



PRC MEDICAL

Monthly Newsletter
JANUARY 2010



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PRC Medical wishes you and yours a very Happy and Prosperous New Year

MEDICARE CONSULTATIONS ARE GONE

As of January 1, 2010, 99241-99245 and 99251-99255 consultations are a thing of the past and in their place you are to bill new or established evaluation and management codes to Medicare. CMS states that the money saved on consults will be used to increase the pay rate on new and established E/M services.

CMS will be issuing a new modifier to be used with the initial care code billed by the admitting physician who is coordinating the patient's care in the hospital or nursing facilities.

The AMA chose to continue to include the consultation codes in the 2010 CPT listings. However, just because they exist doesn't mean payers will pay them. Private payers will decide if they are going to continue to cover consultation services. This is going to be an administrative mess! What payers will cover? What payers won't cover? You will have to contact your carriers to determine which ones will continue to cover consults and educate your providers accordingly.

According to *Medical Office Billing and Collections Alert* there is a "Silver lining" to all this. CMS is raising payment on other E/M codes to offset the consult loss. "For instance, you'll see a 7 percent increase for 99214; with physician work RVUs rising to 1.50 from the 2009 rate of 1.42. However, certain specialists will still end up losing money."



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E-PRESCRIBING PROCESS CHANGES FOR 2010

Effective January 1, reporting an e-prescribing code will be done ONLY when the visit results in an electronic prescription being sent. You will have to report this at least 25 times during the reporting period to qualify.

For complete information on how to file successfully in 2010 go to: [Claims-Based Reporting Principles for E-Prescribing Incentive ...](#)

OIG WORK PLAN FOR 2010

The Office of Inspector General investigates the medical community through audits and reviews. If you want to see what to expect during this year go to: <http://oig.hhs.gov/publications/workplan.asp>

COMPUTED TOMOGRAPHY COLONOGRAPHY

CTC was reviewed by CMS for coverage as a cancer screening procedure. However, CMS determined that the evidence was not sufficient to change their view that this virtual colonoscopy is not covered.

Medicare does cover; fecal occult blood testing, sigmoidoscopy, colonoscopy and barium enema for average risk patients aged 50 and older.

RED FLAG RULES TO AVOID IDENTITY THEFT

The Federal Trade Commission has a site where you can get information on protecting your patients from identity theft. <http://www.ftc.gov/bcp/edu/microsites/redflagrule/> You are required to follow the rules but per *Part B News* you may get some relief as Congress is looking at a bill that would exempt you if you employ 20 or fewer employees.

However, every office should have and use a shredder. No paper with patient information should go into the trash whole. Your patient charts as well as any file with personal information should be stored securely. All your computers should be protected by passwords as well as any PDAs that are carried containing information should be password protected.

MEDICARE ORDERING/REFERRING PROVIDER CHANGES

Medicare carriers have been checking the services that require an ordering/referring provider but, until January 4, 2010, if there has been a problem, they have continued processing the claims and applying a warning on the explanation of benefits. However, for claims received after January 4, 2010, if the services require an ordering/referring provider and there is none listed, the claim will deny. If there is an ordering/referring provider who is not in PECOS and no claims for that provider are in their systems, the claims will be denied. See the MedLearn article here: <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6417.pdf>

BACK TAXES WILL BE WITHHELD MEDICARE PAYMENTS

As of October 2008, if you owe back taxes, CMS was given the authority to withhold your Medicare payments until the back taxes are collected. Your Medicare explanation of benefits will hold the adjustment code "WU" along with this phone number (800) 829-3903. If you have any questions regarding a tax withhold do not contact CMS or your Medicare carrier. Due to privacy regulations the only entity that can discuss tax related issues is the IRS. You can call them by using the above mentioned 800 number that will appear on your remit.

The person calling the IRS must be authorized to represent the provider in tax issues or the IRS will not discuss the matter with you. You will also need your Tax Identification Number (TIN).

Read more here: <http://www.cms.hhs.gov/MLN MattersArticles/downloads/MM6125.pdf>

ANTHEM MAKES CHANGES IN CLAIM EDITS

As of January 29, Anthem is initiating several new claims edits. They are making changes in EKGs (Edits 23; 700; and 708), Dermatology (Edit 717), Muscle Testing (Edit 717), Psychotherapy (Edit 715), Lab Electrolyte Panel with Basic Electrolyte Panel (Edit 714).

Go to Anthem.com and click on "Anthem Customized Claim Edit" for more information about these new edits.

