



**Professional Receivables Control, Inc.
Monthly Newsletter
January 2009**

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START THE NEW YEAR RIGHT

The time is now to start fighting to get your practice under control. You have probably looked at your practice as far as cutting costs where you can but there are three areas that you need to address in the area of increasing your income.

First of all your front desk should be collecting copay and deductible amounts up front. If you have a large Medicare patient base, here is a link to an IVR flow chart that will show you how to use the PalmettoGBA IVR system to eligibility and deductible information on your patients.

[http://www.palmettogba.com/palmetto/providers.nsf/files/Patient%20Eligibility%20-%20Deductible%20IVR%20OHVW%206-2008.pdf/\\$File/Patient%20Eligibility%20-%20Deductible%20IVR%20OHVW%206-2008.pdf](http://www.palmettogba.com/palmetto/providers.nsf/files/Patient%20Eligibility%20-%20Deductible%20IVR%20OHVW%206-2008.pdf/$File/Patient%20Eligibility%20-%20Deductible%20IVR%20OHVW%206-2008.pdf)

Remember, just because a new patient presents you with an insurance card, doesn't mean they are still insured with that company. Your staff should be checking the eligibility before you provide service to a patient especially high dollar services.

Checking for coverage alone can cost you money. You should go one step further and make sure the service you provide meets the insurer's requirements for payment. Especially with expensive testing, check to see if the carrier requires a certain amount of conservative, less expensive tests before they will cover your test. Your staff should make sure to let the carrier know all previous testing and results when talking to the carrier, so make sure they know what to convey. In some cases, you, the physician, may have to get involved to give more clinical information but hopefully, with good directives, the staff can handle most of these inquiries. It's also a good idea to become familiar with carrier's medical necessity standards. All insurers are required to divulge this information to you.

MRIs are a good example of a test that is expensive. You know that, if you've purchased that equipment. Make sure you get paid for every MRI you perform. Take time, before doing the MRI, to make sure it's covered. It's a good time to also check to see if the patient will have an out of pocket amount to pay and let the patient know what's expected. If it's a large sum of money, set up a payment plan. Keep your patient informed, they will thank you for it and appreciate not being blind sided by a huge bill later on.

Another area of contention is your insurance contracts. Do you have a system in place that will allow you to stay on top of the automatic resign times? These are times that you can re-negotiate your contracts. Most insurance contracts roll over to a new enrollment automatically. This is a convenience for you but if you don't use this time to look at what the companies are paying you under your contracts, you are missing an opportunity to raise your payments. I've known offices that don't even know who they are contracted with, let alone, the new roll over enrollment dates. If you have a contract that you signed 10 years ago and you have never approached the company to re-evaluate your payment levels, you are cheating yourself.

A tool to take to the re-negotiation meetings can be found in your management reports supplied by PRC's ELF program. If you don't know how to use them, please contact your PRC client representative for assistance. You can show the insurance company that you are negotiating with what the other payers are giving you for particular services. This is a good bargaining tool.

MEDICARE DEDUCTIBLE FOR 2009

The Medicare deductible remains the same this year at \$135.00. Your patient's premiums also remain at \$96.40 per month. This is the first year since 2000 that the premium did not increase. The law requires premiums to be one-fourth the average cost of Part B services for patients 65 and over. The federal government covers the rest.

WELCOME TO MEDICARE CODE CHANGE

In 2009 you will use G0402 to bill the Welcome to Medicare visit. (G0344 is deleted). Also remember that the patient now has a full year to have their Welcome to Medicare visit instead of the 6 month limit in prior years. The EKG requirement has been removed from this visit but a body mass index measurement and end-of-life planning has been added. There is some confusion about the EKG in that CMS says the EKG will be an "educational, counseling and referral service to be discussed with the individual and order by the physician, if necessary". There is no direction from CMS as to how to determine the necessity. I guess you are on your own with the EKG. I'll let you know if any clarification comes out. If you feel it is necessary do it, if not you won't be penalized if it is not included, as before.

