



PRC MEDICAL

**Monthly Newsletter
OCTOBER 2009**

Please route to appropriate staff

Newsletter access is also available at www.prcmedical.com or through the help menu on StreamlinePM+. If any of the links in this newsletter do not work, please copy and paste them into your browser.

SPECIAL ANNOUNCEMENT

INTRODUCING OUR NEW NAME, LOGO, AND WEBSITE

We are proud to announce our new business Name, Logo, and Website. Effective October 1, 2009, Professional Receivables Control is now doing business as PRC Medical. Our new logo is above, and our new website address is www.prcmedical.com. Please visit our new site to learn more about PRC Medical.

- **New domain name means new email addresses:** All PRC staff email addresses are now first initial, last name @prcmedical.com (mbiller@prcmedical.com). Old email addresses will forward to new email addresses for next few months.
- **New Practice Management System Name:** PRC is retiring the Electronic Ledger File (ELF) brand. Our practice management product name is StreamlinePM+. You will notice this change when you login to our practice management system. StreamlinePM+ is more than the typical practice management software – it's hosted, includes all day closes and backups, includes integrated HIPAA-compliant claims management, and includes patient statement & letter processing.
- **Electronic Medical Records (EMR):** Effective May 2009, PRC offers EMR services. Our StreamlineEMR is CCHIT-Certified, highly rated, and can be integrated with StreamlinePM+. Please call 866-406-2224 to schedule a demonstration.



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CMS LINK TO PANDEMIC FLU

This site will be continually updated with important information from CMS on any Influenza Pandemic Emergency. http://www.cms.hhs.gov/Emergency/10_PandemicFlu.asp

NEW CODES TO BILL H1N1 VACCINE

Since they are saying the vaccine will be available by mid-October here is how to bill for the administration of the H1N1 vaccine.

The Centers for Medicare & Medicaid Services (CMS) has created two new HCPCS codes for H1N1:

- HCPCS code G9141 - Influenza A (H1N1) immunization administration (includes the physician counseling the patient/family)
- HCPCS code G9142 - Influenza A (H1N1) vaccine, any route of administration

Payment for G9141 (Influenza A (H1N1) immunization administration, will be paid at the same rate established for G0008 (Administration of influenza virus vaccine). Use the diagnosis V04.81. The same billing rules apply to the H1N1 virus vaccine as the seasonal influenza virus vaccine with one exception. I gave you the G9142 information above but the H1N1 vaccine will be made available at no cost to you so Medicare will not pay providers for the vaccine. **You do not need to place the HCPCS code G9142 (H1N1 vaccine code) on the claim. However, if HCPCS code G9142 appears on the claim, only the claim line will be denied.**

You can not bill for an office visit if the only reason for the encounter is to give the patient the H1N1 vaccine. This has always been the case and does not change with H1N1.

ICD-9-CM UPDATE

Are you using the new updated diagnosis codes? October 1 is the required date to change to the new updated codes. If you aren't using the correct codes by the October 1, your claims will be denied.

CMS OFFERS INFORMATION ON THE NEW ICD-10-CM

On June 23, 2009 CMS offered a teleconference on the new ICD-10-CM. It covered a lot of information and if you missed it you can get the transcript at:

http://www.cms.hhs.gov/ICD10/06a_2009_CMS_Sponsored_Calls.asp

DIAGNOSTIC TESTS ALLOWED FOR ESRD

CMS has a list of specific diagnostic tests that are deemed payable under the Medicare program with relation to End Stage Renal Disease (ESRD). These tests were omitted from the original manual directives.

You can view the list at: <http://www.cms.hhs.gov/Transmittals/downloads/R1763CP.pdf>

CONSIDERING PQRI?

If you are considering participating in the Physician Quality Reporting Initiative (PQRI) then you need to see this MedLearn Matters article based on Change Request 6514. This is quite detailed. Go to:

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/mm6514.pdf>

BILLING NEWBORN HOSPITAL VISITS

A recent question to “Part B News” addresses the proper V-codes used on the initial and subsequent visits to a newborn in the hospital. The initial examination should be coded from the V30-V39 series. – Live born Infants, According To Type Of Birth. Subsequent visits, if normal, should be coded with V20.2 – Initial and Subsequent Routine Newborn Check)

REMINDER: NOTIFY MEDICARE OF ANY CHANGES IN YOUR PRACTICE

Remember that you have 30 days to notify Medicare of **any changes** in your practice. Some changes might be; ANY address change, name change, phone and fax number, specialty, change in ownership, provider leaving group or retiring, and billing agency.

