



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

**Please route to appropriate staff**

**Newsletter access is also available through the help menu**

**FEE FOR MEDICAL RECORD COPIES**

The Ohio General Assembly controls what you are allowed to charge to copy medical records. Through December 2008, you are not permitted to charge more than has been set in House Bill Number 331 as follows:

Patient or patient representative request for records:

Data recorded on paper: \$2.50 per page for the first 10 pages;  
.50 per page for pages 11 through 50  
.20 per page for pages 51 and higher

Data recorded other than on paper: \$1.70 per page.

The actual cost of any related postage incurred.

If the request is made other than by the patient or patient's personal representative, total costs for copies and all services related to those copies shall not exceed the following:

Initial fee of \$15.35 which shall compensate for records search;

Data recorded on paper: \$1.02 per page for the first 10 pages.  
.51 per page for pages 11 through 50  
.20 per page for pages 51 and higher.

Data records other than on paper: \$1.70 per page

The actual cost of any related postage incurred.

You must provide one copy without charge to the following:

The Bureau of Worker's Compensation  
The Industrial Commission  
The Department of Health and Human Services  
The Attorney General

Copy to patient or patient's personal representative if needed to support a claim under Social Security Title II – Federal Old-Age, Survivors, and Disability Insurance Benefits and accompanied by documentation that a claim has been filed.

You are not required to provide copies free of charge for any other situation than what is listed above.

However, you may enter a contract with the patient or the patient's personal representative at a fee other than what is listed in the following instances:

A patient, a patient's personal representative, or an authorized person;  
An insurer authorized to do business of sickness and accident insurance in the State of Ohio or health insuring corporations. (Note that most of your contracts with insurance companies require you to provide to them, without charge, any records they deem necessary to process your claims)

### **COMMON BILLING ERRORS ON MEDICARE CLAIMS**

There are several billing errors that are repetitive in all practices all of which delay your claim payment and often initiate an erroneous explanation of benefits being sent to your patients.

- 1) HICN (Health Insurance Claim Number) errors. Patient name errors. Always use the name and number exactly as they appear on the Medicare card. Do not use titles, such as Dr., Mr., Rev., M.D., etc. If your patient prefers a nickname, use it on the chart, **do not use it on the demographic screen.** The HIC number has a correct format which is 9 numbers and an alpha suffix (sometimes followed by an additional number) 123456789A. Be sure to use it as it is listed on their card. Be aware that some patients draw from a single social security account and will have the same 9 digits but the alpha suffix will be different. Example would be a wife that is drawing benefits through her husband. His number will be 123456789A (A signifies that the patient is drawing from their own account) and his wife's number will be 123456789B (B signifies spouse of account holder). You must use the correct number and letter or your claim will deny.

Railroad Retirees have a different number which is defined by an alpha prefix (usually 2 alpha characters) followed by a number.

- 2) Complete address based on U.S. Postal Standards for patient and provider. This contains both street name and number or a P.O. Box number. Rural Route (RR) number must be with a box number. It is incorrect to key P.O. in front of the box number when used with a rural route. A star route number is not deliverable so you must use the highway contract route (HC) instead of the star route. RD numbers are no longer valid. If there are rural routes still existing in your area, the correct number should be preceded by RR, then a box number. A Box number or RR number alone is not deliverable. The same holds for a street name without a number. Do not use any symbols such as % denoting "in care of". Use C/O. Remember the post office does not want any commas, hyphens, periods, or any other character. The only hyphen that is accepted is between the 5 and additional 4 digit zip codes...44646-2230.
- 3) Invalid, deleted diagnosis will cause your claim to reject. Remember to use current

ICD-9 diagnosis. The up front edits will stop the claims if the diagnosis is not complete. If there is a 5<sup>th</sup> digit, you must use it.

**REMINDER ON INJECTION ADMINISTRATIONS AND OFFICE VISITS**

If you bill injection administration along with an office visit, the office visit must qualify for the 25 modifier. If you bill them both without modifying the office visit, it will be denied. One exception, you can never bill 99211 lowest level office visit with an injection administration, it can not be modified and will never be paid.

