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All Medicare fees are par, office, national unless otherwise noted.

CMS clarifies 60-day revalidation requirement ahead of 2013 deadline

Don't be lulled into complacency by the 2013 deadline for CMS's latest revalidation initiative. You will have only 60 days to submit a complete revalidation to your Medicare Administrative Contractor (MAC), starting the day you receive a revalidation notice – regardless of the fact that March 23, 2013 is the ultimate deadline (PBN 7/11/11). Miss the 60-day deadline and your Medicare billing privileges could be suspended, according to **MLN Matters** article SE1126.

Remember: Many of your peers have complained about the 2013 revalidation requirement, which applies to all providers who enrolled in Medicare *before* March 25, 2011. Your peers were also upset about having to wait for a letter from their MAC before beginning this latest, off-cycle round of revalidations, a step that's necessary to help MACs manage the workload of a nationwide revalidation effort, says Billy Quarles, a spokesman for Palmetto GBA (North Carolina, South Carolina, Virginia and West Virginia). The staggered revalidation notices also give CMS time to implement significant improvements to its online Provider Enrollment Chain Ownership (PECOS) system (see related story, pg. 3).

*(see **revalidation**, pg. 4)*

Revenue cycle management

5 steps to ensure medically necessary office visits don't become non-payable phone calls

You've got more and more patients calling for refills and referrals to avoid the cost of office visits. It's a trend traceable to rising private payer premiums in a persistently down economy, but you must ensure patients come in for office visits not only to protect your revenues, but also to provide better care, experts say.

"There are times when it's appropriate [to do phone refills and referrals] and there's times when it's inappropriate," says Steve Sinclair, associate administrator at Graves Gilbert Clinic in Bowling Green, Ky.

*(see **phone requests**, pg. 4)*

Meaningful use guide, measures 2, 3, 5 and 6

4 steps to meet list-based meaningful use measures

You will have an easier time meeting the list-based meaningful use measures, but there are still best-practice ways to meet these measures while taking clinical considerations into account, physician experts tell **Part B News**.

Part of a continuing series: Review previous articles in this series to help you earn EHR incentive cash, one meaningful use measure at a time (PBN 8/1/11).

Here are four related, list-based measures that aren't the most difficult measures to explain, but are still part of the 15 mandatory or "core" meaningful use measures you must meet to collect the $18,000 first-year electronic health record (EHR) incentive check.

• **Measure 2** (implement drug-drug and drug-allergy interaction checks). You're only required to enable your EHR software to "pop up" with warnings when there's a potential adverse drug-to-drug interaction, or a potential patient allergy to a certain drug, says Ron Sterling, an EHR consultant and president of Sterling Solutions, a health technology company in Silver Spring, Md.

• **Measure 3** (maintain up-to-date problem list of current and active diagnoses). Specifically, more than 80% of unique patients seen by a provider must have at least one entry stating an active diagnosis, or a statement that there are no problems known.

• **Measure 5** (maintain active medication list). The required level is that more than 80% of unique patients seen have at least one active medication listed, or a statement that no medications have been prescribed.

• **Measure 6** (maintain active medication allergy list). More than 80% of unique patients seen have at least one medication allergy listed, or a statement that there are no known medication allergies.

Meeting measures 2, 3, 5 and 6: Rely on these tips and strategies from three physicians who have successfully attested to meaningful use.

1. Measure 2's interaction checks are usually on by default. Most EHR vendors have their software set to enable drug-drug and drug-allergy checks by default, Sterling says. Just keeping the checks enabled for the duration of the 90-day meaningful use attestation period is enough to meet stage 1 requirements, he says. **TIP:** The problem with measure 2 is clinical usability, says Christopher Tashjian, MD, a family practitioner in Ellsworth, Wis., whose collected his incentive check. "Alert fatigue is the problem, you see enough alerts and you start dismissing them," he says. You can customize the interaction checks on most EHRs to be more or less sensitive to drug and allergy combinations.

2. Begin meeting measure 3, 5 and 6 by copying existing lists. You already have problem lists, medication lists and medication allergies for patients on paper, so the first step is to do the manual data entry required to get this

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information into EHRs as structured data – a tedious but unavoidable step, says Patrick Golden, MD, an internist from Fresno, Calif. **Remember:** Structured data means information that is stored in the EHR as text or numbers, not scanned images such as test results. **TIP:** After going live with his Sage Intergy EHR, Dr. Golden asked his front desk to tell patients to bring written lists of medications for their first few visits to make sure no prescription drugs were being left out of the list for measure 5.

