



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

Please route to appropriate staff

Newsletter access is also available through the help menu

If any of the links in this newsletter do not work, please copy and paste them into your browser.

MEDPAC RECOMMENDS 2010 REDUCTIONS ON TC OF IMAGING

Usually I don't do articles on "ifs and maybe" articles but this one needs some attention. Medicare Payment Advisory Commission (MedPAC) has sent a report to Congress suggesting a change in the formula used to calculate the technical component (TC) of some imaging services.

To try to make a long story short, MedPac reported that there has been rapid growth in expensive imaging services which they attribute, in part, to overly high relative value units (RVUs), which have had the result of providers purchasing expensive machines (MRIs and CTs) and using them as frequently as possible.

Now the payments are currently being calculated by CMS on 25 hours per week use time. MedPAC cited evidence that imaging providers are using CT and MRI machine much more than CMS assumes. The 25 hour per week use factor that is used now has led to higher RVUs for imaging services, according to the report.

MedPAC suggests that the use time be raised to 45 hours per week for costly equipment. This change would result in the reduction of the estimated equipment cost by 44 percent and then the subsequent reduction in reimbursement.

There are several areas of concern with this report. Policymakers have to define "expensive" machines. MedPAC suggests it be defined as a machine costing \$1 million or more. A statutory change would be required because of the Balanced Budget Act of 1997. MedPAC also plans to examine several areas besides the Medical payment policy with regard to lack of adherence to clinical guidelines, incentives in the fee for service system to generate more volume, and financial incentives for physicians who own imaging equipment. *

Find more information in the "Report to Congress: Medicare Payment Policy" (March 2009) available at http://www.medpac.gov/documents/Mar09_EntireReport.pdf.

BUILDING YOUR PATIENT BASE

When you start a new practice, building a patient base is on your mind. What about now? Are you happy with your practice income? Have you noticed a down turn? Today's economy may well be the culprit so what can you do about that?

I read an article recently in *Part B News* about taking control of your patient base and found their concepts very interesting. They talk about a new practice that had the forethought to review its payers and pick an insurance that paid them the best on their services. Once the insurance company was determined, they found a large, local employer who used that insurance company and got in front of that patient base by offering flu shots billing only for what they had to pay for the vaccine. They spent two days at the company and benefited greatly for that time. They gained many new patients all insured with that company that reimbursed them at a high rate.

There is no reason why an established practice can't actively pursue patients covered by their best reimbursement insurance contracts.

Part B News offers this tip: "When you identify a patient or payer that's a good fit for your practice – be proactive. Call a human resource director and ask how you can get in front of their workers... This could be a meeting for a brown-bag lunch and advertising in a company newsletter.

Remember your practice is constantly changing and you should continue to re-evaluate your practice needs as to where you are and where you want to go. Patient mix based on insurance carrier is essential to stay ahead of today's economy.

The Medical Group Management Association is quoted by *Part B News* as stating, "Performance and Practices of Successful Medical Groups" report shows that the average practice payer mix differs by specialty. Example: Better primary care performers have a patient mix of 16.4% Medicare fee-for-service (FFS), 27.6% commercial FFS and 36.8% commercial managed care FFS. Better-performing single specialty practices have a mix of 41.7% Medicare, 29% commercial FFS and 17.5% commercial managed care FFS.

In some parts of the country Medicare pays better than the commercial companies so it's important that you review your particular area when determining your desired payer mix.

Your ELF system is capable of providing you with payment reports. If you need assistance contact your PRC customer representative.

MODIFIERS THAT BYPASS CCI EDITS

Correct Coding Edits are there to allow carriers to catch claims that are in excess of the standards that are set. We all know the familiar ones; global period denials during periods covered during post-op periods. E&M denials based on other services provided the same day, etc. The CCI edits can be bypassed, when appropriate, by using modifiers. You can find information on those modifiers in Chapter One of the NCCI Edits Manual, Chapter One. Go to <http://www.cms.hhs.gov/NationalCorrectCodInitEd/> and scroll down to NCCI Policy Manual for Medicare Services. There is also a good informational section on the proper use of Modifier 59.

Remember to check your CCI listings for indicator "1". As you know indicator "0" means that you can't override the edit but a "1" means you may use a modifier (59) to override the edit if the procedures are separate and distinct from each other.

A Part B News article advises “Get ready for carrier review of modifier 79 claims”. Modifier 79 (unrelated procedure service by the same physician during the postoperative period) usage will be looked at closer this year. Abuse of this modifier has been detected and if you use 79 it could mean slower re-imburement and requests for additional documentation and if not supported eventual denials.

