

# Practice



Spring 2006



*The Academy of Medicine Cleveland/Northern Ohio Medical Association is pleased to offer our quarterly newsletter designed with you in mind—the practice manager, administrator, associate staff, billers and coders—all key personnel in the physician's office. We support your work and recognize the importance of a shared knowledge between our physician members and their staffs—helping us help you confront the rapid changes affecting the practice of medicine and office management today. If you have questions, concerns or a specific issue you would like our Practice Management Department to review, please contact us at 216.520.1000 ext. 314 or email [concerns@amcnoma.org](mailto:concerns@amcnoma.org)*

## PalmettoGBA

Also Inside this Issue:  
2006 Medical Records Fee  
Fact Sheet Update

### Medicare Physician Fee Schedule

- The Deficit Reduction Act of 2005 (DRA) has been signed into law. Among other provisions, the DRA mandates a 0% update from the 2005 MPFS. Some of the fee schedule amounts may have changed from 2005 rates, however. Changes may have occurred in one or more of several factors that are used to calculate the fee schedule amount. PalmettoGBA has begun making automatic adjustments to claims for dates of service January 1 through February 8, 2006, submitted during the same timeframe. The adjustments will be completed over the next several months. They will not adjust claims on which the billed amount is less than the current fee schedule amount. To request a reopening of your claim as a result of a change in the billed amount, please call the Telephone Reopening Line at 1-866-308-5441.

### Provider Contact Center Updates

- Effective this month, the new hours for the Provider Contact Center (PCC) will be 8:30 a.m. to 4:30 p.m. Monday through Friday. Self-service options are available through the Automated Response Unit (ARU) from 7 a.m. through 9 p.m. Monday—Friday. You may reach the PCC toll free at **1.877.567.9232**.
- First level Medicare appeals are now called redeterminations. Using the telephone redetermination process will quickly resolve most claim detail corrections that are appealable denials. For most carriers, the number of issues that can be reported is still limited to 3 claims per call. Some of the most common corrections via telephone include: units/dates of service; diagnosis codes and reference; modifiers (see next bullet point); place of service; incorrect fee schedule allowances' processing errors and clerical or minor errors. Failure to bill for a certain item or service **cannot** be submitted over the telephone. In such cases one must submit a new claim for items or services that were omitted.

### OIG Reports on Modifier Misuse

- The Office of Inspector General (OIG) recently released two reports that bear repeating to all providers: it would serve all practices well to conduct a coding audit of all modifier use, as the Medicare carriers will be auditing in the near future,

whether you do or not. Find and correct your coding mistakes now! Specifically out of the OIG came study results on modifiers 25 and 59 with these advisories:

Modifier 59 is used to indicate that a provider performed a distinct procedure or service for a beneficiary on the same day as another procedure or service. This modifier allows the code pair to bypass the edit and pay for both services. The OIG found that some 40% of these code pairs were improperly used costing an estimated \$59 million in improper payments and recommended that CMS encourage carriers to conduct pre- and postpayment reviews of the use of modifier 59 and ensure that carriers' claims processing systems only pay claims with 59 when the modifier is billed with the correct code. With respect to modifier 25, which is used to allow additional payment for E/M services performed on the same day as a procedure, the OIG found that 35% of such claims did not meet program requirements and resulted in \$538 million in improper payments. The OIG recommended to CMS that the agency work with carriers to reduce the number of these claims not meeting the requirements, provide the proper documentation and that 25 should only be used for E/M services. Also, if a physician provides an E/M service and also provides a therapeutic injection, you must use modifier 25 for the E/M service—without it, the E/M will be bundled into the therapeutic injection code.

#### **More NPI Help Available**

- January may have marked the onset of claims filing with the use of the newly assigned National Provider Identifiers or NPI for Medicare claims, but remember - CMS says it must be listed in addition to your PIN or UPIN or one may expect their claim to be return unpaid. The use of the NPI on the claim is considered phase II of the transition to NPI from the current PIN/UPIN numbers. From now until Oct. 1, 2006 while you are not required to use the NPI on a claim, the 10-digit NPI unique identifier set must be used on all health care claims, regardless of the payer, by May 23, 2007, or May 23, 2008 for small practices and health plans. Before you use the NPI on a Medicare claim, make sure your claims software or clearinghouse can handle the identifier. Have questions on the NPI and whether your organization qualifies to have "subparts?" Visit the new, redesigned NPI help page at <http://www.cms.hhs.gov/NationalProviderStand/>.