CODING RADIOFREQUENCY ABLATION

If your provider is doing radiofrequency ablation for atrial fibrillation using a transeptal approach, 3D mapping, point-to-point mapping, and intracardiac ultrasound, do you know how to code it?

Per a MedLearn, Cardiac Compliance article September 21, 2009, there is no single code to cover all the services so use the following: **93651** for the ablation for atrial fib, which is consider a SVT ablation. Then add **93613** for the 3D mapping, which includes the 93609 (point-to-point mapping) and finish with **93662** for the intracardiac ultrasound (ICE).

NEED HELP WITH CODING?

Check out Codapedia at <http://www.codapedia.com/>. This site offers coding help for physician services, free. There are also other resources in the form of expert articles and forums.

According to the homepage, Codapedia will be 100% free as costs are underwritten by advertisers.

PQRI PAYMENTS

At the end of last year Part B News reported that some providers were not being paid because their reported quality data had either not made it to the carrier or had been rejected. The providers that complained during a call to CMS said their carrier was Palmetto. A Palmetto spokesman said they had no edits that would cause it not to accept PQRI data on a claim, so the issue of receipt had to be either the entire claim being rejected for reasons other than PQRI or omissions by the provider's billing department or clearinghouse of the lines on the claims. PRC always knows if a claim is rejected and either handles that correction and re-file if they can or returns the rejected claims on a list to you to address the reason the claim was rejected. So claim rejection shouldn't be an issue.

However, CMS stated, during the call in September of 2009, that the only way to be sure your PQRI data is received is to watch your remits for remark code N365. One provider stated that her staff made note of the claims a physician submitted with PQRI codes and waited for the remittance advices. When the N365 code was missing then they knew the quality codes didn't go through.

In the PRC Medical program we have not seen any problems. However, if you are receiving and posting your own Medicare payments watch for the N365 code. If PRC is posting your payments electronically and you want to check, after the payments are posted the Medicare remittance advice is viewable for each visit. If you don't know how to access them, call the help desk at PRC for assistance.



PROLONGED SERVICES IN THE OFFICE

There are some instances where you may be providing an extended service to your patient in the office and find that there is no CPT code to bill it out. An example would be a patient being given oxygen therapy during and evaluation and management encounter. In this case there is no code for “oxygen therapy” so look at your prolonged service add-on codes. If your midlevel office visit 99213, which is time related to 15 minutes of face to face service, becomes a 50 minute visit with the oxygen therapy you should be billing 99213 plus 99354 which is prolonged physician service, in the office, face to face beyond the usual service, first hour.

Remember that prolonged codes are directly related to “time” and be sure the total time spent with the patient is documented in the chart.

BILLING FOR SERVICES AFTER COVERAGE RUNS OUT

You should continue to bill the insurance carrier even if the coverage limits have been met. Why? Firstly, the patient will get the denial and make your billing and collecting from the patient a bit easier. Secondly, we are seeing more and more Flexible Spending Accounts (FSA) that will reimburse a patient’s out-of-pocket medical expenses. Some carriers will even automatically forward information to those accounts. If not, the patient will need the denial to file his claim against his FSA.

AETNA JUMPING ON THE “NEVER EVENT” WAGON

Aetna announced last year that they will no longer pay for care related to 28 preventable medical errors. But they didn’t stop there. Aetna is also requiring that you alert Aetna and at least one agency concerned with patient safety such as the Joint Commission or your states’ medical error reporting program. Aetna wants you to analyze the problem and find ways to improve your patient care and communicate with the patient or the patient’s family about the event.

Read more at:

www.aetna.com/provider/medical/resource_med/communications_med/communications.html

CMS ESTABLISHES A NEW SPECIALITY CODE

Per Change Request (CR) #6533, effective April 1, 2010 CMS will establish a new Geriatric Psychiatric specialty code 27. To read more on this CR and for a complete listing of all specialty codes see: <http://www.cms.hhs.gov/Transmittals/downloads/R1836CP.pdf>

NEGOTIATING YOUR NEW CONTRACTS

I was reading an article in *Part B News* about insurance companies “retro-cancellations” and they offer a good tip when you are negotiating your insurance contracts. Negotiate a short “look back” period right up front so if they do cancel a patient’s coverage retroactively, they can’t take the monies back that they paid to you.

As another note on retro cancellation, if this does happen and the patient has Medicare secondary, bill Medicare. Know that you must prove that the primary insurance contract was not in effect during that time. Request a copy of the cancellation from the carrier and when Medicare denies for “other payer”, you will have what you need to appeal.

