Part B News

COLLECT EVERY DOLLAR YOUR PRACTICE DESERVES

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

It's official: You must revalidate by 2013, but wait for a letter before starting

You must revalidate every provider who was enrolled in Medicare before March 25, 2011, but you must wait for a letter asking you to start from your Medicare Administrative Contractor (MAC). Your deadline for this is March 23, 2013, after which payments will be frozen until providers are revalidated in the Provider Enrollment Chain Ownership System (PECOS), whether via the online PECOS website or a paper CMS-855 application.

CMS made the announcement, which confirms previous reporting by **Part B News** (PBN 7/11/11), in an **MLN Matters** article released Aug. 5. "Between now and March 23, 2013, MACs will send out notices on a regular basis to begin the revalidation process for each provider and supplier," the article states. "Providers and suppliers must wait to submit the revalidation only after being asked by their MAC to do so."

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

The EHR Roadmap

'Free' EHRs: 5 pros and cons to keep in mind

Your peers have long cited the upfront cost of an electronic health record (EHR) system as a top obstacle to adoption, but some vendors are offering EHRs for free, based on unique business models. Free EHRs represent just a fraction of the overall market, but they seem to be growing and many have been certified by CMS-approved agencies to meet meaningful use requirements and thus deliver up to $44,000 in EHR incentive cash under Medicare (see pg. 5 for a quick profile of three free EHR vendors).

How they work: Free EHRs are ad-driven, which means your providers will face a variety of graphical and text ads when they are using the EHR system. "De-identified" patient data is used to drive some of the ads, without violating HIPAA, says Jim Tate, an EHR implementation expert and partner at HITECHAnswers.net, an online EHR resource for providers. The fine print for many free EHRs is that practice management system (PMS) components aren't free, and are often made by a different vendor

*(see **free EHR**, pg. 4)*

6 tactics to collect from privately insured patients facing higher premiums

Many practices have seen revenues fall as a result of private payer patients not meeting their copay and deductible obligations. But perfecting your practice's collection techniques is the only way to plug the revenue leak, experts tell **Part B News**.

Private patients under pressure: An increase in premiums, plus employers adjusting their health plans to include higher deductibles have shifted greater financial responsibility to patients, says Brad Boyd, vice president at Culbert Healthcare Solutions in Woburn, Mass. Here are some expert tips to tweak your collections process.

1. Turn every point of contact with the patient into a collection opportunity. Have your staff notify patients of outstanding balances and missed copays every time the patient calls or comes into the practice, Boyd says. It's important to train your front desk staff to bring up patient balances and future copay amounts each time a patient calls or comes in for an appointment, he says. **Example:** "You have $300 left to pay on your deductible, would you like to pay this amount now or set up a payment plan?"

TIP: Do not rely on sending a monthly statement to patients as a means to collect unpaid dues, Boyd warns. It's not sufficient to assume patients will pay just because you send a bill, you have to talk to them about their obligations, Boyd says.

TIP: Collect copays through your practice's website or at the time the appointment is made instead of the day of the visit, he adds. This will preempt forgetful patients who may not be prepared to pay on that day.

2. Push payment plans when patients "forget" their wallet. This is an opportunity to set up a payment plan for sizeable balances and enforce your copay collection policies, Boyd says. Set up three-month payment plans for patients to reduce your practice's risk of low cash flow, says Phyllis Davis, CPC, business office manager for the Kneibert Clinic in rural Poplar Bluff, Mo. If they fall behind, tell the patients that you can no longer extend credit until the balance is paid, she says.

3. Know your patient and payer mixes. How much your practice loses through uncollected copays and deductibles largely depends on the payer mix, Boyd says. Providers with a significant Medicare and Medicaid patient load may not experience a high collection problem due to many copay-free services and lower deductibles compared to that of private payers, he says.

4. Go after uncollected deductibles. Missed copays can hurt practices that mainly bill E/M services versus those that focus on procedures, says Mike Robertson, practice manager at Columbus (Ohio) Gynecology and Adult Medicine. But expensive procedures with high deductibles put your practice more at risk, he says.

5. Track your losses. While there is no set metric, you shouldn't be losing or writing off more than 5% of

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your total revenue, Boyd says. Use your practice management system to compare and report the total number of arrived appointments, sorted by payer, to the amount of cash posted in the system, Boyd says. Doing this will allow you to see how much money you are losing through uncollected copays and will give you a starting point to adjusting your collection policies, Boyd says.

6. Suggest patients split overdue balance payments between visits for those who are unable to pay the remaining deductible due on their account, Robertson says. **Example:** If a patient is unaware of an $80 deductible balance and says they pre-wrote a check for the $20 copay, suggest that they pay $40 now instead of the full $80, but notify them that the remaining $40 is due next vist. *— Lauren C. Williams (lwilliams@decisionhealth.com)*

3 tips to avoid claims denials with modifiers 58 and 78

Your claims with modifiers **58** (staged, related service, post op, same physician) or **78** (return to or for related procedure, post op, same physician) attached have a higher rate of being denied, according to a **Part B News** analysis of CMS claims data. Experts say the onus is on you to ensure proper usage of modifiers.

