



**Professional Receivables Control, Inc.  
Monthly Newsletter  
MARCH 2007**

**Please route to appropriate staff**

**HELP DESK HINT**

To find if an insurance company's address has changed, go to Utilities, Live Content Browser and click on the Insurance Information option. A list of insurance companies will appear. You will find the old and new address as well as the date the information was updated in the ELF. Also as you scroll to the right, there is a note field for any additional information regarding the address change etc. This feature is helpful in case a patient presents an insurance card with the old address and the new address is in the ELF. If you are still not able to locate the patient's insurance in the ELF, please email the information to [helpdesk@prcontrol.com](mailto:helpdesk@prcontrol.com) or fax a copy of the card to attention of the Help Desk at 330-493-7123 so we may have the information added to the ELF.

**CMS INVALID OVERPAYMENTS GENERATED BY MANAGED CARE COVERAGE**

During the week of December 17, 2006 the Medicare systems at CMS were updated with incorrect Managed Care enrollment data. Due to this error many overpayment recoveries were initiated. Per CMS this was corrected in January 2007 and the contractors were notified in change request CR5507 to stop recovery action and reverse the overpayment recovery actions. Per CMS you need not take any action since contractors will automatically make the necessary adjustments as CR5507 is implemented. However, the implementation date is listed as April 26, 2007.

For further information contact Palmetto GBA Provider Call Center at 800-567-9232 between 8:30 a.m. and 4:30 p.m.

**NPI GET IT AND USE IT**

NPI numbers will replace health care provider identifiers as of May 23, 2007. Remember it can take up to 120 days to implement the NPI in current business practices, so get it now. CMS has sources to help you at <http://www.cms.hhs.gov/NationalProvidentStand/> on the CMS website.

See Medlearn Matters Number: SE0679 for more information at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0679.pdf>

If you need more assistance call the NPI enumerator to request a paper application at 1-800-465-3203.

At this time CMS has no plan to provide a NPI listing. It will be your responsibility to share your NPI with all entities with whom you have a working relationship. On May 23, 2007, you will need to submit claims to Medicare NPI only.

## **GETTING READY TO RETIRE?**

In MedScape Business of Medicine, a retiring physician asked, “How long should I keep malpractice insurance after I retire.....”. Their printed response from Carolyn Buppert, NP, JD, an attorney in private practice in Annapolis, Maryland, in summary, stated that the safest plan is to purchase an *occurrence policy* until the date you stop practicing, and then truly **stop practicing**. An occurrence policy covers incidents that occurred during the time when the policy was active, even if a lawsuit is filed years after the policy has lapsed. Compare to a *claims-made policy*, you have to keep this policy active and continue premiums until the statute of limitations has run out or purchase a *tail policy*, extending coverage to the *claims-made policy*.

Statute of limitations depends on the State Law. However, most States, including Ohio begin the time limit from the *time of discovery*. This means that the year limit, to which Ohio holds a patient to file a lawsuit, is started when the patient **discovers** the problem. This is also affected by the age group you serve as the time limit is extended in the case of children.

Per Ms. Buppert, “It is not safe to try to predict the year at which you are free from risk, but to cover your bases with insurance.”

She also warns that you avoid giving medical or nursing care or advice once you retire unless you have malpractice insurance, preferably of the occurrence type.

## **MEDICARE’S “MEDICALLY UNLIKELY EDITS” (MUE)**

January 2007 started a new MUE edits which is a refined version of the “Medically Unbelievable Edits” proposed by CMS in 2005.

In the January 2007 *Radiology Coding Alert* they tell us:

Most of these are billing errors due to clerical or system errors. For example; if a unit error is made, a possible example might be, an anesthesia billing that lists 141 units on a shoulder arthroscopy. The 141 was actually the minutes of anesthesia, not units. Now, the MUE edit will automatically limit the number of units for any service in any 24-hour period. They haven’t assigned a maximum number of units for any given CPT code but they are using common-sense criteria.

If you do run into these edits, they won’t deny the entire claim, only the line that violates the MUE guidelines. You will be able to appeal these denials in the event that you feel it was denied in error.

These edits will be updated quarterly just like the CCI edits.

