



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

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OPEN LETTER FROM PRC PRESIDENT HARRY CURLEY

Dear Valued Office-Based Physician Client,

To continue providing cutting edge service to our clients, PRC is excited to announce our recent acquisition of the StreamlineMD Electronic Medical Record (EMR) software and service. The StreamlineMD EMR is:

- Top rated for small and mid-sized practices
- CCHIT certified
- Complete functionality including e-prescribing, patient portal, fast and accurate clinical documentation, document imaging management, health maintenance reminders and much more
- Remotely and securely hosted and accessible via the Internet
- True Microsoft Windows Application
- Highly customizable with breadth and depth to handle documentation for specialties and primary care

In an effort to remain a leader in the physician services and health information technology industry, PRC searched carefully for several months to find the ideal EMR service provider with not only a top-rated product but also an outstanding track record of implementation success, client service and client satisfaction. With the acquisition of StreamlineMD, PRC gained 50 physician EMR clients, with more than 300 users, in 13 states along with an experienced group of professionals who have expertise in training, implementation, template design and support.

We are now uniquely positioned to offer a true end-to-end solution for office-based physician practices including:

- CCHIT certified StreamlineMD EMR
- Full spectrum Practice Management System including Enterprise Scheduling
- Complete EDI Claims Services including ANSI 837/835, 270/271, 276/277
- Patient Collection Package including Patient Friendly Statements, Third-Party Collection Letters, and Electronic Patient Collection Calls
- Outsourced Billing Services including Coding, Payment Processing, Denial Management, Insurance Follow-Up, Patient Calls, Refund Processing and Monthly Performance Review

You will be contacted by a client relations representative in the next few weeks to give you the opportunity to ask questions or schedule a product demonstration. In the meantime, if you have any questions, please contact your PRC client representative.

We thank you for your business and look forward to continuing to serve you with outstanding service and technology.

Harry G. Curley
 President/CEO
 Professional Receivables Control, Inc. (PRC)
 3333 S. Arlington Road, Akron, Ohio 44312

MEDICARE WILL PAY FOR SWINE FLU TESTS

If you are doing nasal swabs for swine flu testing you may bill **87081**-culture, presumptive, pathogenic organisms, screening only and **89190**-nasal smear of eosinophils to report your procedures. Several V codes are applicable: **V01.8**; contact with or exposure to other communicable diseases, **V72.6**; special investigations and exams; lab exam (this can be reported along with special screening exams. Other V codes suggested in an article in *Part B News* include **V73.0 – V82.9**, **V70.0-V70.7**, **V20.2** and **V71.0-V71.9**.

OFFICE OF INSPECTOR GENERAL OPEN LETTER TO PROVIDERS

The OIG limits what you can self-disclose to avoid penalties for fraud violations. Basically this open letter to you says you can no longer self-disclose if it involves only liability under the physician self-referral law absent of anti-kickback statute violations. They will still accept self disclosures of violations of the anti-kickback laws regardless of violations under the self-referral provision. You can read the letter here:

<http://www.oig.hhs.gov/fraud/docs/openletters/OpenLetter3-24-09.pdf>

If the OIG accepts a self-disclosure of a kickback, there is a \$50,000 minimum amount you can expect to pay.

SECONDARY INSURANCE CLAIMS

Don't short change your patients by not filing their secondary claims on a zero balance after primary insurance has paid. You should always collect your copays based on the primary insurance but even if the primary insurer pays the claim in total you should always file the secondary unless you know for sure that the secondary coverage does not cover copay amounts. Granted this may put you into a credit situation which you then will have to refund to the patient but with new patients, until you are sure of how their coverage works, you should be collecting the copay and then refunding if the secondary pays.

There are two reasons for this approach. Until you know for sure, the secondary may not cover copay amounts or they may make that payment to the patient. On the first claim you should collect the copay and then file. Once you have established that the secondary will cover the copay and make payment to you (not to the patient) then you can mark the account and stop collecting the copay up front.

This goes back to the old adage, “A bird in the hand is worth two in the bush”, would you rather owe your patient a refund or have your patient owe you back copay amounts?

PALMETTO GBA REDETERMINATION STATUS TOOL

If you missed the announcement back in March, PalmettoGBA has an appeal status lookup tool on their website at <http://palmettogba.com/internet/RSDB.nsf/ICNn?OpenForm> . You can also find this tool directly from the homepage under **Cool Tools & Top Links**.