REPORTING ELDER ABUSE

If you are in a pediatric or family practice you already know how to report suspected child abuse but if your practice includes elder patients, do you know how to report suspected abuse on an aged patient? Here is a link to the National Center on Elder Abuse http://www.ncea.aoa.gov/ncearoot/Main_Site/index.aspx or you can call 1-800-677-1116 to report elder abuse, neglect or exploitation. The website has a link to your particular state resources. It also has a lot of educational articles on what to look for and specific statistics.

MEDICARE COVERED PREVENTIVE SERVICES

CMS offers several Preventive Service educational documents. You can download and print to distribute to your patients or keep for reference. Go to:

http://www.cms.hhs.gov/MLNProducts/Downloads/education_products_prevserv.pdf

WELCOME TO MEDICARE PAYMENT TO INCREASE IN 2010

Part B News reports that it is not clear, at this point, what the 2010 payment formula will look like but, “by the 2009 standards”, the payment for the Welcome to Medicare preventive visit would increase from \$92.69 to \$141.74. The code to bill G0402 remains the same. This payment is just being purposed and time will tell what your 2010 payments will end up being.

ICD-10 IS COMING

I’m sure you have heard a lot of information from many sources about the new International Classification of Diseases-10 (ICD-10). ICD-10 is mandated to start by October 1, 2013. ICD-10-CM will replace ICD-9-CM, Volumes 1 and 2 and ICD-10-PCS will replace ICD-9-CM, Volume 3.

ICD-10 will have 54,044 more codes than you have now in ICD-9. The result of having so many more codes will mean that it will reduce your need to send additional documentation to define your diagnosis.

The additional codes will also aid in all phases of electronics as electronic medical records and electronic claims filing, etc.

Palmetto-GBA gives us this comparison of the two systems:

• **ICD-9-CM has:**

- 3, 4 or 5 digits
- Chapters 1 – 17 (all numeric)
- Supplemental chapter
 - 1st digit is alpha (E or V)
 - All others are numeric
- *Examples:*
 - 496 – Chronic Airway Obstruction NEC
 - 511.9 – Unspecific Pleural Effusion
- V02.61 – Hepatitis B Carrier

ICD-10-CM has:

- 3-7 digits
- Digit 1 is alpha* (A-Z)
- Digit 2 is numeric
- Digit 3 is alpha* or numeric
- Digit 4-7 are alpha* or numeric • *Alpha is not case-sensitive
- *Examples:*
 - A69.20 – Lyme Disease, unspec
 - O9A.311 – physical abuse complicating pregnancy, 1st trimester
 - S42.001A – Fx to unspec. part of right clavical for closed reduction

A “crosswalk”, General Equivalency Mapping is available at CMS’s Web site, to aid in the transition from ICD-9 to ICD-10:

www.cms.hhs.gov/ICD10/ - click on *Educational Resources* and look for GEM tools and guides. More information is available also at the National Center for Health Statistics Web site:

www.cdc.gov/nchs/abolut/major/dvs/icd10des.htm and the American Health Information Management Association Web site: www.ahima.org/icd10/understand.asp

E-PRESCRIBING WILL BE EASIER IN 2010

CMS has reviewed the minimum reporting requirements for e-prescribing bonuses. In 2010 you will only have to report successful e-prescriptions 25 times to earn your bonus. That bonus for 2010 is 2% of your total Medicare allowed charges for 2010. In 2009 you are required to report e-prescribing on 50% of all eligible claims.

Remember in 2011 you will be penalized for not e-prescribing so it benefits you to start now and receive your bonuses while they last.

MEDICARE APPEALS PROCESS AND TIME LIMITS

| Appeals | Time Limit | Minimum Amount in Controversy | Notes |
|---|--|---|---|
| Redetermination (initial appeal) | 120 days from the date of the initial claim determination notice | None | You must file a Redetermination Request before filing a Reconsideration Request with the QIC. |
| Reconsideration - Qualified Independent Contractor (QIC) | 180 days from receipt of the redetermination | None | Please include a copy of the redetermination notice with any QIC request. The address for the QIC is located on the form. |
| Administrative Law Judge (ALJ) | 60 days from receipt of the QIC decision | At least \$120 remains in controversy for requests made on, or after January 1, 2009. For request made before January 1, 2009, at least \$120 remains in controversy. | The QIC decision letter will provide the HHS OMHA office to which an ALJ request is mailed. |
| Departmental Appeals Board Review (DAB)/Appeals Council | 60 days from the date of the ALJ decision or dismissal | None | |
| Federal District Court Review | 60 days from the date of the Appeals Council decision | At least \$1,220 remains in controversy for requests made on, or after January 1, 2009. For request made on, or after January 1, 2008, at least \$1,180 remains in controversy. | |

