



Professional Receivables Control, Inc.
Monthly Newsletter
JUNE 2009

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MEDICARE DENIAL CHANGE

Effective June 1, 2009 PR-B7 – provider not certified/eligible to be paid for this procedure/service date on the date of service will be changed to CO-170 – payment denied when performed/billed by this type of provider. Big difference here is the PR to CO designation which changes patient responsibility. **You may no longer bill the patient for this denial.** However, this denial is still eligible for review.

FDA WARNS OF BURNS WITH TRANSDERMAL PATCHES AND MRI

I'm a little late with this one but just in case you weren't aware, in March the FDA put out a warning that some patches contain metal components that can cause burns during MRIs. The FDA is working with manufacturers to update the labeling but we all know that patient's don't necessarily read or understand those labels. For their safety, be sure to check your patients for transdermal patches before performing your MRI. Read further here:

<http://www.fda.gov/medwatch/safety/2009/safety09.htm#chronological> scroll down to **Transdermal Drug Patches with Metallic Backings.**

ANTHEM MEDICARE ADVANTAGE PFFS PAYMENT RECONSIDERATION FORM

Anthem's Medicare Advantage PFFS payment/adjustment form can be found on www.anthem.com/medicare, go to ADDITIONAL INFORMATION>PROVIDER SERVICES>ANTHEM SMARTVALUE PRIVATE FEE FOR SERVICE (PFFS)>PFFS PAYMENT RECONSIDERATION/ADJUSTMENT FORM.

This form should be used for claim requests: to initiate a claim consideration review or claim adjustment request in lieu of calling the plan. It's also to be use to submit a corrected claim (copy of the corrected claim should be attached). Use it to submit additional information to support a claim or to address a special claim situation as needed.

Anthem directs you to send the form to your local plan if the remit advice is from your local Blue plan but if the remit is NOT from your local plan send the form to: **Anthem/PFFS Plan, P. O. Box 795180, San Antonio, TX 78279.**

If you have questions about this form contact Anthem's dedicated provider service line at (866)364-2374.

BLUE CROSS BLUE SHIELD'S "HEALTHCARE TRENDS IN AMERICA"

We are hearing more and more about government backed public healthcare plans. The private insurance sector has its own opinions on this subject and what future healthcare should be. BC/BS put out their "Healthcare Trends in America" reporting data and trends in the private healthcare market. You can download the report here <http://www.bcbs.com/blueresources/healthcare-trends-report/>

RACS TO BEGIN RECORDS REQUEST THIS MONTH

The new Medicare local recovery audit contractors (RACs) may request records from you starting this month. One point to remember, if you choose to appeal an overpayment refund request, is that if you retain the monies while you appeal and lose that appeal the interest rate on those monies is a whopping 11% as of the rate increase on April 16, 2009! Interest rate change information on line at <http://www.cms.hhs.gov/transmittals/downloads/R151FM.pdf>

DISCLOSURE OF PHYSICIAN OWNED HOSPITALS

By June 8, 2009 you should make sure you have physician-ownership disclosure procedures in place to disclose to your patients at the time of referral if you (or your immediate family members) have an ownership or investment interest in the hospital to which you are referring your patients. Failure to do so can result in loss of hospital medical staff memberships.

Hospitals are also required to disclose to their patients if they are physician owned and provide the names of the physician owners and names of immediate family members of the physician who have an ownership or investment interest in their hospital. Failure to do so may result in the hospitals losing their participation agreements with Medicare.

MEDICARE FEE-FOR-SERVICE PROVIDER WEB PAGES

CMS Website offers lots and lots of information. To see the resources available to providers including a brochure with all the Medicare FFS Provider web pages available go to <http://www.cms.hhs.gov/MLNProducts> and click on the FFS Provider Web Pages link in the left hand menu.

You can also find many more resource web pages for topics such as Hospital-Acquired Conditions, Pricer, and the Physician Fee Schedule Look-up tool.

For more Medicare information go to <http://www.cms.hhs.gov> website and check out the pages listed on the MEDICARE tab, under *Medicare FFS Payment*.

MLN is the brand name for official CMS educational products and information. Be sure to take advantage of the no-charge information.

SECRETARY OF HHS CHALLENGES HOSPITALS TO FIGHT INFECTIONS

In May of this year Secretary Sebelius of Health and Human Services spoke before the AFSCME Nurses Conference and addressed the ongoing problem of healthcare associated infections in our hospitals. She made \$50 million in Recovery Act funding available for this purpose.

Secretary Sebelius noted two reports, the annual 2008 National Healthcare Quality Report and the 2008 National Healthcare Disparities Report that indicated safety measures are worse and a good many Americans are not receiving recommended care.

Released by HHS the reports found:

- 40 % of recommended care is not received by patients.