**MEDICAID AND CRITICAL CARE**

*Medicaid allowed units by procedure 99291 = 1 hr and 99292 = 1hr 30 minutes each.*

Medicare will only allow 2 units of procedure 99292. The critical care codes may be billed to report the total duration of time, to a maximum of two (2) hours, spent by a physician providing constant care to a critically ill patient. (Even if the time spend by the physician is not continuous on that day.) Any time over two (2) hours will be denied.

**ANTHEM AND THE NPI CONTINGENCY PERIOD**

Anthem has announced that they will extend the contingency period for the use of the NPI from May 23, 2007 through January 25, 2008. You may submit your electronic or papers claims during this period with your Anthem provider number without the NPI, with the NPI and your Anthem provider number (your tax ID will be required in this scenario), or submit with the NPI only (your tax ID will be required in this case also and you MUST REGISTER YOUR NPI WITH ANTHEM).

| <b>HIPAA Standard Electronic Claims – 837 Professional, Institutional, and Dental Claims</b> |  |   |   |
|--|--|---|---|
|  | <b>Dual Receipt Period</b><br>(Now through 05/22/07) | <b>Contingency Period</b><br>(05/23/07 – 01/25/08)  | <b>Full Implementation</b><br>(Post 01/25/08)<br>(A notification will be sent 60 days before requiring the use of NPI only on transactions) |
| <b>Provider submits a transaction with...</b>  |  |   |   |
| Anthem Provider Identification Number  | Accept Transaction                                   | Accept Transaction                                  | Reject Transaction  |
| NPI & Anthem Provider Identification Number  | Accept Transaction (Dual Receipt)                    | Accept Transaction (NPI must be in primary loops)   | Reject Transaction  |
| NPI Only   | Reject (unless testing is completed with EDI area)   | Accept Transaction (NPI must be registered with us) | Accept Transaction  |

Remember that most insurances have their own contingency plan, go to their websites and search *NPI contingency* and you will find the needed information.

**ANTHEM EDUCATING PATIENTS ON HEALTH CARE COSTS**

Anthem has started an online cost comparison tool called Anthem Care Comparison. They have listed a price comparison for the most common office visits, diagnostic procedures and in/outpatient procedures and services performed at hospitals and outpatient facilities in the Dayton area which started in the Spring of 2007. They are

expanding the program to include Cincinnati, Ohio; Lexington and Louisville, Kentucky and Central Indiana.

In addition they have information on the numbers of a certain procedure performed by a facility (self reported).

This tool helps patients compare actual prices of common procedures, how often they are performed by the facility and a quality comparison.

This is becoming a trend in the insurance community and you will see it in other plans also.

### **MEDICARE AND PROLONGED CARE**

Billing prolonged care is based strictly on time durations which are listed in your CPT book. Medicare does not require documentation to be sent with the claim but you must maintain that information in the chart. **The time spent must be charted.**

### **MEDICARE INTERACTIVE REDETERMINATION REQUEST FORM**

<http://www.palmettogba.com/palmetto/providers.nsf/44197232fa85168985257196006939d/6180aa5fc4cc14be852572df005443f6?OpenDocument> use this link to access the interactive redetermination request form. You can download it to your desktop and use it to create neat requests. Be sure to sign the form before mailing.

### **PROVIDER NUMBER, UPIN, LEGACY AND NOW PTAN**

If you haven't noticed by now Medicare has once again change the name of the identifying number assigned to providers and locations. Now it is the PTAN, Provider Transaction Access Number. Don't let this confuse you. If you call Medicare this number is the number assigned to the location where your service is performed. Click on the location, click on the change icon, then on the yellow tab at the bottom "Code". The PTAN is listed on the right as Medicare Code and the Provider Call Center only need the digits. Example SU7891234, all they want is the 7891234. Same as before, just a new name.

### **HELP DESK HINT**

Here are some Payment Posting hints...

If you want the payment you're posting to a particular patient's visit to appear on the insurance claim, please remember to press the space bar when you get to the "Include Payment on Ins Form?" box. You will need to do this even when you've checked the "Co-Pay?" box.

Also on the payment screen, if you want to use today's date as the Payment Date, you can press the " \* " key on the number pad of the keyboard and the ELF will auto fill today's date for you.

If you are posting a check with multiple payments and you would like to save the check # and payment date, press the Ctrl/Alt/S keys after you've entered the payment date. You will press the same keys after you've cleared out the check # and payment date to have the ELF stop auto filling in this information.

Mable Scott