Some tips offered: Restrict use of 79 to major surgical procedures with 90 follow-up period. For lesser procedure with only 10 follow-up periods consider using modifier 59 (distinct procedural service) if appropriate. Remember “same physician” in 79 description means physicians of the same specialty in the same practice. Modifier 79 should only be used if you return to the operating room. If you do a related procedure to the primary surgery but do not return to the operating room to do that procedure you can not bill it separately. Do not use 79 for routine complications. However, if you do a minor procedure the first time and find that a more extensive procedure is necessary you should bill that subsequent procedure with modifier 79.

This brings us back to my old favorite **documentation**. As with any service make sure your documentation supports why you didn’t do the second surgery while the patient was on the table for the first surgery and be clear about it.

TOOL TO HELP CONVERT ICD-9-10 TO ICD-10-CM AND ICD-10-PCS

CMS is offering a tool to help with the conversion of ICD-9-CM to and from ICD-10-CM and ICD-10-PCS fact sheet, through their MLN Product Ordering Page. This is now available in print from the Centers for Medicare & Medicaid Services Medicare Learning Network. To place your order, visit <http://www.cms.hhs.gov/MLNGenInfo/> scroll down to “Related Links Inside CMS” and select “MLN Product Ordering Page.”

NEW SPECIALITY CODE

If you have tried to bill palliative care in the past and ran into trouble trying to do so, CMS has finally added a new specialty code 17 (Palliative or Hospice) which should help in those situations where your palliative physician is co-managing a patient in hospital under their internist.

If your physician is interested in changing his/her specialty designation, see this link for more information:

<http://www.palmettogba.com/palmetto/providers.nsf/DocsCat/Providers~Ohio%20Part%20B%20Carrier~Articles~General~Adding%20a%20New%20Specialty%20Code%20for%20Hospice%20and%20Palliative%20Care?opendocument>

DMEPOS ACCREDITATION EXEMPTIONS

Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) requires all DMEPOS suppliers to meet quality standards and be accredited by **9/30/2009**. All those required to be accredited but fail to do so by 9/30/2009 will have their Medicare billing rights revoked as of 10/01/2009.

However, the following professionals are exempted from the need to be accredited:

• Physicians	• Physical Therapists	• Occupational Therapists
--------------	-----------------------	---------------------------

• Opticians	• Physician Assistants	• Nurse Practitioners
• Clinical Nurse Specialists	• CRNAs	• Certified Nurse-Midwives
• Clinical Social Workers	• Clinical Psychologists	• Registered Dieticians
• Nutritional professionals	• Orthotists	• Prosthetists
• Qualified Speech-Language Pathologists	• Audiologists	

Palmetto GBA, April 2009, Spring Update

For more information see: <http://www.cms.hhs.gov/MedicareProviderSupEnroll> and select DMEPOS Accreditation link.

2010 ICD-9 CODE SETS

Part B News reported that CMS has released nearly 150 new ICD-9 diagnosis codes, 170 E codes effective in October. They also report that there will be less than half the new diagnosis codes than there were for this year.

Remember there is no grace period so make sure you have your new ICD-9 code books for 2010 ready by October 1, 2009

MEDICARE PAYS FOR TRAINING DIABETIC PATIENTS ON HOME MONITOR UNITS

Diabetes self management training (DSMT) is covered by Medicare when the training is done by a certified provider who meets Medicare's quality standards. The training includes instructions in self monitoring blood glucose levels; education on diet and exercise; an insulin treatment plan which is patient specific and insulin dependent; and motivating the patient to use all these skills for self-management of their diabetes.

The above services may be covered as long as the physician or qualified non-physician provider certifies the services are needed and maintain a plan of care in the patient's medical record. The documentation must state why individual training is needed instead of group training.

For details on what is required in documentation, definitions of initial and follow-up training, billing codes, certification requirements for those providing the services and more go to: <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0905.pdf>

PHYSICIAN RATING WEBSITES

Word of mouth has always been a great way to expand a business. Your medical practice probably has a good number of patients that you received because a friend told them that you were a good doctor. Today that word is being spread in new ways via websites set up exclusively to give the public a venue to rate their physician. One of the largest is HealthGrades.com <http://www.healthgrades.com/>.

Per Part B News, an interview with Scott Shapiro, senior vice president for this site is quoted, "Historically we've been focused on objective information. If [patients] want to have an extended rant about a doctor, there are probably other web sites that they could do that on."

You can create a free account on HealthGrades and list your practice information. You can also add photos to your profile and enhance them with background on your physicians. There is a warning in listing your practice on websites. You MUST keep the records current. One practice is quoted as having problems with patients getting the wrong office address off a website that was not updated when the practice moved so make sure, if you choose a website to advertise your practice, that you keep the listings current.