3. Keep data updated by delegating to ancillary staff. The workflow once an EHR is implemented involves ancillary staff such as medical assistants asking patients whether medications have changed or new allergies have cropped up, especially for patients who see other physicians of different specialties, says Salvatore Volpe, MD, a solo internist from Staten Island, N.Y. "When you delegate the responsibility of asking questions, you will make it faster and easier on your practice," he says. "The staff are also choosing medications and allergies from a list, so you're not asking them to spell a medication, cutting down on transcription errors."

4. Measure 3's problem lists involve clinical judgment. Problem lists involve some clinical judgment to distinguish ongoing, chronic conditions such as diabetes, hypertension and coronary artery disease from acute problems such as the flu, Dr. Tashjian says. "We distinguish between the kind of thing medical assistants can ask during collecting vitals and the problem list, where the provider has to say what's important enough to be on the problem list and what's a problem that just needs to be in the patient's note." **TIP:** Have physicians or non-physician practitioners make the call on problem lists.
— Grant Huang (ghuang@decisionhealth.com)

CMS will make major, time-saving improvements to online PECOS in 2012

You will have many more reasons to switch from paper enrollment forms to CMS's web-based Provider Enrollment Chain Ownership System (PECOS) in 2012, **Part B News** has learned. Currently, online PECOS lets you enter most enrollment updates or new enrollment information electronically, but you must still sign and mail paper forms as part of the process.

This will change in 2012, according to sources who attended an Aug. 11 CMS PECOS "power users" meeting. The power users are made up of physician advocacy groups and consultants who give CMS feedback on the online PECOS site.

Here's a summary of the biggest changes coming to online PECOS in 2012. "A lot of these are convenience features that save time and also prevent errors," says David Zetter, a consultant with Zetter Healthcare Management Consultants in Mechanicsburg, Pa., who attended the power users meeting.

• **Electronic signatures**. You won't have to hunt down blue ink pens for signing paper certification statements anymore, Zetter says. Electronic signatures will get rid of the current need to mail paper certification within seven days of an electronic PECOS application.

• **Rejected applications will be saved for corrections**. In what will be one of the biggest timesavers in the enrollment process, you will be able to access online applications that get rejected by CMS and correct them for resubmission, Zetter says. "On paper you would have to fill out another form, with PECOS now you have to enter the data all over again, so there's a lot of time savings here."

• **Search function in enrollment forms**. You will be able to enter exact words to search the online PECOS enrollment forms, letting you track down any field or box quickly without having to flip back and forth between web pages, Zetter says.

• **Error checking, verification on every page**. The online PECOS system will inform you right away when it detects obvious errors, such as missing data, mismatches or other problems, Zetter says. Problems will appear in an "error-check" tab in real time instead of being summarized at the end of an application. All information you manually enter that is part of a provider's national provider identifier (NPI) will be compared to the NPI data automatically – this means any typo on a name or date of birth will be caught immediately, Zetter explains.

• **Self-populating data fields**. Once you enter a tax ID number, the PECOS system will link to IRS databases and pull relevant data such as managing control information and populate all relevant fields automatically, Zetter says.

• **All addresses will be saved to avoid repeat data entry**. All addresses entered on an application will be stored in PECOS, and can be chosen from a drop-down menu once entered the first time. You can also go back and edit these addresses to keep them updated on the drop-down menu, Zetter says.

• **All paper forms will be part of online PECOS**. Paper Medicare participation agreement forms and the CMS-588 electronic funds transfer (EFT) form will be converted to online PECOS, negating the need to mail these in as well. CMS told power users that this change is set for April 2012, or July 2012 at the latest. — *Grant Huang (ghuang@decisionhealth.com)*

revalidation

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Submitting application cuts risk: To avoid billing deactivation, you don't have to submit a perfect revalidation that sails through processing within 60 days, you just have to submit a complete application, Quarles says. "While the application is in process there is no deactivation risk," he explains. "The only constraint/risk from that point is timely response to any development request from your contractor that may occur with an incomplete submission." The 60-day deadline, once a revalidation notice has been received, is not a new requirement, as you would be required to submit revalidations within 60 days during CMS's regular, five-year revalidations, Quarles says.

Remember: You have 30 days to mail responses to development requests or additional information requests. Missing this deadline could again result in deactivation of billing numbers, CMS says.

