

# CLIENT ALERT



Medical Management Strategies, 3000 Broad Street, Suite B217, San Luis Obispo, CA 93401

April 7, 2010

## **LOOKING TO CAPTURE EHR BONUS MONEY?**

If you are serious about installing an EHR in your office and want to receive the incentive bonus payments for doing so, then it will be important for you to read this article.

To capture EHR bonus money you are going to need to begin the process of choosing, procuring, and installing an EHR immediately. There is no time to waste if you are interested in receiving the maximum incentive bonus payments. The amount of work that is ahead of you is considerable. We estimate the following timeline for achieving the procurement, installation, training and using the EHR in a meaningful way as follows:

1. The selection process of a Certified EHR that is guaranteed to meet meaningful use: 3 – 6 months
2. The preparation, set-up and installation of EHR: 90 days
3. The training and rearranging of the office to begin using the EHR in a basic way: 120 days
4. The processes of redoing the office work flow and the development of using the EHR to satisfy the 25 meaningful use criteria to qualify for the bonus pay incentive requirements: minimum of 180 days

***This schedule would leave you barely enough time to hit the 2011 deadline***, and leave the practice with billing delays, coding errors and insufficient documentation if speed is more important than smooth implementation.

One EHR expert estimates a five-physician practice would need between six and 10 months to select purchase and adopt an EHR, including staff training time. It would take another four to six months to see enough patients to meet the 25 requirements laid out in the proposed rule.

With a qualified EHR system you may qualify for an additional bonus for E-prescribing. The E-prescribing incentive payment for 2010 is 2% of the total estimated allowed charges for professional services covered by Medicare Part B. The sooner you participate in the program, the greater your incentive payment. Beginning in 2012, providers who are not successfully E-prescribing will be subject to a penalty on allowed charges.

Medical Management Strategies' sister company, Global Health Systems has your answer for Electronic Health Records. We have certified technicians available to install and support your system. GHS has successfully implemented several Electronic Health Records systems in client offices as they prepare for their reporting and demonstration of meaningful use. For information on GHS' services please contact Ryan Loughlin at (805) 547-1255, ext. 102 or visit our website at [www.ghsinc.org](http://www.ghsinc.org).

**Health Net will no longer pay for inpatient consultation codes for dates of services May 1, 2010 and after. Claims will need to be resubmitted with appropriate codes. Outpatient consult codes will be recoded through December 31, 2010. After January 1, 2011, Health Net will no longer reimburse claims submitted with an outpatient consultation code and will require providers to resubmit the claim using the appropriate outpatient office visit code.**

**MultiPlan, Inc has acquired Viant, Inc.** (formerly Beech Street PPO) as announced on March 15, 2010 making it one of the largest national PPO networks. They state their plan is to "more effectively leverage" their expertise "to improve efficiencies and patient flow for providers, driving significant savings for healthcare consumers and payers."

## **Medicare PECOS Enrollment Update & Reminder**

If you order or refer items or services for Medicare beneficiaries and you do not have an enrollment record in PECOS, you need to submit an enrollment application to Medicare. Some information about the enrollment process includes:

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- Medicare stated that as of October 5, 2009 Medicare would not pay claims for billed services that require an ordering/referring provider if an ordering or referring provider is not reported on the claim.
  - Currently claims are being paid but an informational message is being included on the remittance indicating the claim failed the ordering/referring provider edits.
  - Providers have until January 3, 2011 to establish their Medicare enrollment records in PECOS.
  - Provider may enroll online at the PECOS website or with a paper application. Processing could take 45 – 60 days, sometimes longer.
  - Waiting too late to begin this process could mean that your enrollment, or that of a physician who refers to you, will not be able to be processed prior to the implementation date, which is January 3, 2011.
  - Providers who are eligible to order or refer items or services for Medicare beneficiaries are:
    - Physicians
    - Physician Assistants
    - Certified Clinical Nurse Specialists
    - Nurse Practitioners
    - Clinical Psychologists
    - Certified Nurse Midwives
    - Clinical Social Workers

If you are unsure of your status in the Medicare PECOS system, you can call Palmetto Customer Service at (866) 931-3901 or contact MMS for assistance.