REOPENING VERSUS REDETERMINATION OF MEDICARE CLAIMS

The quickest way to address a minor error made on a Medicare claim is to have it reopened and avoid the longer redetermination process. There are specific errors that justify reopening:

- Mathematical or computational mistakes
 - If you submitted an incorrect number of units (e.g., 1 instead of 2 in item 24G or its electronic equivalent), please be sure to adjust the charge accordingly
- Transposed procedure or diagnostic codes
- Inaccurate data entry
- Misapplication of a fee schedule
- Computer errors
- Duplicate denials, when you believe that the duplicate denial is incorrect (e.g., ambulance trip denied as duplicate, but there were two identical trips on the same day)
- Incorrect data items, such as provider identifiers, use of a modifier or date of service (month and day only)
- Adjustments to claims that were submitted in error that will result in an overpayment. Palmetto GBA will initiate the overpayment process when you notify us that this situation has occurred.

You can also correct the following modifiers through reopening:

| CPT Modifiers | HCPCS Modifiers |
|--|--|
| 21, 25, 26, 50, 51, 54, 57, 58,59, 66, 73, 74, 76, 77, 78, 79,80, 82 | AA, AD, AT, E1, E2, E3, E4, G8, G9, GV, GW, LT, KD, KX, QJ, QK, QR, QW, QX, QY, QZ, Q3, RT, SG, TC |

PalmettoGBA, in Ohio, reopening phone number is (866) 308-5441 Monday through Friday 9 a.m. through 3 p.m. (closed 12 to 1 for lunch hour). You can reopen 3 claims per call. Remember rejected claims with denial code MA130 must be corrected and resubmitted and are not eligible for phone reopening.

First Coast Service Options, in Florida, telephone (877) 847-4992 and follow these steps to do a **TELEPHONE REOPENING OF A CLAIM**

- From the main menu, press 2, then press 4
- For changes to the date of service, press 4, press 1
- To add, delete, or change a modifier, press 4, then press 2
- To change a diagnosis press 4, then press 3

Check with your local carrier for how to access reopening.

LOCAL CARRIERS TO INCREASE REVIEWS BASED ON RAC TARGETS

Your local Medicare carrier will more than likely increase its audits based on what areas your district RAC is targeting. Per *Part B News* it just makes sense that the local carriers do not want the RAC to come in and find millions of payment made in error by the local carrier. Therefore the local carriers will target the same areas that the RACs target.

If you are audited and there is a Medicare adjustment on your remittance advice it will carry Code N432 to alert you that there has been a RAC audit adjustment made.

For the CMS RAC Overview page, go to: www.cms.hhs.gov/RAC . Their email address is RAC@cms.hhs.gov.

RACs are required by law to post their target areas on their websites so check your RACs target areas and run your own internal audits to make sure you are billing correctly.

| RAC | Website | E-mail | Telephone Number |
|---|--|--|--|
| Region A: Diversified Collection Services | www.dcsrac.com | info@dcsrac.com | 1-866-201-0580 |
| Region B: CGI | http://racb.cgi.com | racb@cgi.com | 1-877-316-7222 |
| Region C: Connolly Consulting | www.connollyhealthcare.com/RAC | RACinfo@connollyhealthcare.com | 1-866-360-2507 |
| Region D: Health Data Insights | Not Operational Yet | racinfo@emailhdi.com | Part A: 866-590-5598 Part B: 866-376-2319 |

MEDPAC WATCHING OBSERVATIONS

The Medicare Payment Advisory Commission (MedPAC) did a study and found that in recent years there has been an increase in the rate of bills received for observations. The utilization of subsequent observation days has increased by over 300% since 2003 which has triggered the Office of Inspector General and your local carriers to look at these claims much closer. As with all medical services, medical necessity is key to using observation.

If you would like to view the MedPAC payment report go to:

<http://medpac.gov/documents/Jun09DataBookEntireReport.pdf> Congress is looking at ways to contain health care costs and one consideration may be to allow MedPAC to set Medicare payment rates. Time will tell what this blossoms into.

Part B News states, "Remember: Observation codes are per diem codes, meaning you can only bill for observation once a day. (You can not bill an observation on the same day as an admission. Follow these rules when you bill for the service:

- ✓ When a patient spends less than eight hours in observation, only bill 99218-99220.
- ✓ When the patient spends at least eight hours in observation on one calendar day, bill 99234-99236.
- ✓ When the patient is admitted for observation and discharged on a different calendar day you bill 99218-99220 for the initial care and then the discharge code, 99217.
- ✓ Bill an outpatient E/M code (99212-99215) for subsequent observation services."

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