Letters could come at any time: One wrinkle with waiting for a revalidation letter before starting the applications is that you could receive it anytime between now and the 2013 deadline, says Allison Brown, senior advocacy advisor for the Medical Group Management Association (MGMA) in Washington. "If you get the revalidation letter tomorrow you may not be ready for it so soon, because the 2013 date is in everyone's head. And if you get it late, you may be implementing [electronic health records] and suddenly you get a letter having to revalidate 200 providers."

The MGMA has asked CMS to require that MACs post a broad timeframe of when revalidation notices go out, based on provider's last name or the last few digits of their NPI (e.g. providers A-F can expect letters in Q1 2012), Brown says. CMS hasn't promised anything, but is in a regular "dialogue" with the MGMA to try and reduce the workflow burden on practices, she says.

Ordering/referring rule may not matter much: A broad revalidation effort will render the ordering/referring rule moot, because it will require far more providers to revalidate than the latter rule, which still has no enforcement date from CMS, Brown says. — *Grant Huang (ghuang@decisionhealth.com)*

Editor's note: Don't face the biggest, most unpredictable Medicare revalidation effort ever launched by yourself. Join nationally recognized PECOS expert David Zetter, whom CMS relies on for feedback, on Sept. 20 as he explains exactly how the new 2013 revalidation process will work and how you can quickly get providers into PECOS without risking billing deactivation. Visit *www.decisionhealth.com/conferences/A2160/home.html* for details and to register.

phone requests

(continued from pg. 1)

"But there's no question about it, we're seeing less visits because of cost pressures on the patients, and more and more pressure do things over the phone, whether it's drugs or referrals."

Follow these steps to get patients who need to be seen into the office:

1. Use front desk to collect requests. Your front desk staff are the first to field requests from patients over the phone for refills and referrals, says Ron Rosenberg, CEO of the Practice Management Resource Group in Tinley Park, Ill. Their job is to record a patient's request and to say that only a doctor can make the decision, Rosenberg says. "You want to create an efficient system where the front desk can say 'we don't have the authority to do that, we'll have the doctor review it and get back to you within 24 hours,'" he explains.

2. Non-physicians can 'triage' requests. When you get many requests for refills or referrals, save physician time by having non-physician practitioners be the first review the list of requests from the front desk, Rosenberg says. They can use their clinical judgment to pick out the clearly unacceptable requests, such as those for new drugs, refills on narcotics or referrals to specialists for conditions not diagnosed by the primary care provider. That way, physicians get a pared-down list, Rosenberg says.

3. Have physicians set guidelines to speed decision-making. Drug refills and referrals for HMO patients to specialists are both clinical decisions, Sinclair says.

Only doctors who know the patients are in a position to judge whether it's a good idea to grant such requests without seeing them personally to monitor drug dosage or see if a specialist's opinion is really needed. That said, having your doctors get together to develop some common guidelines can help them make the decision more quickly and provide more consistent care, he says. Primary care physicians must be particularly careful about handing referrals to HMO patients for complaints they haven't examined, Rosenberg says. Capitated plans offer the opposite incentive – because you're paid the same, there's no financial reason not to fire off a quick referral. This is why it's a good idea to set down clinical guidelines in writing, he says.

4. Offer payment plans and discounts where possible. When you deny patient requests and ask them to instead come into the office, many patients trying to avoid the cost of the visit will refuse to come in. But don't be quick to take no for an answer, Rosenberg says. Have the front desk be prepared to offer to put patients on payment plans, especially with high-deductible insurance, he says. Another option is to offer a discount on the visit for self-pay patients, says Nancy Giffin, billing manager at Swedish Urology in Seattle. The practice offers self-pay patients a 20% discount on visits, on the rationale that 80% is better than nothing – and better than granting a phone request that isn't clinically responsible. Discounts can't be doled out for patients who have insurance that you have contractual obligations to collect from, Rosenberg says.

5. Have doctors schedule routine follow-ups for complex cases. When patients do come in for office visits, it's a good idea to have physicians schedule them for a routine follow-up, especially for complex patients with multiple chronic conditions, says Dianne Wilkinson, RHIT, a compliance auditor at West Tennessee Healthcare in Jackson, Tenn. Physicians can point to the follow-up as the best opportunity to have drugs refilled or the dosage or type modified, she says. — *Grant Huang (ghuang@decisionhealth.com)*

3 tips to get paid for E/Ms billed with modifiers 24 and 25

Your specialty practice has likely seen its share of modifier-related claims denials, but the risk is much higher with a total loss of nearly $600 million in denied claims with surgical modifiers **24** (unrelated E/M visit, post op, same physician) and **25** (separate, significant E/M, same physician, same day), according to a **Part B News** analysis of CMS claims data from 2009.