## **CONSULTS OR OFFICE VISITS?**

Some coders are still having a problem deciding what service is provided but Consults are really very simple to discern. Consultations (CPT 99241 through 99255) are easy to apply by remembering the **3 – Rs. Request** – for an opinion, **Rendering** – of services and **Report** – to the requesting physician.

CMS has added a **4<sup>th</sup> – R** which is **Reason**. The requesting physician must document the **reason** he is asking for the consult in the patient’s medical record.

It is suggested by coders (per the Neurological Coding Alert) that a possible **5<sup>th</sup> – R** is added for **Return**. This helps demonstrate that the patient is **returned** to the requesting physician for treatment of the problem

Also in 2007 follow up consultations were deleted so IF you continue to see the patient after the initial Consultation it is assumed, and rightfully so, that you are now “treating” the patient and should be billing the appropriate E/M code.

So if another physician **Requests** that you see a patient for your opinion, and you have **Rendered** that opinion in the form of a written **Report** sent back to the requesting physician, and you have **Returned** the patient back to the requesting physician **without you treating the patient for that specific illness = THIS IS A CONSULTATION.**

If you begin **treatment**, then you are now performing evaluation and **management** (E/M) and bill accordingly.

**Hospital Consults:** I am also seeing where some clients are trying to bill two consultations during the same hospital stay. Remember this can be done **ONLY** if the problem is different for the second consultation, not related to the problem on the first consultation. Medicare will deny the second consult as excessive or a duplicate. If you return to see a patient after you have done your initial consultation, you are then to use the subsequent care codes. There are no more follow up consult codes, these were deleted from CPT in 2006.

I also had a second consult denied even after review and records sent because the patient problem was the same even though the patient was inpatient for the first consult and days later transferred within the hospital to a SNF floor. The change of location didn't matter because the problem was the same.

### **CARE PLAN OVERSIGHT**

Remember when billing Care Plan Oversight of any kind, whether it is nursing or hospice, you must enter the facility number assigned to the home health care agency in the **auth** field on the visit. Medicare will deny or claim without that field completed.

### **MEDICARE FEE SCHEDULE REGULATION FOR 2007**

Effective January 1, 2007 Medicare:

- 1) Will increase physician payment for the time spent talking with Medicare beneficiaries about their health care. 2007 final rule increases the Relative Value Units' (RVU) work component for the face-to-face visits (evaluation and management) during which the physician and patient discuss the patient's health status and steps that can be taken to improve the patient's health.
- 2) Adopts work values for CPT codes 97802, 97803, 97804, and HCPCS G0270 and G09271.
- 3) Expands preventive services by adding a one-time preventive ultrasound screening for abdominal aortic aneurysms (AAA), for at risk beneficiaries, only available as part of the Initial Preventive Physical Exam. (Welcome to Medicare Physical that has to be done within 6 months of the patient's effective date on Medicare Part B). Insuring more accurate and reliable bone mass measurements are performed for Medicare beneficiaries; and exempting the colorectal cancer screening benefit from Part B deductible.

- 4) Adds diabetes outpatient self-management training and medical nutrition therapy to the list of covered services.
- 5) Caps payment rates for imaging services under the physician fee schedule for the same services when performed in hospital outpatient departments
- 6) Includes a discussion of exceptions to the therapy cap for 2006 and 2007 and announces that the 2007 cap is \$1,780.
- 7) Amends the reassignment of payment regulations to state that an individual supplier furnishing a service has unrestricted access to the billings submitted by the entity receiving the Medicare payment for services furnished by that supplier, irrespective of whether the supplier is an employer or independent contractor.
- 8) Announces that the drug add-on adjustment to the end stage renal disease (ERSD) composite payment rate for 2007 will increase from 14.5% to 15.1%

### **HOMETOWN SECURE CARE**

You will see new Secure Care cards that are difficult to determine what the true plan is, except that it says "Medicare Advantage Plan" above Secure Care on the card. This plan is Hometown Secure Care which has changed its name to The Health Plan. It does mention The Health Plan on the back of the card. Be sure to use Hometown Secure Care in Massillon as the payer.

**Mable Scott**