You will need the Internal Control Number (ICN) from your remittance notice. If you submitted multiple claims for the same service use the ICN from the initial claim determination remittance notice. If the remit shows a remark code MA130 then the notice is **not** considered an initial claim determination as the code MA130 is a rejection due to claim error and these services cannot be appealed but have to be corrected and resubmitted.

JURISDICTIONAL PRICING WILL USE FULL 9 DIGIT ZIP CODES

Currently, Medicare contractors may take up to a month to process claims for services provided in areas with new 4-digit ZIP code extensions that haven't yet been added to the CMS 9-digit ZIP code file. The shared system will make necessary revisions to allow +4 ZIP codes extensions which do not appear in the CMS ZIP code file but are valid according to the USPS and therefore speed up the jurisdictional pricing.

As of July 6, 2009, claims processed by Medicare contractors will add valid 4-digit ZIP code extensions more quickly to the 9-digit ZIP code file that the contractors receive quarterly from CMS. This should avoid any further delays in processing claims.

PQRI QUESTION AND ANSWER

Palmetto GBA, the Ohio Part B carrier, had this question and answer in their question and answer section.

Q: Does a Physician Quality Reporting Initiative (PQRI) code that is separated from the qualifying procedure code and returned as unprocessable still report to CMS?

A: In order for the PQRI codes to report to CMS, all measure-specific coding must be on the same claim. If a claim submission error caused the PQRI code to separate and be returned as unprocessable, the PQRI code will not be counted toward 'successful reporting.

Read more PQRI updates here http://www.cms.hhs.gov/PQRI/02_Spotlight.asp#TopOfPage

NEW PATIENT VERSUS ESTABLISHED IN MULTI-PRACTITIONER GROUP

If your practice is “multi-specialty” you need to make sure that you understand the new versus established patients within your practice. Basically it's based on the specialty. If an internist sees the patient as a new patient and that same patient is seen 3 months later by another internist in the practice, then the patient is considered established on the second visit even though that internist has never seen the patient before. However, if the second visit it to a cardiologist in the same practice, then the cardiologist can also bill as a new patient.

The key to this is how the providers are registered with Medicare. If you run into a snag, double check the Medicare certification. If you have a physician who was and is registered as an internist but is working now as a cardiologist you need to update that certification to reflect his current specialty.

Another issue might be in subspecialties that do not have their own designation. *Medical Office Billing and Collections Alert* warns that a few areas might run into this problem. They list otology being a sub-subspecialty of otolaryngology and two others that might run into this issue include neuro-ophthalmology and neurology-otology among others.

PTAN REACTIVATION

If your Medicare provider number (PTAN) has been deactivated and you need to reactivate you must use one of the following forms:

INDIVIDUAL PROVIDER – CMS -8551 application form

GROUP MEMBER – CMS-8551 and the CMS-855R application forms

GROUP OR ORGANIZATION – CMS-855B application form. Remember that reactivating the Group will not reactive the group members. You will have to reactive each individual with a CMS-8551 as stated above.

You can download the forms via the CMS website here: <http://www.cms.hhs.gov/CMSForms/CMSForms/list.asp?filtertype=dual&datefiltertype=&datefilterinterval=&filtertype=keyword&keyword=855&intNumPerPage=10&cmdFilterList=Show+Items>

PERIPHERAL VASCULAR CATHETER PLACEMENT BILLING

If your cardiologist is performing PVC placement you may be experiencing a lot of denials. An article in *Part B News*, March 30, 2009 gives some advice on how to minimize denials. Ruth Fisher, practice administrator for Academic Heart and Vascular PLLC in Detroit has been billing these services for years and offers the following suggestions:

1. "Make sure your physicians are dictating accurate, thorough notes. "Doctors have to be very specific about how the catheter was placed," says Kristen Griffith CPC, billing manager for Academic Heart and Vascular. **The operative note must include:**

- which limb was used for insertion,
- where the catheter was placed,
- where the catheter itself ended up, and
- which areas were being examined for diagnosis.

2. Ask your physicians to educate your coding and billing staff. Peripheral vascular catheter procedures are so complex that many coders need a better explanation of the clinical side, Griffith says. When she began billing these services, she asked her physicians to sit down and explain the points on the body the catheter was being placed in. "Try and put in perspective, it really helps the billers and coders," she says. "I really don't think you can pick it up by just sitting down and reading your CPT book." The face time with physicians also gives coders a chance to tell doctors if their notes are unclear, Griffith says. "If I'm seeing a pattern in the reports, that something is missing or lacking, I sit down with the physicians and explain to them the importance of their dictation for the operative report."