Here's the numbers on how you and your peers are faring, plus tips from coding pros on how to stop denials on the front end.

Modifier 24

Modifier 24 claims saw an overall 26% denial rate in 2009, according to CMS claims data. Ophthalmology, general surgery and cardiology saw the highest denial rates. Denials on modifier 24 claims has increased or stayed the same (above 10%) across the majority of specialties since 2007, the data shows.

CMS only pays claims with modifier 24 after receiving supported documentation, says Seth Canterbury, CPC, education specialist with University of Florida Jacksonville Physicians. Many Medicare Administrative Contractors (MACs) won't accept the required documentation along with the initial claim and instead prefer to deny an electronic claim, and then request an amended one with the documentation, he adds.

1. Only use these modifiers for E/M services. Providers mistakenly use modifiers 25 and 25 with any surgical procedure, says Betsy Nicoletti, CPC, consultant with Medical Practice Consulting in Springfield, Vt. It's important to only use them in regard to E/M services and know the difference between each to avoid denials.

2. Make sure that the diagnosis codes are different. Many providers get modifier 24 denials because they don't indicate two separate, truly unrelated diagnosis codes, Nicoletti says, and tend to use only slightly unrelated diagnosis codes that end up being related, says John Burns, CPC, senior consultant for DecisionHealth Professional Services (DecisionHealth is the publisher of **Part B News**).

Incorrect use: Physician records diagnosis code for headaches during a post op E/M visit for who for a patient just had neurosurgery, Burns says. This claim would get denied because it is easy to assume headaches would be a result of the neurosurgery.

Correct use: A doctor is managing multiple medical conditions and performed surgery for one, Canterbury says, such as repairing a broken leg on a car collision victim who also has a brain hemorrhage. The brain bleed is still present after surgery, so the subsequent E/M visit to manage the hemorrhage is unrelated to the surgery, he says.

NOTE: Modifier 24 cannot be paired with diagnostic tests during in the postoperative period. Diagnosis codes for both the original and post-op E/M visits may rarely be same but are in fact unrelated. In this case, you should document this when you file your claim, according to TrailBlazer's modifiers manual. **NOTE:** Complications during the postoperative period are not separately payable under Medicare but are in some cases when billing CPT, Nicoletti says.

Modifier 25

Modifier 25 is used for procedures with a global period of zero to 10 days to indicate that on the day of the procedure a separate and significant E/M was also performed. Claims with modifier 25 had a 25% denial rate in 2009, down 6% from 2007, according to CMS claims data.

Typically, the primary purpose of the visit can be for either a minor procedure such as a tissue biopsy that is then paired with an E/M because the patient is complaining of chest pain; or for an E/M to manage a patient's diabetes that is then paired with a skin tag removal. However, you can use modifier 25 for related procedure and E/ M on the same day (PBN 3/31/08).

When the procedure and E/M visit performed are related, there has to be a clear distinction of significant and medically necessary work for the provider, Nicoletti says.

Correct use: A patient comes in with a laceration on his forehead that will require a minor procedure, such as a suture. But the physician still performs an E/M service, which could be medically necessary for many reasons. For example, the patient is new and the physician needs to review his history, or the patient has symptoms that show the laceration is infected.

Incorrect use: If a patient complains of warts and the doctor confirms that diagnosis and removes the warts, it is not appropriate to use modifier 25 because it is too limited of a procedure and you would only be able to bill for the procedure, not the E/M, Nicoletti says. The same applies to a situation in which the patient requires a biopsy during a follow-up visit, she adds.

3. Watch out for payer edits preventing the overuse of modifier 25. Claims with modifier 25, in general, should not be denied for planned, repeat procedures, Nicoletti says. But you must beware that some payers have edits to prevent fraudulent and frequent use of modifier 25 which could result in denials, she warns. **Remember:** Payment for deciding to perform any procedure is included with that of the procedure, according to the National Correct Coding Initiative (CCI) manual. However, separate payment for the E/M is only warranted when considerable, extra work is medically necessary as a result of the patient's condition unrelated to the surgery. *— Lauren C. Williams (lwilliams@decisionhealth.com)*