Your reimbursement for this Welcome to Medicare visit is commensurate with what is paid for a 99203 (Per Part B News). Also this is a limited visit and this adds to the confusion of patients who come in and think they are going to get a complete physical. They may be disappointed. You should make sure your patients understand what they are going to get for this visit. Keep in mind the payment if you are inclined to do a "complete" physical, it surely won't be worth what Medicare will pay you.

There are also a new set of codes for the EKG. In 2008 G0366 was replaced in 2009 by G0403. EKG Tracing in 2008 was G0367 but in 2009 is replaced by G0404. EKG Interp was G0368 in 2008 and replaced in 2009 with G0405.

CMS OFFERS SEPARATE INCENTIVE PROGRAM FOR E-PRESCRIBERS

This new incentive has been removed from the PQRI program for 2009. Per *Part B News*, CMS has set the parameters for the e-prescribing bonus. In 2009 you will be eligible for a 2% bonus, based on 10% of your Part B payments coming from a list of 33 office-based services. This list includes the most commonly used new and established E/M outpatient codes. (See listing below)

To qualify you must report your e-prescribed or attempted e-prescriptions 50% of the time during those eligible visits. *Part B News* gives this example: A gastroenterologist receives \$100,000 in

Medicare Part B payments annually, \$85,000 for procedures but \$15,000 for office visits. The physician is eligible because 10% of his income is from office services where he has access to his e-prescribing system. The 2% bonus from the program would be applied to ALL payments under Part B and not just for e-prescribing. In this example, the physician would get \$2,000 for the \$100,000 in Part B services provided. In 2009 and 2010 the bonus is 2%. That drops to 1% in 2011 and 2012 and 0.5% in 2013. By 2012 CMS will also start reducing payments for eligible providers who do not e-prescribe, reductions will be 1% in 2012, 1.5% in 2013 and 2% beyond.

There is no registration required for this program and you can begin reporting for the bonus anytime in 2009. Dr. Michael Rapp, CMS's Office of Clinical Standards & Quality is quoted as stating, "One could conceivably wait until April 1, but you would then have to report 75% of the time. Or you could wait until July and report 100% of the time." Basically the bonus they are paying is to entice you to start the e-prescription service now instead of later.

There are 3 G-codes to be used in connection with one of the 33 codes listed below: **G8443** – prescription by e-prescribing, **G8446** – some prescriptions handwritten, or **G8445** – prescription not generated at encounter. G8446 is only used if you have an e-prescribing system but you have to write or phone in the prescription due to a federal or state law or the pharmacy system was unable to receive and electronic transmission, or a patient requests a handwritten script. CMS judges "successful reporting" as e-prescribing on at least 50% of eligible patients.

Services or patient encounters to be used for e-prescribing include E/M visits, consultations and eye exams. The CPT or HCPC codes are: 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 92002, 92004, 92012, 92014, 96150, 96151, 96152, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, G0101, G0108 and G0109.

Read more at http://www.cms.hhs.gov/pqri/03_EPrescribingIncentiveProgram.asp#TopOfPage and <http://www.cms.hhs.gov/EPrescribing/>

MEDICARE TIGHTENS UP ON ENROLLMENT ERRORS

New CMS rules for 2009 changes the timeframe you have to make changes and retro-bill for Medicare services. **You will have only 30 days to retroactively bill**, previously you had 27 months. You also used to have 90 days to correct enrollment mistakes and supply additional information but **now you have only 30 days to correct and add information**.

Part B News reported that CMS will allow you a 30-day grace period prior to 1) The date the Medicare contractor received and initially processed your enrollment application or 2) the date a provider started furnishing services at a new location or address in the case that those providers are already enrolled in Medicare. "CMS says the later of these two dates will be used."

Example: You start working at a new office on January 1, 2009 but the Medicare contractor does not receive your new enrollment application until January 6, 2009. The 30 day grace period starts on January 6, 2009.

Hopefully, CMS's new PECOS online enrollment system helps with the timely enrollment. Per *Part B News*, you will need your national NPI and NPI pass code to register for PECOS and **not** the Individuals Authorized Access to CMS Computer Services.

