Welcome!

The UMWA Funds has been a partner with providers in caring for many UMWA families since 1946 and has been the Medicare Part B payer for Funds beneficiaries for over forty years. We are introducing this newsletter as a way to offer information that will help you keep informed of changes in the Funds and to highlight resources available to you. It will also include information about changes to the Medicare program and ways your practice can comply with and benefit from those changes.

Most Funds beneficiaries are Medicare eligible and, as their Part B payer, the Funds is required to comply with the many requirements of that program. Some of you participated in a recent Medicare claims audit of the Funds. We appreciate your cooperation and are pleased with the quality of documentation you provided.

The Funds has a dedicated phone number for phone inquiries about eligibility and claims, direct Internet inquiry to claims and payment status and Provider Representatives who can assist you with larger questions or issues. The Funds has a team of professional nurses, social workers, and in-field representatives living in our beneficiaries’ communities who can help patients access community services and comply with your health care directives.

We welcome you to this inaugural UMWA Funds provider newsletter. If you have questions or suggestions, please forward them to:

provider.relations@umwafunds.org
or
call (804) 335-1904

Thank you,

Keith Holly,
Director, Network Development and Provider Relations
Ambulance Claims

How to Bill Fractional Miles

In 2011, CMS established a new procedure for reporting fractional mileage amounts on ambulance claims to improve reporting and payment accuracy. Effective January 1, 2011, all Medicare ambulance providers and suppliers are required to bill mileage that is accurate to a tenth of a mile.

NOTE: Currently, the hardcopy UB-04 form cannot accommodate fractional billing, therefore, hardcopy billers will continue to use previous ambulance billing instructions provided in effect prior to January 1, 2011, that is, providers that are permitted to file paper UB-04 claims will continue to round up to the nearest whole mile until further notice from CMS.

Effective for claims with dates of service on and after January 1, 2011, ambulance providers and suppliers must report mileage units rounded up to the nearest tenth of a mile for all claims (except hard copy billers that use the UB-04):

- For mileage totaling less than 100 covered miles, providers and suppliers must submit fractional mileage using a decimal in the appropriate place (e.g., 99.9). Medicare contractors will truncate mileage units with fractional amounts reported to greater than one decimal place (e.g., 99.99 will become 99.9 after truncating the hundredths place).

- For trips totaling 100 miles and greater, providers and suppliers must continue to report mileage rounded up to the nearest whole number mile (e.g., 999). Medicare contractors will truncate mileage units totaling 100 and greater that are reported with fractional mileage; (e.g., 100.99 will become 100 after truncating the decimal places).

- For mileage totaling less than 1 mile, providers and suppliers must include a “0” prior to the decimal point (e.g., 0.9). For ambulance mileage HCPCS only, Medicare contractors will automatically default to “0.1” unit when the total mileage units are missing in Item 24G of the CMS-1500 claim form.

Signature and Authentication

Please remember, in order for the documentation on the trip ticket or other supporting documentation to be considered, the documentation must be legible, signed and appropriately authenticated.

The Funds follows Medicare guidelines for authentication. If hand-written records are not legible, please also submit a typed or printed version of the record reflecting its content word-for-word.

Ambulance personnel must always sign records to include credentials (EMT, EMT-I, EMT-P, etc). Ambulance company signature logs must be made available with start date, end date of employment, credentials, and provided when medical records are requested for review or audit.

To learn more about signature and authentication guidelines, please go to:

Durable Medical Equipment Network

The Funds Durable Medical Equipment (DME) Network consists of the following seven vendors who offer both local and national service to Funds beneficiaries:

• American HomePatient
• Appalachian Regional Healthcare
• Community Home Care Services, Inc.
• Cooley Medical
• Home Care Alliance of Virginia
• Medical Services of America (Medi Home Care)
• Progressive Medical

The DME Network is exclusive for DME equipment and some supplies. All equipment and diabetic and incontinent supplies must be purchased from one of these seven providers. Beneficiaries are not limited to the Network when obtaining other types of medical supplies, but are encouraged to do so. DME services provided while a beneficiary is in a hospital, skilled nursing facility, rehabilitation facility, or hospice are not subject to the program.

