



**Professional Receivables Control, Inc.  
Monthly Newsletter  
December 2008**

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**HAPPY HOLIDAYS FROM ALL OF US AT PRC**

**HAVING TROUBLE RUNNING YOUR ELF OR SCHEDULER?**

Do you feel you need some training on the ELF and Appointment Scheduler? Contact Nora at PRC (330) 564-2614.

**SNF CONSOLIDATED BILLING -NEW EDITS FOR 2009**

The first week of this month, CMS will post new Excel and PDF files at <http://www.cms.hhs.gov/SNFConsolidatedBilling/> Per CMS, it is imperative that you view the General Explanation of the Major Categories PDF file at the bottom of each year's FI (Fiscal Intermediary) update so you understand the Major Categories including additional exclusions not driven by HCPCS codes. The FIs already have edits in place that won't allow payment for services provided to a patient in a Part A covered SNF stay which are covered by the consolidated billing. They are adding more edits to the existing ones.

**MEDICARE SECONDARY CONDITIONAL PAYMENTS**

What is a Medicare Secondary Conditional Payment? A Medicare Conditional Payment is when there is another payer who should be primary but fails to make payment. Medicare steps in and pays the claim with the condition that the Medicare payment is returned if the primary payer finally pays the claim.

**WHEN WILL MEDICARE MAKE A CONDITIONAL PAYMENT?** Medicare will make a conditional payment for Medicare covered services in the situations listed below. For more specific circumstances under which a Medicare conditional payment may not be made, refer to the CMS Internet-Only Manuals, Publication 100-05, Medicare Secondary Payer Manual.

- If the Workers' Compensation (WC), No-Fault (NF), or liability insurance will not pay or will not pay promptly (i.e., within 120 days), Medicare makes conditional payments to prevent the patient from using his or her own money to pay the claim. However, Medicare has the right to recover any conditional payments. Refer to the MSP Manual, Chapter 1, Section 20, for the definition of "Promptly."

Note: If the injury resulted from an automobile accident and/or there is an indication of primary coverage under a Group Health Plan (GHP), the provider bills the liability insurer or no-fault insurer and/or GHP as appropriate before requesting conditional Medicare payments.

In Third Party Liability (TPL) cases, the provider may, after 120 days:

- Bill Medicare for conditional payments while withdrawing all claims/liens against the liability insurance/patient's liability insurance settlement (liens may be maintained for services not covered by Medicare and for Medicare deductibles and coinsurance), or
- Maintain all claims/liens against the liability insurance/patient's liability insurance settlement. If this option is chosen, Medicare may not be billed until the settlement is reached and only then if no monies were paid to the patient. All usual claims processing rules would still apply. The provider may charge beneficiaries actual charges, up to the amount of the proceeds of the liability insurance less applicable procurement costs but may not collect payment from the patient until after the proceeds of the liability insurance are available to the patient.
- If because of physical or mental incapacity of the patient, the provider or patient failed to file a proper<sup>1</sup> claim with the primary payer.
- When benefits have been exhausted under the non-group health plan (WC, NF, Liability).
- When the provider files a proper claim with the GHP and the GHP denies the claim in whole or in part for reasons that include:
  - The patient is not entitled to benefits,
  - The plan benefits are exhausted,
  - The services rendered are not covered services under the plan,
  - The patient is appealing the GHP's denial (refer to MSP Manual, Chapter 5, Section 40.6 for exception),
  - The primary payer is bankrupt or insolvent and proceedings have concluded (Refer to MSP Manual, Chapter 5, Section 40.5 for additional information).

## **VERIFYING INSURANCE COVERAGE**

Taking time to verify insurance coverage is a tedious job, at best, but necessary. When your income is reliant on receiving payment from a third party carrier, it is a must to make sure you have the right information and make sure your patient's coverage is intact.

Here are some tips to make this job easier:

1. Get insurance information on all patients, new and established at the time you make their appointment.
2. Avoid peak calling times by setting aside a time during the day to call on all the patients scheduled for the following day.
3. If you have 4 patients all covered with the same company, get all verified with one call. Sort your patients by insurance company to make your calls.
4. Copy all cards each time the patient comes in, even if the carrier is the same. Especially at the beginning of the year patients may have the same company but the coverage may have changed in terms of coverage and copays, etc. Note that not all contracts start anew at the beginning of the year so be diligent in copying the cards.
5. Use carrier websites to verify coverage when ever possible. It's a good idea to familiarize yourself with the carriers that offer this online service. Make a list and don't waste time calling these carriers when you can verify via their websites

## **CMS POSTS EXCEPTION TO NPI RULE FOR MAMMOGRAPHY**

CMS Transmittal 1624 gives an exception to the NPI rule for mammography when services are done outside your Medicare Administrative Contractor (MAC) jurisdiction. See the transmittal here: [www.cms.hhs.gov/transmittals/downloads/R1624CP.pdf](http://www.cms.hhs.gov/transmittals/downloads/R1624CP.pdf)

### **COLLECTING UP-FRONT DEDUCTIBLES**

2009 is around the corner and another period of patient's meeting their deductibles and out of pocket expenses. Once you have verified insurance coverage, the next step is to find out if the patient still owes a dollar amount toward their required yearly deductible and educate your patients, prior to their appointment, to the fact that they will owe that deductible amount at the time of service.