I would hope that all of you know, when your contracts come up for renewal, that you should take a good look at how you are being paid. Don't fall into a rut by ignoring the automatic renewals that occur. The insurance companies are not going to tell you that they are paying at a low rate compared to the competition. You can run reports through your system that will give you comparative payments from your contracted carriers. If you need help with those reports contact **PRC Medical** help desk.

CERT REPORTS

CMS' Comprehensive Error Rate Testing (CERT) reports identify 184 diagnosis related groups (DRGs) with the highest payment errors. You can use the reports to identify any "at-risk" services you provide and perform your own analysis of your practice. Find the report here: http://www.cms.hhs.gov/CERT/01_overview.asp#TopOfPage

Per a MedLearn question and answer session they suggest you review the entire database to customize your internal monitoring and audit strategy. "Focus on high volume, high relative weight, high improper payment risk, and one day length of stays", states CMS. Hopefully, you can then avoid any future problems with improper payments.

The highest reasons for improper payments have been found in a combination of the following:

- Medically unnecessary services and potentially inappropriate settings is responsible for 60% of the improper payment dollars ;
- Incorrect coding is responsible for 30% of the improper payment dollars ; and
- Other reasons (insufficient documentation sent or no documentation sent) is responsible for 10% of the improper payment dollars.

PAYMENT PLANS VERSUS COLLECTION AGENCIES

In today's economy we may need to work out different payment plans to help our patients through difficult financial times. In the past many offices ran routine scenarios for billing cycles, letters sent and finally turning accounts over to an outside agency. I think we all know that the percentage of funds collected through collection agencies is small to say the least. Wouldn't it be better to help our patients by working out payments plans directly with them?

In a good economy, experts told us that ultimately the longer it took to actually collect a payment the less real value we got from those payments. This is true, sound science of economics but today our economic crisis has changed those thoughts.

Medical Office Billing and Collections advises us that it is important to maintain good patient relationships and so is collecting for services provided. A consensus is offered that at least with offering payment plans, you have some income coming in versus sending them to collections and possibly never getting paid. It also shows how much you care about your patients and that you are willing to work with them, not to mention the fact that turning over an account to an outside agency means you are turning over a portion of any payment collected, further reducing your income.

In some areas nothing has changed, such as front end collections. You should be collecting the copay amounts upon the patient arrival, not after the patient has been seen. Your front desk personal should be greeting the patient and know the copay amounts. (PRC's system has a copay field on the demographic

screen). If you are doing surgeries or large dollar amount diagnostics you should be checking with the patient's insurance before providing the service. Find out if there is an unpaid deductible that will be applied and what the coverage percentage will be. Let the patient know up front what is expected. Collect those dollar amounts before the service is provided or set up a payment plan in writing with the patient signature agreeing to the arrangements. It's a good idea to collect an initial amount and then divide the patient balance into agreeable monthly payments. Each patient should be handled on an individual basis. It's a good idea to try for a two month pay off but that is not always possible. Is \$50 a month acceptable to you both? Would \$100 a month be acceptable? You might set up the plan for only two months with an understanding that you will re-evaluate the account at the end of two months.

Set up a template with certain blanks left to be filled in on an individual basis but holding to certain consistent items.

A payment agreement should list:

- The outstanding balance amount
- The monthly payment agreed upon
- Finance Charge (If you are charging interest)
- The date payment is due each month
- The consequences of missing a payment
- The patient's signature
- The office manager's signature

Don't be aggressive when corresponding with the patient. Be compassionate and understanding and as the old saying goes, "you get more bees with honey than with vinegar". Hopefully, we can all help each other get through tough times. (I did an article in the PRC Newsletter from January 2009, on "Hardship" determination you may want to review that article)

MEDICARE SECONDARY PAYER LOOKUP TOOL

In case you haven't found this yet, PalmettoGBA put out a Medicare Secondary Lookup Tool on their website at: <http://www.palmettogba.com/palmetto/providers.nsf/nonStandard?openform&Code=msp>

Even if Palmetto isn't the Medicare adjudicator in your state, you can still use this tool as the rules are at the federal level and apply to all states. You simply answer each question by clicking on a yes or no answer. If you choose "no", then the next question appears. If you choose "yes", additional information opens up and directs you how to handle the situation. For instance, if the question is, "Is the patient's condition related to an accident or injury?" and you answer "yes" then it asks, "Is it work related?" If you answer "no" the next question is, "Is the accident or injury an auto or other liability situation?" If you answer "yes" then it explains the situation, what you need to document and how for file the claim. Be sure to bookmark this one.

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