DME that is rental and rent to cap or over $300.00 must be pre-certified by the Funds medical management reviewer.

Medicare Signature Requirements for Patient Health Records: What You Need to Know

Many of you may have worked with the Funds in a recent audit by Medicare. From this experience, we would like to take this opportunity to alert providers of the signature and authentication requirements utilized by Medicare for medical review. Providers submitting claims for Medicare reimbursement may be required to submit medical documentation from time to time for medical review or post payment audit to ensure claims are being paid appropriately. Documentation which is legible, complete, appropriately authenticated and support medical necessity for services reported on the claim is required. The medical reviewers will be reviewing the documentation based on the guidelines summarized below.

☐ You must be familiar with your Local Coverage Determination (LCD) policy on authenticating records as these policies will take precedence over the guidelines below.

☐ If your LCD does not have specific signature requirements regarding the legibility and presence of a signature, your reviewer may follow the guidelines below to determine the identity and credentials of the signator.

Guidelines for Determining the Identity and Credentials of a Provider

☐ If, in the course of a patient health record review, a signature is found to be illegible, the reviewer will look for a signature log or attestation statement to determine the identity of the provider.

☐ A signature log includes a list of the typed or printed name(s) of the author(s) of the associated initials or illegible signature(s).
ICD-10 Update

The International Statistical Classification of Diseases, 10th Revision (known as “ICD-10”) is a code set of more than 14,400 different codes. The United States was set to begin official use of ICD-10 on October 1, 2013; however, on August 24, 2012, the US Department of Health and Human Services (HHS) announced a final rule that delays the adoption of ICD-10 until October 1, 2014.

New ICD-10 Implementation Handbooks Now Available

The Centers for Medicare & Medicaid Services (CMS) has developed Implementation Handbooks as resources to assist with the transition from ICD-9 to ICD-10 codes. Each guide provides detailed information for planning and executing the ICD-10 transition process. The appendix of each handbook references relevant templates which are available for download in both Excel and PDF files. The templates are customizable and have been created to help entities clarify staff roles, set internal deadlines/responsibilities, and assess vendor readiness.

You can view the step-by-step plans and relevant templates by going to: www.cms.gov/ICD10/02b Latest News.asp

- The signature log can be included on the page where the initials or signature are present, or may be in a separate document.
- All signature logs should be considered regardless of the date the log was created.

Attesting to a Signature’s Validity

- Providers can include an attestation statement in the documentation they submit.
- Only the author of the medical record can attest to the record in question.
- Attestations will be accepted by reviewers regardless of the date of the attestation, except in those cases where the regulations or policy indicate that a signature must be in place prior to a given event or a given date. For example, if a policy states the physician must sign the plan of care before therapy begins, an attestation can be used to clarify the identity associated with an illegible signature but cannot be used to “backdate” the plan of care.
- CMS recommends that, rather than backdating a patient health record, providers should use the signature authentication process explained below.

- In some situations, a provider may be contacted by a contractor and asked to submit an attestation statement or signature log.
- To be valid for Medicare medical review purposes, the attestation statement must be signed and dated and contain sufficient information to identify the beneficiary. An example is included below:

  “I, _______________[print full name of the physician/practitioner] __________, hereby attest that the medical record entry for _______ [date of service]_______ accurately reflects signatures/notations that I made in my capacity as ______ [insert provider credentials, e.g., M.D.]______ when I treated/diagnosed the above listed Medicare beneficiary. I do hereby attest that this information is true, accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to administrative, civil, or criminal liability.”
To ensure that Funds beneficiaries receive the greatest value for their drug benefit dollar, the following method(s) of drug distribution are preferred whenever possible:

**Specialty Medications**
For specialty drugs such as those used for rheumatoid arthritis, leukemia and multiple sclerosis, the Funds preferred pharmacy is CVS Caremark’s Specialty Pharmacy. Nurses and pharmacists serve as a liaison between you and the Funds beneficiary to assure maximal effectiveness of therapy through proper adherence, storage and monitoring of the specialty medication. The medication can be delivered directly to the beneficiary’s home or to your office. With the beneficiary’s consent, you may enroll a Funds beneficiary in the CVS Caremark Specialty Drug Program by calling **1-800-237-2767**.