3. Watch out for bundling issues. Bundling mistakes account for many denials, says Linda Gates-Striby, compliance manager for The Care Group in Indianapolis. "Peripheral billing rules state you can't bill a non-selective code and a selective code in the same session," she says. "A selective code takes precedence over a nonselective code." So 36200, a non-selective code, The one exception: a non-selective and a selective code can both be billed on one claim if two sites of access were used. This must be clear in the documentation, Gates-Striby says.

4. Don't forget modifiers. Sometimes multiple modifiers – including modifier 59 (distinct procedural service) – must be appended to codes for proper claims processing, Griffith says. This can get complicated, fast. Example: 36215 is bundled into 36216 (place catheter in artery, \$1,211.84), but you'll need to bill for both when a selective bilateral carotid angiography is performed. You must bill the right common carotid catheter placement using 36216 and the left as 36215 because they are two different vascular families, Griffith says. You'll need to use the RT modifier on 36216 to indicate it was on the right carotid and the LT modifier on 36215 to indicate it was the left carotid. On top of this, you'll need to use modifier 59 with 36215 to show it was distinct and separate from the 36216 in this situation."

GENERAL EQUIVALENCE MAPPINGS (GEM) WHAT IS IT?

ICD-10 is coming and CMS has put out a MedLearn Matters product that migrates ICD-9-CM to and from ICD-10-CM and ICD-10-PCS. Find it here: http://www.cms.hhs.gov/MLNProducts/downloads/ICD-10_GEM_factsheet.pdf and here <http://www.cms.hhs.gov/MLNProducts/downloads/ICD-10Mappingfactsheet.pdf>.

CMS HAS NEW MEDICARE PILOT PROGRAM TO ELIMINATE RE-ADMISSIONS

CMS announced back in April that 14 communities around the country have been chosen for their Care Transitions Project. CMS tells us that their data shows that nearly one in five patients will be re-admitted to the hospital within one month of their initial discharge and more than 75% of those re-admissions are preventable.

In their pilot program they have assigned state quality improvement organizations (QIO) that already exist in the states, to look at the re-admission problems in their areas and work with all levels of health care within their communities to provide smooth transitions between health care settings. Rather than making a national one size fits all approach they are looking at each of the 14 areas at the local community level and will design a system that will fit those areas particular needs.

The 14 regions involved are Providence, R.I.; Upper Capitol Region, N.Y.; western Pennsylvania; southwestern New Jersey; metro Atlanta east, Ga.; Miami, Fla.; Tuscaloosa, Ala.; Evansville, Ind.; Greater Lansing Area, Mi.; Omaha, Ne.; Baton Rouge, La.; northwest Denver, Colo.; Harlingen, Tx.; and Whatcom County, Wa.

To read more about this go to: <http://www.cfmc.org/caretransitions/> and <http://www.cms.hhs.gov/qualityimprovementorgs>

Later this year CMS will make the tracking information they gather through this project available at <http://www.hospitalcompare.hhs.gov>

CMS PAYMENT TOOL

CMS offers a great tool for you to use if you want to research their payments on services or procedures. Find it here: http://www.cms.hhs.gov/pfslookup/02_PFSsearch.asp Remember you never charge only what they will pay but you can use this information to help you determine your charges. Your PRC client representative is available to help you determine fees to charge.

CIGNA CARE COST ESTIMATOR

Cigna has made a care cost estimator available to you and your patients. If you are registered on their website www.cignaforhcp.com you can use this tool to let your patient's know in advance what their insurance will pay and what they will be responsible to pay out of pocket.

CIGNA TRANSITIONING OUT OF SSN ON ID CARDS AND RECORDS

Cigna has announced that they will, as other insurance companies have, remove SSN information from ID cards. Cigna is also doing the same with their Great West Healthcare products. Be sure to use the ID numbers listed on the cards and ask for the cards at each visit as new cards with new ID numbers will be issued.

As Cigna and other companies work to remove SSN from ID cards new cards may be issued throughout the year so looking at the insurance cards at each visit is imperative to make sure you have all the ID updates as the new cards are issued.

Remember to register on the Cigna website www.cignaforhcp.com and the Great West website www.GreatWestHealthcare.com/Providers . On Cigna click on “Register Now” and they will walk you through the process, on Great West click on “Register”. A guide and instructions are available at “Help & User Tools”. Once registered, you can access eligibility and benefit information, deductibles, out-of-pocket, and lifetime maximums; submit and view precert requests; access policy and procedure information on both sites. On Cigna’s site you can also request fee schedule information, inquire about claim coding and covered services. Cigna also has a function that allows you to designate access to the site to other uses. Both sites also have online forms to update and changes in your practice.