Revenue cycle management

Pros and cons of using health information networks to collect

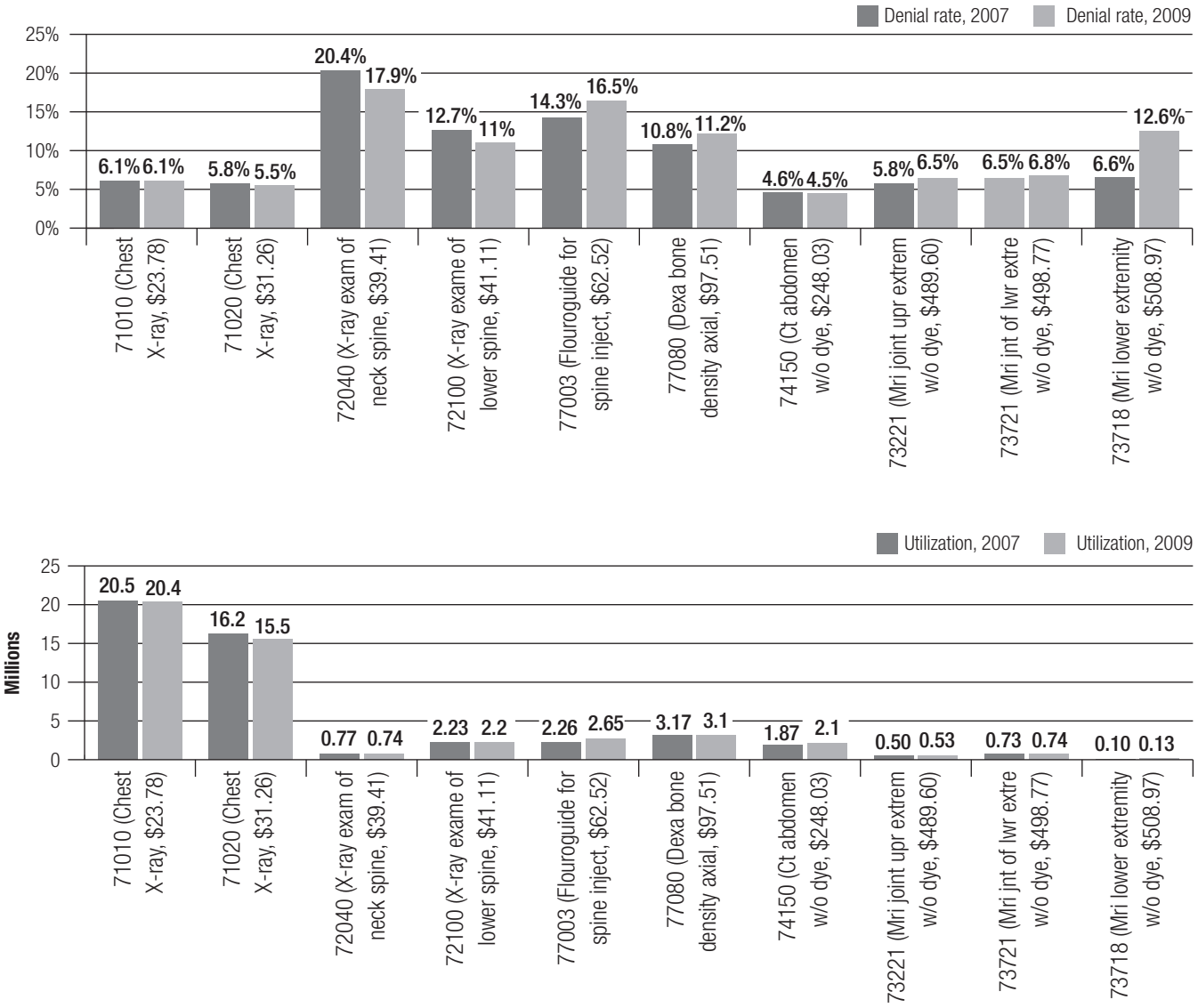
You must know whether your private payer patients are in network, owe a deductible and how much they have left on it before they walk in your practice – not knowing slows down collections and threatens cash flow.

Benchmark of the Week: What impacts imaging denials, 2007 vs. 2009

Summary: Does greater volume of utilization impact denial rates for imaging services, or does the actual value of the Medicare payment have a greater effect? These charts sort 10 imaging services by their 2011 fee schedule charge, from lowest to highest value, and show the denial and utilization rates in 2007 and 2009. **NOTE:** A range of imaging codes was selected based on their fee schedule charges and denial/utilization rates. While 2011 payment data is used, the denial and utilization data is based on CMS claims data from 2007-2009.