- Only 40% of diabetic patients received three recommended diabetic preventive exams in the past year, and this rate has not improved over time.
- Only half of obese adults and children are given advice to exercise more and eat a healthy diet.
- Seven out of ten adults with mood, anxiety, or impulse disorders received inadequate treatment or no treatment at all.
- Disparities in health care persist. Minority patients receive disproportionately poor care compared to Caucasian patients. At least 60 percent of quality measures have not improved for minorities compared to Caucasians in the past six years.
- One in seven hospitalized Medicare patients experience one or more adverse event.
- Patient safety measures have worsened by nearly 1% each year for the past 6 years.
- Central line associated blood stream infections (CLABSIs) strike hundreds of thousands of patients each year.

Health care associated infections (HAI), those that patients get during a hospital or nursing home stay are in the top ten causes of death in the US today and are driving up health care costs.

To read the reports issued today, visit: <http://www.ahrq.gov/qual/qdr08.htm> . To read the checklist referenced by Secretary Sebelius, visit <http://www.ahrq.gov/qual/clicklist.htm>.

NEW CODE 95992 NOT PAYABLE

Canalith Repositioning Procedure is a status B code that will never be paid by Medicare and not billable to the patient. This is another instance where a code exists but is not payable under any circumstance. This simple maneuver is to reposition the head in a series of maneuvers in order to move loose particles within the ear from the posterior semicircular canal into the utricle, as a treatment for positional vertigo.

NEW PATIENT STATUS QUESTION

Question: *"A patient went to the emergency department with pelvic pain and the physician told the patient to call us for an appointment. While in the hospital, the patient had a test which our physician interpreted. We saw the patient later that week. Can we charge for a new patient E/M if the patient has never been seen before, but we did interpret the test?"*

Answer: "Yes, you can. CMS makes it pretty clear that interpreting a diagnostic test does not trigger a change in status from new patient to established patient (CMS Pub 100-04, Chapter 12, Section 30.6.7.A)." *

* Taken from *Part B News Weekly Round-Up* February 26, 2009

DRUG DISPOSAL

How do you dispose of expired drugs? Most offices have a good supply of sample packets of drugs supplied by local drug company representatives. Hopefully, you are distributing them in a timely fashion to your patients. However, sometimes these drugs hang around the office long enough to have to be discarded.

The FDA gives specific directions on acceptable methods of disposing of drugs. Most drugs tell you how to dispose of them in the patient information sheets that come with the drugs.

If you throw the drugs into the trash, remove them from the containers and put them into a sealable plastic bag or other sealable container to keep them from spilling out into the trash. Add a good supply of old used coffee grounds. Most offices have a coffee maker going throughout the day. This makes them less appealing to anyone finding them in trash.

Check within your community trash service and see if they have a drop-off for unused drugs. You could also check with your hospital. I'm sure they have a method of disposal and possibly they would allow you to take advantage of dropping your expired drugs off at their disposal site.

DO NOT FLUSH DRUGS DOWN THE TOILET unless you are directed to do so by the manufacturer. Some drug labels tell you to flush, mostly narcotics, but I have a concern about how this affects our ground water. However, you certainly wouldn't want to put a dangerous narcotic out in the trash, so we are instructed to flush those drugs.

Here is a link to the FDA Drug Disposal Directives
http://www.fda.gov/consumer/updates/drug_disposal062308.html#Guidelines

OVERPAYMENT REFUNDS

Your office should have in place a procedure for finding and handling overpayment refunds. Your ELF system can produce a report for this purpose. If you need help with those reports contact PRC Client Rep.

Once you have determined an overpayment exists, the first thing you want to do is review the claim and account detail to make sure it is truly an overpayment and not just an entry error. Even if a carrier contacts you for a refund, be sure you verify before refunding.

Another item you want to check is the timeliness of a carrier requested refund. Many states now have regulations on "timely" requests for refunds. Check with your state to see if they have a regulation in this regard. Florida has now limited refund requests to within 12 months of payment. If your state has a timely regulation it will affect carriers ability to take monies back no matter what state the carrier is in. Don't let an out of state insurer say they don't have to abide by your states regulations because they are in another state. The regulations are based on where the service is provided not where the payment emanates from.*

Once you have verified that an overpayment has been made contact the carrier before sending the check to verify where and how they want it handled. Medicare carriers generally have a form that they want you to use. Other carriers may want it sent to a particular address. Some carriers may not want refunds at all but may want to handle the overpayment by deducting it from your future payments. You want to avoid falling into a refund/take-back situation. By that I mean, you don't want to send a refund check only to find out that they have done a withhold from an already issued payment resulting in duplication of the refund. Sometimes it is an ugly can of worms to get that corrected.

Just because you have an overpayment that has not been timely requested by the carrier doesn't mean you can keep that money. Each state has unclaimed property laws that require you to send those monies to the state. These laws are referred to as Escheat Laws.*

* Taken from Medical Office Billing and Collections Vol. 8, #11

IRS DEBT WILL BE DEDUCTED FROM YOUR MEDICARE PAYMENTS

If you owe back taxes, you may find your Medicare reimbursements reduced. CMS MedLearn Matters 6125 revised on January 8, 2009 tells us that the Taxpayer Relief Act of 1997, authorizes CMS to reduce certain federal payments, in this case, your Medicare payments, to collect overdue taxes. If you owe back taxes you may see the adjustment code **WU** and see a 15% reduction or the amount of the tax owed if it is less than 15% of the payment. You will also be given the IRS toll free phone number (1-800-829-3903). Note that the IRS will only speak to you or a person who is authorized to represent you regarding tax matters. The caller must have your TIN and state that the

recovery was from a Medicare payment. Also remember that a tax withhold by your carrier may take a few days to show up on the IRS computer systems.