#### **CMS New Physician Fact Sheet for Help with Part D**

- The Centers for Medicare and Medicaid Services has created a new fact sheet regarding the Medicare prescription drug benefit with specific resources and links for physicians to aid in the process of prescribing under the new program. This includes general information to utilize in dealings with patients, as well as dedicated email and toll-free phone lines for use only by physicians to help sift through the voluminous information for themselves and those they serve. To view and/or print out the CMS fact sheet, visit [www.cms.hhs.gov/MedlearnProducts/downloads/Part\\_D\\_Resource\\_Factsheet.pdf](http://www.cms.hhs.gov/MedlearnProducts/downloads/Part_D_Resource_Factsheet.pdf). Additionally, much streamlining has occurred on the CMS provider Web site, offering assistance and information on a host of Medicare/Medicaid related topics. To visit the updated fee-for-service provider site, go to [www.cms.hhs.gov/center/provider.asp](http://www.cms.hhs.gov/center/provider.asp)
- CMS also updated payment allowance limits for Medicare Part B Drugs, effective April 1, 2006 through June 30, 2006, as well as revised payment files for the January 2005, April 2005, July 2005, October 2005 and January 2006 Quarter APS Medicare Part B Drug Pricing Files. Be aware that certain Medicare Part B drug payment limits have been revised and that the CMS updates the payment allowance quarterly.  
How can I know if a patient is eligible for Medicare Part B? Determining a beneficiary's eligibility is a feature available by calling the Palmetto Provider Center at 1.877.567.9232 using the IVR.

## **Third Party Payors**

#### **Anthem Lands Medicaid Contract for Northern Ohio Region**

- Anthem Blue Cross and Blue Shield is expected to enroll up to 75,000 Medicaid beneficiaries through a new agreement with the Ohio Department of Job and Family Services. The company, an operating unit of WellPoint, Inc., said the three year contract will cover individuals in and around the Toledo, Cleveland and Youngstown areas. Anthem will become one of six managed care plans to provide such services in these regions, where there are about 460,000 Medicaid-eligible adults and children. Services will include hospital care, physician and specialist visits, prescription drug coverage as well as vision, dental and behavioral health benefits. The contract with the state will run from July 1, 2006 through June 30, 2009 and is part

of the overall plan to expand Medicaid managed care as part of the state legislature's effort to slow increasing costs in the program.

#### **BWC Releases "Agenda 06" Plan**

● The Ohio Bureau of Worker's Compensation unveiled "Agenda 06" recently in which the agency promises to improve both efficiency and effectiveness in all operations. CEO Bill Mabe indicated that when the strategies laid out in Agenda 06 are implemented, a savings of more than \$530 million could result. One part of this is expected to come from improved sources of revenue, but additionally the BWC will improve its underwriting capabilities by focusing on employer compliance and auditing/collections to ensure businesses are responsible for their own liabilities. The bureau promises to work on better coordinating services to reduce the hassle-factor for physicians and other providers, which will also reduce expenses.

#### **Aetna Licenses Bridges to Excellence to Help Improve Quality Health Care**

● Aetna announced recently that it has entered into a licensing agreement with Bridges to Excellence (BTE). BTE is based upon physician recognition programs designed by the National Committee for Quality Assurance (NCQA) and its partners, the American Diabetes Association (ADA) and the American Heart Association/American Stroke Association. BTE operates several pay-for-performance (PFP) programs including Diabetes Care Link, Cardiac Care Link and Physician Office Link. Both Diabetes and Cardiac Care Links focus on meeting approved standards for treating chronic conditions, while Physician Office Link provides incentives for improving patient information processing and data management. Aetna already participates in existing BTE markets in Cincinnati, Ohio, and Louisville, Kentucky. Aetna is the seventh health insurer to license BTE, following CareFirst BlueCross BlueShield, CDPHP, CIGNA Corp., MVP Health Care, UnitedHealth Group, Inc., and Humana, Inc.