Breakdown: Denial rates for these codes have shifted both up and down over the three-year window, while utilization has been fairly flat in comparison. Of the high-denial services with rates above 10%, **72040** (X-ray exam of neck/spine, $39.41) continues to be the biggest troublemaker, despite falling from a denial rate of 20.4% in 2007 to 17.9% in 2009. Two chest X-ray codes, **71010** and **71020**, have some of the lowest denial rates and are by far the most commonly billed, with more than 20 million and 15 million claims billed in 2009, compared to only 3.1 million for the nearest competition. **TIP:** Remember that 72040 is bundled into 72010, and that it's typical for an X-ray code with a low number of views to be bundled into one with many views (PBN 11/12/09). You can unbundle using modifier **59** (distinct procedural service).

Takeaways: Imaging services with very high utilization but relatively low dollar value tend to be denied less often than codes with low utilization and high dollar value. There isn't any visible relationship between the value of a service, by itself, and the denial rate. **Example:** The highest-paid MRI scan, **73718** is worth $508.97 and had a 12.6% denial rate in 2009, but the same year 72040 and **77003**, worth $39.41 and $62.52 respectively, had similarly high denial rates.



While you can always devote staff time to calling payers and having specific patients looked up, using a **health information network** (HIN) can greatly reduce that time and streamline the whole collections process, practices say.

The best practice solution for ensuring adequate cash flow and recouping patient balances and deductibles starts with frequent communication between your practice, your patients and their carriers, says James Akimchuk, Jr., vice president and chief financial officer for Culbert Healthcare Solutions, a practice consulting firm in Woburn, Mass. Practices of all sizes can benefit from having this kind of communication via HINs, he says.

HINs such as WellPoint, Availity and Emdeon, are third-party vendors that sync payer information with the patient's account. Providers can readily access estimated copays, remaining deductible balances and payment amounts from the site using a created username and password and entering the patient's name or identification number.

Consider these pros and cons:

Pro: Access payer updates and information in real-time. It's not always possible to get a patient's deductible information in advance of the appointment, says Debra Stevens, Accounting Credentialing Manager for Trumbull Mahoning Medical Group, a multispecialty practice based in Warren, Ohio. Availity helps by allowing you to pull up any patient's information, regardless of payer, and see if they are still covered, what they have left on their deductible, if changes have been made to their plan, she says.

NOTE: Many private payers have free online tools, called claims estimators, that providers can access via the payer's website to retrieve similar data, says Terry Luman, longtime Emdeon user and office manager for Alliance Orthopedic Labs in Annapolis, Md. But it can become time-consuming and difficult to manage if you have several payers, because you would have to visit the sites individually for each patient, she says.

Instead of going to each individual payer's site to look up policy changes or use eligibility verification tools, you can just go to one site, enter the patient's information and have everything you need in front of you, Stevens says.

Pro: Helps foster patient communication with outstanding balances and deductibles. Having deductible information readily available at the time of a patient's check-in makes it easier to collect because you have the most current information available at your fingertips, Stevens says.

Pro: It can work with your practice management and EHR systems. Emdeon offers its services through an online portal but allows you to exchange files between it and your practice management and electronic health records (EHR) systems so that data created in these systems can be used in Emdeon Office or vice versa, says Emdeon spokeswoman Amanda Woodhead. **NOTE:** You may have to upload or download files into or from your PMS or EHR systems depending on the process.

Con: It costs money. Cost varies and depends on practice size and number of providers using the product, Woodhead says. **NOTE:** However, investing in a third-party service could be money well spent. "It certainly does pay for itself," Luman says. The practice saves one and a half hours daily using the benefits and eligibility verification features alone, she estimates.

— Lauren C. Williams (lwilliams@decisionhealth.com)

Ask a Part B News Expert

This week's question is answered by Regan Tyler, CPC, CPC-H, CPMA, CEMC, ACS-EM, content manager for DecisionHealth and consultant for DecisionHealth Professional Services.

Q I would like clarification of information in a **Part B News** article from March 21, 2011 for certification rules for Medicare coverage clarified by CMS. For the third hospice benefit period, a face-to-face visit must be documented in the certification form. It states that a hospice physician or nurse must do the certification. At the end of the article you then state "remember, the certification may also be done by the hospice medical director *when the patient does not have an attending physician.*" Does that mean the attending physician may do the initial, subsequent and third certification for hospice benefit? I was under the impression that the attending could do certifications.

A Yes, CMS is stating that the certification exam must be done by a hospice physician or contractor of the hospice. If the patient does not have an attending physician to perform the exam, the medical director may perform this. Typically we see the attending or a hospice contractor or hospice non-physician practitioner conduct the exam.

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