TO BILL OR NOT TO BILL FOR NO-SHOWS

No-shows have always been a problem in a medical practice but it’s likely that in today’s economy you are seeing more of them. Now the question is how to handle them. Your first step is to review your insurance contracts to make sure they don’t prohibit your billing their subscribers for no-shows. Medicare used to prohibit no-show billings but CMS changed that policy as long as you bill no-shows for all your patients, not just Medicare recipients. Most insurance companies will not allow a no-show charge, if the patient cancels at least 24 hours prior to their appointment time. You should also check with your particular state to make sure there are no state laws prohibiting no- show charges.

Now that you’ve decided to start looking into this problem, you may want to set up a no-show tracking code in your system to determine if you really have a no-show problem within your practice. Contact your PRC Customer Representative and she will be glad to help you set up a tracking code. You can then run this code for report purposes to determine if you really do have a no-show problem. You can also use this code to track no-shows for a patient warning program that I detail later.

Once you have determined that no-shows are indeed causing you a loss of income, you have to set up a no-show policy and make your patients aware of that policy. Most practices charge \$25 to \$50 for no-shows. *Medical Office Billing & Collections Alert* gives this example: “Failure to give 24-hour notice of cancellation of an appointment or not showing up for an appointment can result in a charge of \$25.00 on your account. This charge is non-covered by your insurance company and is your responsibility. Failure to pay a no-show fee will be treated the same as our policy on unpaid patient balances and will be subject to reporting to a collection agency if unpaid.”

You may also decide that you will send out a warning letter and only charge for no-shows on chronic no-show patients. For example, each time a patient doesn’t keep an appointment, the tracking code should be entered in the computer (no charge or billing) and the chart marked with the date and “no-show”. The physician needs to know about the no-shows to deal with non-compliance issues with the patient. You may decide to allow two no-shows then send a warning letter explaining that the patient chart shows two previous no-shows and if they continue you will be billing the patient \$25.00 for each appointment not cancelled within the 24 hour set time period.

This is one way to help educate your patients on how your office is handling this loss of income. Each office has to decide how they want to handle this problem and set up tracking and billing codes.

Another benefit to tracking no-shows and marking them in the chart is that it will enable your physician to decide if he/she wants to release the chronic no-show patient for non-compliance. If the problem becomes a health issue your physician may decide he/she doesn't want to continue to be responsible for that patient. Charting the no-shows keeps the physician in the loop.

Remember you never bill an insurance company for a no-show fee. These are always billed to the patient. I believe that you should only initiate a no-show charge if you find you have chronic no-show problems. This can result in a PR problem with your patients and should be dealt with on a case by case basis keeping good communication between your practice and your patient.

I have samples of a no-show warning letter and a dismissal letter. If you want them email me at mrscott@comcast.net and I'll send you a copy.

PQRI AND E-PRESCRIBING BONUSES

If you haven't added G codes used for e-prescribing to your route slips, you may want to make your physician's life a little easier by doing so. The addition of these codes will make it easy for your physician to check off the appropriate code when performing new patient, established patient, consults and screening and diabetic training.

As I reported previously, by 2012 you will experience a 1% cut in pay from Medicare if you are not e-prescribing so, in the next few years, make sure you get this started. If you are already using e-prescribing don't forget that you can still report G8446 (e-prescribing system available, but not used for one or more prescriptions due to patient/system reasons) to get your bonus on those narcotics and other controlled substances that you prescribe that are banned from being electronically prescribed. You can also use this code for prescriptions where your state laws prohibit e-prescribing specific drugs. It's also okay to use it if you don't e-prescribe because the pharmacy can't receive e-prescriptions or when the patient specifically requests a paper prescription.

MEDICARE COVERING GASTRIC BYPASS IN DIABETIC PATIENTS

On and after February 12, 2009 CMS determined that open and Laparoscopic Rous-en-Y gastric bypass , laparoscopic adjustable gastric banding, and open and laparoscopic biliopancreatic diversion with duodenal switch in Medicare patients who have type 2 diabetes mellitus **will be covered as long as the body mass index is greater than 35**. If the body mass is under 35 CMS deemed the above procedures do not meet the medical necessity standard that they use to determine coverage. See the complete Medlearn Matters article here <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6419.pdf>. Also the surgery has to be performed at an approved facility. For a list of CMS approved facilities go to <http://www.cms.hhs.gov/MedicareApprovedFacilitie/BSF/list.asp#TopOfPage>

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