel free to contact your board members or staff if you have questions or concerns, or would like to be included on committees. We do value your input.

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Welcome New MCA Member

Vione Standish, DC
Pray, MT



Attorney/Lobbyist Report

Mark Staples, MCA Legal & Legislative Counsel

Seasoned legislative hands will point out to you that a fair number of legislators are farmers/ranchers, another solid bunch are teachers, and yet another group are state or local employees, not to mention the large contingent of lawyers.

What do you think that does in terms of power for those folks' peers in their professions? In a word...lots!

Likewise, there are M.D.'s, nurses, contractors, and even a D.V.M. There is however, a profession without one single representative in the legislature...yours!

For our size and financial limits we have done very well over the years, but if we actually had one of our Chiropractic leaders in the legislature, or better yet, two or three or more,

your public policy reach would be immeasurably fortified and the understanding of your role in the health care universe greatly expanded.

If one of you would ever consider giving the legislature a go, please talk to me. Yes, its a sacrifice, but every legislator I've ever known thought the sacrifice was well worth it, and far outweighed by what they all call a life-changing experience.

If the idea even piques you a bit, let's talk. I'll go through the plusses and minuses with you and give you an honest assessment whether I think you'd have a fair chance to win in your area and have the temperament to serve if you're elected. Give it a thought. It would serve your community, your State, your profession and yourself.

Reminder from the Montana State Fund: Change to ACS for WC Processing and Payments

Peter Strauss, Vice President, Operations Support, Montana State Fund

Montana State Fund is changing from CorVel to ACS for WC medical bill processing and payments effective January 1, 2012.

877 - 591 - 8028 is the new dedicated number for medical offices to contact ACS regarding MSF WC bills and payments. Do not call the ACS number you have for Medicaid bill processing, for workers compensation bill inquiries.

CorVel is concluding their processing this week, and should have everything just about completed. ACS will start processing bills effective with the first business day of the new year, January 3, 2012. First checks from ACS should start going out the next week as MSF Claims Examiners approve payments that first week of the year.

For bills that were received by MSF through December 12 (not based on date of service, but date of receipt), offices should call CorVel if they have questions. After January 1, offices can call the new dedicated ACS MSF WC bill line, 877 -591 -8028, with questions they may have. MSF will

pay all bills appropriate for payment at the appropriate levels under the workers' compensation rules; however, December payments or denial decisions for bills that arrive at MSF after December 12 will take longer than usual to process. Our goal is to minimize the delay, but we cannot eliminate it

We appreciate the patience medical offices have had with us during the transition, and expect most of the delay issues to be resolved by the end of January. This delay at the end of this year is not typical and is only related to this transition. ACS Medicaid bill processing for the state, and the MSF WC bill processing are two separate operations and share only corporate ownership.

Offices do not have to make any changes to their billing process. Bills should still be sent to MSF, as they are today. The only change will be the company processing the bills and issuing checks on our behalf. For questions during the transition period, contact Peter Strauss at 495-5370 or Bridget McGregor at 495-5277.

SpineMED Table For Sale

We are selling our SpineMED Spinal Decompression table purchased in 2007. It has both the lumbar and cervical components. The table is in near new condition and used very little. The '07 units list for \$39,000 on ebay and we're asking \$26,000.

Phone: 406-862-7891
Email: flipchiropractic@yahoo.com



Health Care Providers Should Prepare Now for the Version 5010/ICD-10 Transition. Will You Be Ready?

Article Submitted by CMS Denver Regional Office



Are you prepared for the U.S. health care system's change from ICD-9 to ICD-10 diagnosis and procedure codes? The switch to ICD-10 takes effect on October 1, 2013. Leading up to the October 1, 2013, compliance date, there are other important dates:

- Beginning January 2011, providers should begin testing Version 5010 transaction standards with their trading partners
- January 1, 2012, the date for Version 5010 compliance

Prepare now to avoid potential reimbursement delays. If you do not use Health Insurance Portability and Accountability Act (HIPAA) Version 5010 transaction standards starting January 1, 2012, and ICD-10 codes when submitting claims with dates of service on or after October 1, 2013, your claims may not be paid.

What's Changing and Who Is Affected?

Unlike ICD-9 codes, ICD-10 diagnosis codes are alphanumeric, have 3 to 7 digits, and are much more descriptive. ICD-10 will affect diagnosis and inpatient procedure coding for everyone covered by the HIPAA, not just those who submit Medicare claims. This change does not affect Current Procedural Terminology (CPT) coding for outpatient procedures.

In addition to the code set changes, standards for electronic administrative transactions (such as eligibility inquiries and remittance advices) are being updated from the current Version 4010/4010A1 to Version 5010 on January 1, 2012. Version 5010 accommodates both the ICD-9 and the ICD-10 code set structures. To allow adequate time to meet the January 2012 implementation date, providers should begin testing Version 5010 with their trading partners starting in January 2011. Providers who use practice management software, a clearinghouse, third-party biller, or some other way to transmit information between themselves and a

health care plan, will need to upgrade their software or work with a clearinghouse or billing service whose systems can accommodate both the Version 5010 standards and the ICD-10 code sets.