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## **United Healthcare News**

United Healthcare has released a new Administration Guide for 2010 effective April 1, 2010. It is available online at [www.unitedhealthcareonline.com](http://www.unitedhealthcareonline.com). Click on the tab for “Tools & Resources”, and then choose “Policies & Protocols”. The link for the United Healthcare Administrative Guide 2010 can be opened at this page.

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## **Office Workers Compensation Programs (OWCP)**

Effective March 1, 2010 this payer no longer accepts Consultation Codes for inpatient and office settings. Denial messages will say, “The requested procedure is not a covered service.” This is in compliance with the CMS protocols.

As of April 19, 2009 bills submitted with multiple surgeries no longer require the submission of modifier 51. The “primary” surgery will be priced at the lower of actual charge or the fee schedule amount for the procedure. Other surgical procedures performed on the same day will be priced at the lower of the actual charge or the fee schedule reduced by 50 percent.

Reminder: Providers must bill with their ACS PWCP provider number in Box 33 of the HCFA 1500.

## **NEWS FROM AETNA OFFICE LINK NEWSLETTER – MARCH 2010**

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### New Aetna Program May Request Patient Medical Records

Aetna may be requesting and reviewing selected medical records to compare the clinical coding to the corresponding clinical services that were provided to Aetna members. In some cases, records will be requested based on the characteristic of the claim (such as the charges billed in conjunction with the procedure performed). In other cases, records will be requested based on the provider who submitted the claim. These providers have been selected based on claim analysis, which identified different billing practices in these providers when compared to their peers.

**Affected Providers:** orthopedic surgery, neurosurgery, hand surgery, podiatry, plastic surgery, ENT, neurology, physiatry, sports medicine and pain management.

**Affected procedures:** Spine surgery, knee surgery, TJR, hand surgery, foot surgery, grafts/nails derm procedures, wound care, breast reconstruction, mammoplasty, hand/nose/face surgery, nerve blocks, injections/trigger points, neurostimulators, NCV, nose surgery and endoscopy.

*–from Aetna Officelink 03/2010*

### Aetna changes rates for physicians assisting surgeries

Effective May 1, 2010 the rate will change for assisted surgeries from 20% of the negotiated rate or recognized charge, based on Aetna reimbursement policies, to 16% of the negotiated rate or Aetna recognized charge. Multiple eligible assistant surgery codes will be reimbursed as follows:

- 16% for the primary procedure
- 8% for the second procedure
- 4% for each additional procedure

### Reimbursement Change for Mid-Level Practitioners

Beginning with June 1, 2010 dates of service, Aetna will pay mid-level practitioners at 85% of the contracted rate for covered professional services (consistent with CMS payment policy). The policy applies to nurse practitioners, physician assistants, certified nurse midwives and registered nurses. As of June 1, you will need to list the mid-level practitioner's name in the servicing provider field when you submit claims for services rendered by a mid-level practitioner.

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## Medicare Services Denied if Provider Ineligible or Has Been Deactivated

Effective April 1, 2010, when a Medicare provider has been deactivated for non-billing or when other circumstances result in your Medicare billing privileges being revoked, the responsibility for charges denied with message code PR-B7 will change from PR (patient responsibility) to CO (contractual obligation).

This also includes denials for Independent Diagnostic Testing Facilities (IDTF) when the submitted services do not meet the IDTF's qualifications.

These services will be specified on the Medicare remittance notice with the message code CO-B7 (This provider was not certified/eligible to be paid for this procedure/service on the date of the service.)

You may not bill the patient for services that are denied as contractual obligation. If you believe the services were denied incorrectly, you have the same appeal rights that you would have for any other 'contractual obligation' denials. To appeal a denied claim, fill out and submit a Redetermination Request, along with any supporting documentation. This request must be filed within 120 days of the claim decision. If claims are submitted and denied multiple times, the 120-day timeframe begins with the date of the first claim determination.

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