MEDICARE ADJUSTMENT CODE 213

Effective January 1, 2009, Implemented January 5, 2009: Unless an exception applies (as referenced below), section 1877 of the Social Security Act, prohibits a physician from referring a Medicare patient for certain Designated Health Services (DHS) to an entity with which the physician (or his/her immediate family member(s)) has a financial relationship. A “financial relationship” includes both ownership/investment interests and compensation arrangements (for example, contractual arrangements).

The following services are DHS:

- Clinical laboratory services
- Radiology and certain other imaging services [including magnetic resonance imaging (MRI), computerized tomography (CT) scans and ultrasound]
- Radiation therapy services and supplies
- Durable medical equipment and supplies
- Orthotics, prosthetics, and prosthetic devices
- Parenteral and enteral nutrients, equipment and supplies
- Physical therapy, occupational therapy, speech-language pathology services
- Outpatient prescription drugs
- Home health services and supplies
- Inpatient and outpatient hospital services.

Section 1877 of the Act also prohibits the DHS entity from submitting claims furnished as a result of a prohibited referral to Medicare, the beneficiary, or any entity for DHS.

Note: Violations of this statute are punishable by: 1) Denial of payment for all DHS claims, 2) Refunds of amounts collected for DHS claims, and 3) Civil money penalties for knowing violations of the prohibition.

Here is the link to the *MLN Matters* article [MM6131](#).

DETERMINING FINANCIAL HARDSHIP

In today's financial climate practices may be dealing with more and more patients who declare “financial hardship” which basically means they tell you they can't afford to pay their bill. CMS requires you to make a good faith effort to collect but leaves that “effort” up to you. It may mean sending 2 bills and an initial collection letter, what ever you decide.

In an article in *Medical Office Billing & Collections Alert*, they warn against just taking the patient's word that they have no way to pay you. It is suggested that you collect the following information from the patient to prove and document the hardship; **1)** Gross monthly household income, including salary and wages and any court-order payments; **2)** Other income, including dividends, interest payments from property rental, support from family members, pensions, Social Security benefits, veteran benefits, unemployment compensation, trusts and gifts; **3)** Assets, including cash, all bank accounts, stocks, bonds, real estate equity and equity in personal property, such as cars and boats; **4)** Essential monthly household expenditures, such as mortgage/rent, utilities, insurance and food and **5)** Number of dependents in the household (include the patient).

You should also get copies of income-tax returns and W-2 and 1099 forms as proof of income to determine whether the patient's earnings meet state and federal poverty guidelines.

They also caution you that just because a patient has a lot of credit and loan debts that does not mean he qualifies for financial hardship discounts. You should NOT count non-essential or luxury items. Simply look at what the patient earns and subtract what he needs to live. One billing supervisor from a cardiology practice in New York says she looks at how much the patient makes,

how much debt they have, and compares that with the poverty guidelines. If they have much left over, this is a subjective number, they bill them up to half of what they owe. If they are below the poverty level, they write off the balance. Remember that these arrangements are for a single service or visit and should not be applied to future services, visits unless the financial hardship continues and you should be rechecking that status before applying additional write-offs.

Most offices have a “financial policy” as part of their new patient information and release papers. Make sure you tell the patients that you have a financial hardship option available for those who qualify and tell them who to talk to, in your office, for additional information. You need to decide in advance just how you want to handle each situation.

Hopefully, you won't have a lot of these hardship situations but remember to copy all the documents supplied by the patient in a safe place, NOT IN THE CHART and not available to all staff. These documents should be kept under lock and key, possibly in the manager's office. You should notate the chart that the information has been gathered but that is the limit of information added to the chart.

Once you have determined what course of action you are going to take, reduction or write-off, the patient and the physician should sign a statement detailing that you have reviewed the proof of financial hardship and list what charges you are reducing or waiving. You should keep a copy and give a copy to the patient.

All of the above information was in reference to a patient who has insurance but can not pay the copay and/or deductibles. Now the question is, how do you handle hardship in self pay patients? You can offer a discount to these patients as long as you offer the same to your third party payers. Here is the way to deal with this situation. Tie your discount to the requirement that the self pay patient pay on or before the day of service. **This is the only way you discount.** This way you can offer the same discount to your third party payers and it is very unlikely any third party payer will pay in advance or on the day of service.