Again, this is a communication/education effort on your part to avoid gaps in your income base. Be aware that the deductible issue isn't just during the beginning of the year. If your patient has not had enough medical care to meet their deductible at the first part of each calendar year, you may encounter deductibles later in the year as well.

### **INDEPENDENT DIAGNOSTIC TESTING FACILITY RADIOLOGY RESTRICTIONS**

Unlike inpatient and outpatient hospital patients, if you, as a radiologist, are working in an IDTF you are required to have an order from the treating/ordering provider for all tests provided. You may not change the tests ordered nor add any additional testing without an order.

A radiologist who performs therapeutic interventional procedures is a treating physician. However, a radiologist who performs a diagnostic procedure is **not** a treating physician.

CMS rules do allow some leeway. Medicare Manual, section 15021 (E)(1) states that "unless specified in the order, the interpreting physician may determine, without notifying the treating physician/practitioner, the parameters of the diagnostic test (e.g., number of radiographic views obtained, thickness of tomographic sections acquired, use or non-use of contrast media)" See the full transmittal at [www.cms.hhs.gov/Transmittals/Downloads/R80BP.pdf](http://www.cms.hhs.gov/Transmittals/Downloads/R80BP.pdf)

Be aware that these guidelines give the leeway to the radiologist but do not give the same leeway to the technologist.

*Radiology Coding Alert* warns: "If your IDTF can't reach the treating physician or practitioner to get a new order or change the original one, MCM section 15021 provides an exception to the additional diagnostic radiology test order requirement.

Pay attention: Documentation must note the failed attempt to reach the treating provider. And you must be sure you meet all of the criteria below:

1. The testing center performs the diagnostic test ordered by the treating physician/practitioner;
2. The radiologist at the testing facility determines and documents that, because of the abnormal result of the diagnostic test performed and additional diagnostic tests are medically necessary;
3. Delaying the performance of the additional diagnostic test would have an adverse effect on the beneficiary's care;
4. The radiologist communicates the test results to the treating physician/practitioner who uses them in the treatment of the beneficiary;
5. The radiologist at the testing facility documents in her report why the patient received additional testing.

## **ACCREDITATION REQUIREMENTS FOR ADVANCED IMAGING**

For some time there has been an ongoing argument between radiologists and non-radiologists with regard to the ability of non-radiologists to perform and interpret advanced imaging services.

Per a congressional order to CMS they have been told to initiate the required accreditation for physicians (non-radiologists) who perform advanced diagnostic imaging by 2012. Those services that will require accreditation are diagnostic resonance imaging, nuclear medicine, computed tomography and others. No accreditation will be required for x-rays, ultrasounds or fluoroscopies. By the end of 2009 CMS will choose the accreditations groups.

Another thing to be aware of is that CMS has been directed to review imaging services for two years to make sure these services are not being abused by overuse.

The Office of Government Accountability has reported on the increase of imaging services and the shift of these services to physician's offices. You can find that report here; <http://www.gao.gov/new.items/d0852.pdf>

## **PRIVATE FEE-FOR-SERVICE MEDICARE PLAN CHANGES**

Some time ago I did an article on private fee-for-service Medicare plans warning you that if you treated a patient with one of these plans and failed to notice the delineation of the plan on the card, you, for all intent and purposes, were "contracting" to accept their allowables.

One change that came with the Medicare Improvements to Patients and Providers Act (MIPPA) is a law that will require, in the year 2011, that any plan in a county that is serviced by two or more of these FFS plans must develop a provider network. This means that you will have to be in their "network" by signing a contract and will no longer have to be on your guard for these plans "deeming" you into an agreement.

However, in areas where there are no non-PFFS plans or only one other PFFS plan they will be able to continue the practice of "deeming" you into the agreement upon treatment of a subscribed patient.

You will be contacted in the next year or two if the plans are required to form networks in your county.

Another interesting note is that the government is now prohibiting how Medicare Advantage plans sell their products. No more free meals, no more cold calls to patients. I believe that the cold calls were prohibited before but it seems the "business" of Medicare Advantage plans has forgotten the verbal rules so now there will be consequences for them if they "forget".

## **CARRIER COMPUTER DENIAL ERRORS**

I'm sure you've heard the old adage, "garbage in – garbage out", in reference to computer systems. This holds true of insurance carriers especially when they do "updates". All of us feel that cold chill run up our spine when we hear that word.

For example let's think about the updates we've run up against in the past. Local LCD changes at Medicare, often causes problems if errors are made in the update. When you run your payment reports watch for a sudden rise in denials in any given area. If you find one, look for any update publications and make sure you have followed the changes they cover. If you've done your claims correctly, according to the carrier directives, then contact the carrier to have them look at the

denial to determine if it is carrier error. Be aware that “carrier error” with Medicare will allow you latitude with the 120 day limit on getting these claims reopened.