## News You Can Use

CMS first announced the **Physician Voluntary Reporting Program (PVRP)** in October 2005 as a precursor to restructuring physician payment based on performance of various quality measures. Physicians participate in PVRP by adding additional codes, called G-codes, to their Medicare claims forms. CMS has indicated it intends for PVRP to be a temporary measure and that any permanent physician pay-for-performance program will be accomplished through health information technology, rather than G-codes.

#### **The 16 measures in the PVRP core starter set are:**

1. Aspirin at arrival for acute myocardial infarction
  2. Beta blocker at time of arrival for acute myocardial infarction
  3. Hemoglobin A1c control in patients with Type I or Type II diabetes mellitus
  4. Low-density lipoprotein control in patients with Type I or Type II diabetes mellitus
  5. High blood pressure control in patients with Type I or Type II diabetes mellitus
  6. Angiotensin-converting enzyme inhibitor or angiotensin-receptor blocker therapy for left ventricular systolic dysfunction.
  7. Beta-blocker therapy for patients with prior myocardial infarction
  8. Assessment of elderly patients for falls
  9. Dialysis dose in end stage renal disease patients
  10. Hematocrit level in end stage renal disease patients
  11. Receipt of autogenous arteriovenous fistula in end-stage renal disease patients requiring hemodialysis
  12. Antidepressant medication during acute phase for patients diagnosed with new episode of major depression
  13. Antibiotic prophylaxis in surgical patients
  14. Thromboembolism prophylaxis in surgical patients
  15. Use of internal mammary artery in coronary artery bypass graft surgery
  16. Pre-operative beta-blocker for patients with isolated coronary artery bypass graft
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In related news, the **AMA** signed a pact with Congress to develop more than 100 standard measures of performance which doctors will report to the federal government. In 2007, the agreement says, doctors will voluntarily report to the federal government “on at least 3 to 5 quality measures per physician.” In addition, doctors “should receive” some additional payment to offset the costs of collecting and reporting the data. The pact states that by the end of 2077 physician groups will have developed performance measures to cover a majority of Medicare spending for physician services. Many medical specialty societies around the country were already developing performance measures and have objected to this confidential pact promulgated by the AMA and its timetable for assessing doctors’ performance. The Medicare payment system for each physician service was frozen this year. Under current law, doctors’ face cuts of more than 4.5 percent in each of the next eight years. Congress could stipulate that doctors must report measures of clinical performance as a condition of getting a small increase in Medicare fees. Many specialty groups have written to Congress stating that the AMA cannot be the sole representative for the groups who are paramount to the development and implementation of quality measures. The AMC/NOMA will continue to monitor how this develops and provide additional information to the practice managers supporting our membership.

## **CUYAHOGA COMMUNITY COLLEGE’S CENTER FOR HEALTH INDUSTRY SOLUTIONS**

The AMC/NOMA is proud to partner with Cuyahoga Community College in their practice management seminar and class offerings, with significant discounts made available to AMC/NOMA members and their staffs. Below is a class list for Spring 2006. Interested staff will need an exclusive AMC/NOMA course number to register and obtain the discount. For course numbers, call Linda Hale of AMC/NOMA at 216-520-1000, ext. 309.