To view the CMS transmittal 367 go to <http://www.cms.hhs.gov/Transmittals/downloads/R367OTN.pdf>

LACK OF PHYSICIAN ORDERS ON DIAGNOSTIC TESTING

It's hard for me to believe but Medicare is still reporting that the lack of physician orders is still an ongoing error. As a diagnostic provider you must have an order from the treating provider to be paid for your services.

There are three (3) acceptable ways to deliver orders: 1) Written document signed by treating provider which is hand-delivered, mailed or faxed to the testing facility; 2) Telephone call documents in **both** the treating provider and testing facility records; 3) E-Mail.

If documentation is requested on a claim, be sure to include the orders when returning the documentation.

Relative articles:

See Medlearn Matters: <http://www.cms.hhs.gov/MLN MattersArticles/downloads/MM6100.pdf>

See CMS directives: <http://www.cms.hhs.gov/Transmittals/downloads/R94BP.pdf>

MM6100 was revised on February 2nd to include a statement; "Specifically, it notes that a physician's signature is not required on orders for clinical diagnostic tests that are paid on the basis of the clinical laboratory fee schedule, the Medicare physician fee schedule, or for physician pathology services. While a physician order is not required to be signed, the physician must clearly document in the medical record his or her intent that the test be performed."

DENIALS ON WOUND CARE

In a recent article in *Part B News* they reviewed the high rate of denials on wound care services (11040-11044). The quote Bill Hickerson MD, director of the burn and wound center at the Regional Medical Center in Memphis, Tennessee as saying, "It's because people are just not documenting what they're doing and how they're doing it. You see these wounds over and over and you just write a small little note that says 'wound debrided (what dressings) were applied.'"

As in past articles I've done, here we go again with **documentation**. Again, if you don't write it down, it didn't happen! The note quoted above is fine for your purposes but not if you want to be paid. Dr. Hickerson is quoted again, "You didn't say that you took dead skin off, or fat and muscles off, and you didn't say what the base of the wound looked like, whether there is bone or tendon in the wound."

As a physician you have to set your mind as to what the insurance carrier will be looking for. Remember that the insurance industry looks at a claim with the mind set, "What can I find to keep from paying this claim?" You must not stop your documentation with the clinical details but go on to describe details for the "reimbursement answers"

Per *Part B News*; **all wound care must contain the following:**

- ❖ Medical diagnosis and indications for debridement;
- ❖ the type of anesthesia used, if any;
- ❖ the level or depth of tissue debrided;
- ❖ wound characteristics such as diameter, color, and presence of exudates or necrotic tissue;
- ❖ the vascular status;

- ❖ narrative of the operative procedure;
- ❖ patient-specific goals and/or response to treatment.

When billing 11040-11044, be sure to include depth or thickness of the tissue being removed and not the depth of the wound itself, per Highmark LCD. <http://www.highmarkmedicareservices.com/cptdisclaimer.html>

Check with your local carriers to see if they have an LCD for wound care.

Here is a link to CMS on a “wound” search <http://www.cms.hhs.gov/mcd/results.asp?show=all&t=200931012194> scroll down to the LCD section.

PATIENT PREPAY OPTIONS

Today’s economy has put many strains on your practice. One way to help with keeping your AR in control is to collect any patient responsibility up front. By the time you receive the results of your claims filings the service has already been provided and now it becomes a “collection” problem.

Some insurance companies are offering a real time tool to help you determine what the end result of your claim will be with regard to how much the patient will owe you out-of-pocket. Highmark of Pennsylvania is one of those companies along with United Healthcare, Humana, Tricare, and Blue Cross Blue Shield of South Carolina. The real time claim information offered by the insurance companies allows you to research how the claim will process and collect the patient responsibility prior to providing the service or set up a payment plan.

This will also benefit your patient in that they will know in advance their cost and whether they want to go ahead with the service.

How you set up this information gathering in your office will vary but *Medical Office Billing and Collections* suggests that your front desk staff, those, “who encounter the patient at points of collection...” be the ones that gather the information and convey that to the patient as they are most likely the staff members who will be scheduling the procedures.

Check with your local carriers to see if any provide this service.

PQRI ACCEPTED MODIFIERS

I will preface the following accepted PQRI modifiers by saying that they are not valid on all quality measures and direct you to the CMS website for additional information on specific indications for each modifier www.cms.hhs.gov/pqri

CPT Reporting Modifiers	Descriptions
1P	The quality measure was not applied due to medical reasons
2P	The quality measure was not applied due to reasons related to the patient
3P	The quality measure was not applied due to system reasons
8P	The quality measure was not applied due to other reasons

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