Other areas to watch are CCI updates. If the carrier hasn’t entered the updates into their system you could have denial errors. Another update to watch is your ICD-9 coverage updates. If the carrier fails to add a new covered diagnosis to their system you will be denied for medical necessity.

Be sure to research the CCI and ICD-9 updates before calling the carrier. Have that information available to support your claim.

## **REDEFINING THE MEDICAL OFFICE**

Some of you, who know me, know that I was a medical office manager for years before coming to PRC. I just read an article in *Medscape Business of Medicine* that really brought to light a problem that I knew well. It dealt with the changes in the job descriptions of the medical office and the separation of physician from support staff.

In the past the office manager was the “divider” between support staff and the physician. Our job was to keep the office running smoothly and protect the physicians from dealing with anything other than the care of the patients. Today offices are dealing with a conversion to what *Medscape* calls the “medical home”.

In this “medical home” environment it is necessary for a crossing-over effect of job descriptions and responsibilities. Basically, what the article says is that in today’s office it is necessary for everyone to be part of the basic plan to make the office run smoothly and efficiently, providing the best care to the patients. Simply what this means is that everyone has the responsibility to make sure everything they come in contact with is being done in an efficient manner promoting a “second-order” of problem solving. For example if a nurse is supplying one room by taking supplies from another room instead of stocking from the stock room, it is her responsibility to address why she doesn’t have time to do this properly. How many of you have problems with missing charts. Wouldn’t it be nice to find out what is going on with the charts and correct it? How is this done? By use of the monthly or weekly, if necessary, staff meetings. I know this is a dreaded option and most offices hate these meetings but seriously these meetings can alleviate a lot of ongoing problems. It is virtually impossible for a single person, office manager, to be every where all the time. It should be the responsibility of the staff and the doctors to address those problems they run into everyday in the performance of their duties at the staff meetings. Put all your minds together to improve your practice.

Another way to encourage these actions is to reward the “noisy” staff members when they call attention to recurring problems and help all staff to reframe problem areas.

So, take a look at your office and your frazzled office manager and see if some “reconstruction” is in order. Let all staff help with all problems. It will help the morale and certainly help correct ongoing problem areas. *Medscape* offers a referral to a book *The Team Handbook* (Madison, WI: Oriel Incorporated; 2003) and states that this book has a wide range of practical team building strategies and is written in a very accessible style.

## **ANTHEM TO STANDARDIZE I D CARDS**

The Blue Cross/Blue Shield Association has mandated that all BC/BS carriers across the country standardize the look of the identification cards. You may have started to see some of those as

early as October. So be sure to ask all your patients for their current insurance cards as there are some changes. I will include samples of the new cards as they become available.

### **CORRECT USE OF CCI EDITS**

As of July, 2008, if you have documentation that supports the use of modifier 59 (distinct or independent from the other non-E/M services performed on the same day) with a CPT code that contains codes from Column I and Column II of the CCI Edits you must attach the modifier 59 to the Column II code only. Here is the link to the CMS website CCI Edits <http://www.cms.hhs.gov/NationalCorrectCodInitEd/> . I like to use this site because CMS keeps it updated and current.

If you find that your claim was denied because you failed to apply the modifier 59. Do not send these into reconsideration. Call the reopening phone and they will add the modifier for you. Palmetto reopening line is 1-866-308-5441. Before you make the call, be sure to recheck the CCI edits to make sure the modifier is allowed. CCI edits are updated quarterly and the requirements might have changed.

Here is how the CCI Edits work:

- Code pairs identified with indicator 0 in the CCI list cannot be submitted separately for reimbursement under any circumstances. There are no exceptions to the CCI edits for indicator 0 codes.
- Code pairs identified with indicator 1 may be submitted separately for reimbursement if the two services are performed in a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same physician. Documentation must be maintained in the medical record to support the use of this modifier. No special documentation is required with the claim when CPT modifier 59 is submitted.
- Code pairs identified with indicator 9 are not subject to CCI edits. No modifier is required in these situations.
- When another modifier is appropriate, it should be used rather than CPT modifier 59.

### **ANTHEM AND ADVANCE DIRECTIVES**

Anthem checks for advance directives, on appropriate patients, when they do a chart audit in your office. They define appropriate patients as, "Appropriate members are defined as all Senior and/or Medicare Advantage members and those with chronic or catastrophic illness." For information on state-specific advance directives go to [www.ama-assn.org](http://www.ama-assn.org) and search key words *advance directives*.

Make sure you are, at the very least, asking your patients if they have an advance directive and if the answer is "no", then offer one for them to sign and keep a copy in their chart. Anthem will supply your office with a pamphlet explaining advance directives. Contact Cynthia Purtell, R.N. at (513)336-4733 or [Cynthia.purtell@anthem.com](mailto:Cynthia.purtell@anthem.com)

Mable Scott, [mrscott@comcast.net](mailto:mrscott@comcast.net)