**Retail and Mail Service Pharmacies:**
A Funds beneficiary may choose any one of over 64,000 pharmacies to fill his or her prescription. For many Funds beneficiaries it is most cost-effective to fill prescriptions at the Funds preferred mail service pharmacy, CVS Caremark Mail Service Pharmacy. If the beneficiary has enrolled in the mail order program, you may order a 90 day supply of maintenance medications for them by:

- **Telephone:** 1-800-294-4741, option #1
- **Fax:** 1-877-278-0328

**Preferred Product and Generic Savings Program:**
Out-of-pocket expenses are lower for Funds beneficiaries if generic medications are prescribed when available. Prescribing a non-preferred medication may require that the beneficiary pay a higher amount. For 2012, the Funds has four (4) therapeutic categories of drugs that include preferred medications. The therapeutic categories included in the “Preferred Product Program” are: (1) GI drugs; (2) Cholesterol drugs; (3) ARBs; and (4) Sedative hypnotics. To obtain a listing of these and/or a Funds-specific pocket formulary, please call **1-800-291-1425**.

**Did you know? The Funds will provide non-emergency transportation**
The Funds Non-Emergency Transportation Program provides beneficiary transportation to physicians’ offices, dialysis, and other health-related treatment facilities when other means of transportation are not available. The Funds’ Transportation Desk helps to find transportation services in the local community and substitutes appropriate alternative methods of transportation depending on the needs of the beneficiary. Alternative transportation includes van transport, wheelchair vans, community transportation services and taxis. In some cases, reimbursement to family or friends is provided for the mileage driven for transportation to the closest health care facility when the service is medically justified by a physician and the beneficiary has no other means of transportation.

Beneficiaries and providers can call **1-800-292-2288** and select option 4 to reach the Non-Emergency Transportation staff for assistance and more information.
Effective October 1, 2012, the arrangement between the Funds and the Department of labor (DOL) ended. This means claims for the treatment of black lung submitted on or after that date (regardless of date of service) for these beneficiaries must be submitted to DOL at the following address:

DCMWC, P.O. Box 8302, London, KY 40742-8302

All claims for treatment of black lung for beneficiaries who have black lung benefits through DOL must be sent to the DOL Black Lung Program. This does not include claims for beneficiaries who receive black lung benefits from programs other than the DOL Black Lung Program. Beneficiaries receiving benefits through the DOL Black Lung Program should be presenting their new black lung card whenever they receive services from health care providers. This card contains information on registering as a black lung provider, billing information, and contact information for the DOL Black Lung Program.

The Funds will continue to process claims for services and supplies not related to black lung. A separate claim must be submitted to the Funds claim processing address you currently use for these services and supplies.

DME Network providers should continue with the established policy for submitting claims to DOL, as there has been no change. Effective October 1, your billing instructions may change for claims that are submitted for your Black Lung patients. For the most recent billing updates from the DOL Black Lung Program, please log on to:

http://owcp.dol.acs-inc.com

DOL Black Lungs’ latest billing developments are posted on the right side of the page. Of particular interest is the DCMWC billing update regarding how DOL Black Lung will reimburse physicians based on the first diagnosis on the HCFA-1500.

If you have any questions, you may contact the Funds at 1-888-865-5290.

Reminder of Change in the Submission of Black Lung Claims

If you are not already registered with DOL as a Black Lung Provider, you must do so. Please contact DOL at 1-800-638-7072 for instructions or go to www.dol.gov/owcp/dcmwc/regs/compliance/blcbpoutreach.htm for further information.