Preparing for the Version 5010/ICD-10 Transition

Start with a gap analysis to determine the impact on your organization of both Version 5010 and ICD-10. Use that information to develop an implementation plan, with a detailed timeline, and estimate of costs. Providers should take the following steps now:

- **Check with your billing service, clearinghouse, or practice management software vendor.** Your third-party biller and clearinghouse need to make sure that you will be compliant by the deadlines. Software vendors should be developing and testing products that will enable Version 5010 testing with your payers and billing services starting January 2011. Testing with ICD-10 should start sometime after Version 5010 implementation in January 2012, to allow for full ICD-10 implementation on October 1, 2013.
- **Start planning to implement the ICD-10 transition.** Meet with your professional and support staff. Discuss where codes are used within your organization to help you assess impact. Assign roles and responsibilities for addressing the transition.
- **Identify needs and resources.** Consider changes that might be required. Develop a budget and timeline that take into account specific workflow needs, vendor readiness, and staff knowledge and training.

Version 5010/ICD-10 Resources

There are many professional, clinical, and trade associations offering a wide variety of Version 5010 and ICD-10 information, educational resources, and checklists. Check the Web sites of your associations and other industry groups, or call them, to see what resources are available.

The Centers for Medicare & Medicaid Services (CMS) Website, www.cms.gov/ICD10/, has official CMS resources to help you prepare for Version 5010 and ICD-10. CMS will continue to add new tools and information to the site throughout the course of the transition.

2010 PQRI Feedback Reports are Now Available

Susan McClelland, FICC, McClelland Consulting LLC

The Centers for Medicare and Medicaid Services (CMS) is pleased to announce that the 2010 Physician Quality Reporting Initiative (PQRI) feedback reports are available for download on the Physician and Other Health Care Professionals Quality Reporting Portal (the Portal) available at <http://www.qualitynet.org/pqri>.

Holding of 2012 Date-of-Service Claims for Services Paid Under the 2012 Medicare Physician Fee Schedule

*Susan McClelland, FICC,
McClelland Consulting LLC*

The negative update under current law for the 2012 Medicare Physician Fee Schedule is scheduled to take effect on Sunday, Jan 1, 2012. Consequently, as on numerous occasions in the past, CMS will instruct its Medicare claims administration contractors to hold claims containing 2012 services paid under the Medicare Physician Fee Schedule for the first 10 business days of January 2012 (i.e., Sun Jan 1 through Tue Jan 17). The hold should have minimal impact on provider cash flow because, under current law, clean electronic claims are not paid sooner than 14 calendar days (29 days for paper claims) after the date of receipt.



Medicare Physician Fee Schedule claims for services rendered on or before Sat Dec 31 are unaffected by the 2012 claims hold and will be processed and paid under normal procedures and time frames.

The Administration is disappointed that Congress has failed to pass a solution to eliminate the sustainable growth rate (SGR) formula-driven cuts, and has put payments for health care for Medicare beneficiaries at risk. We continue to urge Congress to take action to ensure these cuts do not take effect.

CMS will notify you on or before Wed Jan 11, 2012, with more information about the status of Congressional action to avert the negative update and next steps regarding the claims hold.

Summit GR Committee Update on the ACO Final Rule

Article Submitted by COCSA

CMS released their final rule regarding the CMS Shared Savings/Accountable Care Organization Program. As you will recall, in May the Summit Government Relations Committee drafted a comments template for use by states in response to the proposed rule. The major argument made in our comments was that DCs should be eligible to participate in ACO's and be able to share in any savings and bonuses achieved by the ACO. In CMS' final rule, CMS indicated that nothing would "preclude Medicare enrolled chiropractors from participating in ACOs, or from sharing in the savings that an ACO may realize in part because of the quality and cost-effective services they may be able to provide."

In addition to recognizing that DCs should be able to fully participate in ACOs, CMS also noted the strong response of the chiropractic profession in response to the Proposed Rule. CMS stated, "We received many comments from chiropractors and chiropractor associations recommending that the definition of ACO professional for purposes of the Shared Savings Program should be expanded to include chiropractors. These commenters cited the quality and cost efficiency of chiropractic services, and many also cited other statutory definitions of "physician" as precedents for including chiropractors within the definition of "physician" under the Shared Savings Program."

I believe this is a HUGE win for the profession. We went from just being a potential part of the ACO team to actually being able to "sharing in the savings that an ACO may realize." CMS made a number of other changes to the program in an effort to increase participation in ACOs. We are still working through the complete rule, and will report more at a later date.

CMS Launching Medicaid.gov Website

Article Submitted by CMS Denver Regional Office

The Center for Medicaid and CHIP Services (CMCS) is pleased to announce the initial launch of <http://medicaid.gov>, the first Federal government website devoted to the policies -- and the people -- of Medicaid and the Children's Health Insurance Program (CHIP). This website is the culmination of efforts at the Center for Medicaid and CHIP Services to revitalize and reorient the information the Federal government makes available about these programs. As part of our commitment to transparency and information sharing, *Medicaid.gov* brings to the forefront the items that States, the health policy community and other stakeholders have said they care about most, including: our Federal policy guidance; lists of pending and approved waivers; highlights of our Affordable Care Act implementation efforts; State-specific program information and data; and improved search capabilities.



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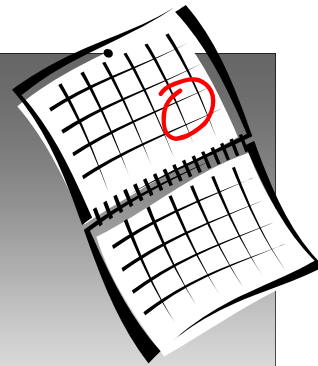
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**FEATURING:
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