The patient has to pay with cash, check or credit card, as I stated above, on or before the day of service. Do NOT put CPT or ICD-9 codes on the receipt given to the patient. Should the patient actually have insurance he can't use your receipt to get money from his insurance. After all, you gave him a discount based on the fact that he told you he had no insurance. If he later states that he needs claim filed, you tell him his discount was based on “self-pay” and you will be glad to file the insurance claim but the full charges will be reinstated to his account and he will be charged for the copay and coinsurance.

As with the insured hardship patient, be sure to print out the discount arrangement and have the patient and the physician sign. Keep one copy and give the patient the other copy with the receipt for the money paid.

Here is a link to the United States Department of Health and Human Services Poverty Guidelines. <http://aspe.hhs.gov/poverty/index.shtml> At time of this writing this site held the 2008 Guidelines and I am presuming it will hold any 2009 Guidelines by this time, if there are any changes.

PQRI AND INCORPORATED GROUPS

If you are an incorporated group practice and have at least one provider reporting PQRI quality measures date to Medicare, you can access feedback reports. Go to this MedLearn Matters Number SE0831 revised November 25, 2008, for further information: <http://www.palmettogba.com/palmetto/providers.nsf/DocsCat/Ohio%20Part%20B%20>

NEW ESRD CODES FOR 2009

There are three new ESRD codes, 90960-90962, that depend on the number of monthly visits. These replace 90921 – ESRD related services, month. Also new is 90925 to replace 90970 – ESRD services for dialysis, for patients age 20 and over. 90960 is used for 4 or more face-to-face visits per month. 90961 is for 2-3 visits and 90262 is for 1 visit per month. There are like codes for patients under 20 years of age. **At this point it is unclear whether Medicare will replace the existing HCPCS codes it uses for ESRD services with the new codes.** I will keep you informed if Medicare makes that decision.

ANTHEM PAYMENT POLICY CHANGES

Modifier 78 – return to the operating/procedure room by the same physician following an initial procedure or related procedure occurring during post-op period of initial procedure. This will be paid at 70% of the global fee for the surgical procedure starting January 1, 2009.

Anthem will also consider any E/M services incidental to any chemotherapy services on the same day unless modifier 25 – separately identifiable service applies to the E/M.

KEEPING THE MONIES PAID FOR SPLIT/SHARED VISITS

More and more offices have non-physician practitioners (NPPs) to ease some of the burden from the doctors. One way to do this is using the NPP to make rounds at the hospital. However, this practice, if not used correctly, can end up costing you money if you are audited. The Office of Inspector General (OIG) may view the way you bill as improper and take back monies you have been paid with interest.

Some offices have adopted the practice of having the NPP do the bulk of the work and then the doctor drops in to see the patient. Then the services are billed under the doctors NPI when in fact the split/shared rules have been misused.

The Medicare manual plainly states; “a split/shared E/M visit is ... a medically necessary encounter with a patient where the physician and a qualified NPP each personally perform a substantive portion of an E /M visit face-to-face with the same patient on the same date of service. A substantive portion of an E/M visit involves all or some portion of the history, exam, or medical decision making key components of an E/M service.” (Sec. 30.6.13-H of the Medicare manual)

Seth Canterbury CPC, an education specialist at the University of Florida-Jacksonville is quoted in *Part B News* as pointing out the primary wording here is “**substantive portion**”. This portion of the manual is often ignored due to a more lenient definition found in chapter 12, sec. 30.6.1B: “E/M shared between a physician and an NPP from the same group practice and physician provides any face-to-face portion of the E/M encounter with the patient, the service may be billed under either the physician’s or the NPP’s UPIN/PIN...” This is much more lenient than the “substantive portion” mentioned above which may be used to take back split/shared payments in an audit.

HAVE A HAPPY, HEALTHY AND PROSPEROUS 2009

Mable Scott,
mrscott@comcast.net