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| <ul style="list-style-type: none"> <li>❖ <b>CPC CERTIFICATION EXAM REVIEW for AAPC Exam</b> April 8 9a-2:45p<br/>Corporate College East Price \$120.00</li> <li>❖ <b>CCS-P CERTIFICATION EXAM REVIEW for AHIMA Exam</b> April. 22 9a-2:45p<br/>Corporate College East Price \$135.00</li> <li>❖ <b>CPC-H CERTIFICATION EXAM REVIEW for AAPC Exam</b> April 29 9a-2:45p<br/>Corporate College East Price \$120.00</li> <li>❖ <b>RADIOLOGY: HIGH TECH/DEMAND CODING (3 CEU-AAPC)</b> April 26 8:30a-12p<br/>Corporate College East Price \$135.00</li> </ul> | <ul style="list-style-type: none"> <li>❖ <b>MEDICAL TERMINOLOGY/ANATOMY &amp; PHYSIOLOGY</b> Corporate College East<br/>May 1-June 7 (Mon &amp; Wed) 6-8:30 pm &amp; June 6-July 18 (Tues &amp; Thurs) Corporate College West- June 7-July 17 (Mon &amp; Wed) 6-8:30 p.m.</li> <li>❖ <b>MEDICAL BILLING REIMBURSEMENT</b><br/>Corporate College East –May 11-Jun 29 (Thurs) 6-9 pm Price \$282.00<br/>Corporate College East –July 26-Sept 13 (Wed) 6-9 pm</li> <li>❖ <b>SURGICAL CODING FUNDAMENTALS (48 Hours)</b><br/>\$282.00 CorporateCollege East April 27 6-9:30 pm</li> </ul> |
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## **Responding to a HIPAA violation**

Violations of the Privacy Rule of the Health Insurance Portability and Accountability Act (HIPAA) can happen in your office or facility. The most likely scenario is the verbal disclosure of protected health information. If a provider takes proactive measures to prevent such violations and addresses HIPAA complaints appropriately, the liability associated with a HIPAA violation will be minimized.

### ***Simple rules for avoiding verbal HIPAA violations***

- Professionals should only share patient information if there is a legitimate professional reason to do so.
- Common area conversations should be avoided.
- Patient issues should not be discussed in a common area of the office unless the area is closed to third parties (i.e. drug representatives, patients, etc.) and the staff is aware that conversations in the area may be protected under HIPAA.
- Information should never be repeated outside of the office.

### ***Responding to the allegation of a HIPAA violation***

Upon receipt of a HIPAA complaint, a provider has an obligation to:

1. Document the complaint;
2. Determine if a violation occurred and how information was disclosed;
3. Mitigate damages and take steps to prevent further disclosure of information;
4. Provide the patient with an accounting of the disclosure upon request;
5. Apply sanctions against employees who fail to comply with HIPAA policies;
6. Keep a record of the sanctions that have been applied.

### ***Imposition of employee sanctions***

HIPAA requires that appropriate sanctions be imposed against employees who violate the Privacy Standards. These sanctions may take the form of a reprimand, requirement to attend additional training classes, suspension without pay, or even termination. It is important to understand that implementing sanctions against an employee may raise employment

law issues and the HIPAA compliance officer should consult with a labor attorney prior to imposing sanctions in order to minimize liability.

***HIPAA follow-up***

The privacy officer must take appropriate steps to avoid future disclosures of confidential information. These steps may be additional HIPAA training, circulation of an inter-office memo or the revision of office policy. As a proactive measure, a provider should identify high-risk areas in the practice setting that pose a high probability of breach of confidentiality.

***HIPAA enforcement***

The DHHS Office of Civil Rights (OCR) is charged with enforcing the Privacy Rule. OCR's enforcement initiative is to promote voluntary compliance with the Privacy Rule. If you are contacted by OCR, you should immediately contact your legal counsel. Your legal counsel should be your contact person for the investigation.



# Practice Management *MATTERS*

The AMC/NOMA can provide you information on topics from balance billing to managed care to terminating the physician/patient relationship. Our Practice Management Department catalogs newsletters, brochures and booklets we make available to our physician members and their staffs covering topics from Medicare reimbursements to effective tips for staffing the medical office. Whatever your question or concern, the Practice Management Department is available to address or investigate any issue left unresolved. We support our members in being strong advocates for all patients and in promoting the practice of the highest quality of medicine.

Call us at 216.520.1000 or email [concerns@amcnoma.org](mailto:concerns@amcnoma.org)

6000 Rockside Woods Blvd.  
Suite 150  
Cleveland, Ohio 44131

**[www.amcnoma.org](http://www.amcnoma.org)**

216.520.1000 Executive Offices  
216 520 0999 Facsimile