HealthGrades does not allow "free text" in rating physicians but there are other sites that do such as www.RateMDs.com and www.Vitals.com. Part B News advises, "If you feel a comment is false or inappropriate, flag the comment for review by clicking on the little red flag icon beneath each comment on RateMDs.com. Their staff will look over the comment and remove it if they agree with your complaint. RateMDs service is entirely free and paid for by ads and you can not change your practice information but you can respond to ratings for free.

Remember that getting involved with these sites can be frustrating. You may feel that a comment is libelous or just unfair and with some sites you can return a comment as mentioned above, some site do not allow this. However, if you use the patient comments as a way to improve your practice, these sites may have some positive value.

From Part B News here is a review of these three popular sites:

1. www.HealthGrades.com. The largest and best-known physician review site, HealthGrades has approximately 750,000 physician profiles and gets an estimated 7 million visits every month.
 - **Review type:** numerical scale only, aggregated.
 - **Patient services:** free physician profile search, free physician ratings, detailed physician background reports (fee).
 - **Provider services:** free profile management, consulting services (fee), appointment-booking capability (fee).
2. www.RateMDs.com. A popular site fueled by ad revenues, RateMDs has a database of 800,000 physician profiles, but only 194,600 of those have actually ratings by patients. Roughly 900 new ratings are added by patients daily.
 - **Review type:** numerical scale, free-text comments.
 - **Patient services:** free physician profile search, free physician ratings/comments.
 - **Provider services:** free responses to comments, ability to flag potentially offensive ratings/comments.
3. www.Vitals.com. Vitals is similar to RateMDs, but also offers physicians a tracking service that sends alerts when patients give ratings. The site has a database of 720,000 physicians, though many have no rating or only one rating. The site gets about 1.4 million unique visitors monthly, according to a spokesman.
 - **Review type:** numerical scale, free-text comments.
 - **Patient services:** free physician profile search, free physician ratings/comments, online physician Q&A (fee).
 - **Provider services:** free responses to comments, free profile management.

Basically the old “comment box” way of gathering your patient’s opinions and requests on how your practice is doing has expanded to the internet and is now available to future new patients. Whether you choose to use them is totally up to you but you may want to take a look and educate yourself on what information is out there on the net.

PRIVACY RULE OF THE HIPPA ACT

We have all been aware of the need to protect the privacy of our patients. This is nothing new but knowing and doing may be two different things. All members of your staff should be made aware of the restrictions and permitted disclosures of your patient’s personal health information.

Health and Human Services (HHS) provides guidance in these areas. Per PalmettoGBA HIPAA does not require patient signatures to share information with other providers where treatment is concerned. There are several places where you can find guidance information from HHS.

You can review answers to frequently asked questions at www.hhs.gov/hipaafaq . Use the search engine to research areas like “treatment”. Another is the consult fact sheet, “Uses and Disclosures for Treatment, Payment, and Health Care Operations,” at www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/usesanddisclosuresfortpo.html .

You can review the “Summary of the HIPAA Privacy Rule” at www.hhs.gov/ocr/privacy/hipaa/understanding/summary/index.html. Review the provider’s guide on communicating with the patient’s family at www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/provider_ffg.pdf . HIPAA does allow you to report suspected child abuse or neglect to appropriate authorities. See more information at www.hhs.gov/ocr/privacy/hipaa/understanding/special/publichealth/index.html.

Another point to remember is that HIPAA does allow physicians to use e-mail, telephone, or fax to communicate with patients and other doctors as long as you use common sense and appropriate safeguards to protect your patient’s privacy. This is discussed at www.hhs.gov/hipaafaw/providers/smaller/482.html.

You may want to “bookmark” these sites for future reference.

ANTI-MARKUP PRICING LIMITATION ON PURCHASED DIAGNOSTIC TESTS

If you are considering taking on billing for *purchased diagnostic tests*, now being called *anti-markup tests*, there is a lot to consider. Basically, any time you bill for the Technical Component (TC) or Professional Component (PC) when those services are performed by a provider not in your practice, you are limited in what you can charge. Those charges may not exceed what you are billed by that provider. But that amount is limited to the billing physician or other supplier’s actual charge and/or the fee schedule amount for the test that would be allowed if the performing provider billed Medicare directly.

There is a lot more information available in this MedLearn Matters 6673 <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6371.pdf> .

MEDICARE CHANGE IN ROUTINE FOOT CARE FOR DIABETIC PATIENTS

In short they are limiting payment to once every 6 months, as of 6/08/2009. The original directive Transmittal 1731, has been rescinded and replaced with Transmittal 1742 <http://www.cms.hhs.gov/transmittals/downloads/R1742CP.pdf>. Scroll through to page 6 for your directive.

Mable Scott,
mrscott@comcast.net