Nearly one in five, or 19%, of claims with modifier 58 were denied in 2009, with general surgeons, podiatrists and orthopedic surgeons hit hardest, CMS data shows.

Claims with modifier 78 performed almost the same, with a 20% average denial rate in 2009, and surgeons faring the worst – general surgeons, orthopedic and vascular in particular.

When billing modifier 78, you must demonstrate that the complication was unforeseen and unplanned. **Example:** A hematoma, sepsis or an infection at the surgical site that requires debridement and wound vac would qualify, says Sean Weiss, vice president and chief compliance officer of DecisionHealth Professional Services (DecisionHealth is the publisher of **Part B News**).

Modifier 78 should only be used for unforeseen surgical complications while modifier 58 can be used for both planned and unplanned surgical work or more extensive work, such as performing a lumpectomy and deciding that a full mastectomy is the best course of treatment, says Seth Canterbury, CPC, education specialist with University of Florida Jacksonville Physicians.

NOTE: Some payers may require or suggest submitting additional documentation to justify the use of modifiers 58 or 78, Canterbury says.

Also, claims with modifier 58 attached could be getting denied because the payer wants to save money, says John Burns, CPC, senior consultant for DecisionHealth. Using 58 restarts the global period and payers often have to pay more than they would with modifier 78, which only pays the intra-operative pay rate.

NOTE: "Do not use modifier 58 for a truly unrelated procedure that is performed within the follow-up period of another surgery by the same surgeon. Modifier **79** (unrelated procedure or service during post-op) would be the correct modifier for the second procedure," TrailBlazer instructs in its modifier manual.

Here are three tips to make sure your claims are not denied for inaccurate modifier usage:

1. Make sure the diagnosis codes are different. You can avoid initial denials by making sure that the primary diagnosis and the post-op diagnosis code for the E/M visit are entirely unrelated, Burns says.

2. Be careful if you are billing two surgeries on the same patient in the same day. Providers might need additional modifiers to explain why the service was performed, especially if a second procedure is on the same patient and day, Canterbury says. **Example:** A physician performs an aneurysm repair, which ruptures and needs to be repaired again. You could use modifiers **76** (repeat procedure, same provider, same day) and 78. For a staged procedure, like a wound debridement that requires multiple sessions in one day, 58 is appropriate.

3. You must communicate with your payers. It's up to the provider practice to know the different rules governing modifiers for each payer, says Jenny Jackson, practice affairs associate, for the advocacy and health policy division of American College Surgeons. Some payers use Medicare rules and others do not, Jackson says.

NOTE: Rules on correct modifier use vary state-to-state and carrier-to-carrier, Jackson says. If you are seeing a lot of modifier-based denials from a certain payer, you must call and identify the cause of the denials, she says. Some payers may prefer the use of one modifier over the other depending on the scenario, Canterbury says, which warrants a conversation with the payer.
— Lauren C. Williams (lwilliams@decisionhealth.com)

revalidation

(continued from pg. 1)

This requirement to wait for a notice is very burdensome on large groups, says Leslie Witkin, president of Physicians First in Orlando. "I've got groups with 300 to 350 providers that have to be revalidated now, and they want to start this right away," she says. "You never know how long it could take because if one thing is wrong, you may end up having to resend the enrollment application."

Why you must wait: CMS has been silent so far on why you must wait, but at least one MAC says the reason is simple: to avoid a massive, simultaneous wave of revalidations. "Because of the scope and magnitude of this project, providers are requested to only revalidate when the request is made of them," says Billy Quarles, a spokesman for Palmetto GBA (North Carolina, South Carolina, Virginia and West Virginia).

NOTE: If you have any "normal enrollment changes," such as needing to add a new physician to your practice, changing office addresses or adding a practice location, you don't need to wait for anything, Quarles says. However, "revalidation without any associated change needs to be handled within the scope of this national project, which includes managing the workload."

If you revalidate before getting a letter: Providers who revalidated on or after March 25 have met the new 2013 deadline. March 25, 2011 is the "key date" because this is when MACs began processing enrollment applications using new screening and enrollment verification rules created in the Affordable Care Act (aka the health reform law), Quarles says. **Remember:** Health reform is the reason CMS has launched this new revalidation effort off its normal five-year cycle for revalidations (PBN 6/20/11).

Remember: Revalidation means resubmitting your entire enrollment data, and is intended as an anti-fraud measure. Here's a quick review of the steps needed to revalidate a provider with Medicare.

1. Choose either online PECOS or the right CMS-855 form. You'll need to complete the entire application.

2. Send supporting documentation. This means IRS documents such as the CP-575, which shows your employer identification number (PBN 9/29/08). A faxed copy will suffice. **TIP:** If you're going the online PECOS route, don't forget to mail in the signed, two-page certification statement within seven days of doing PECOS.

3. Get the details right. Signatures can't be stamped and must be in blue ink to show they aren't copies; you'll also need to enter your full nine-digit ZIP code (PBN 6/3/10). — *Grant Huang (ghuang@decisionhealth.com)*

free EHR

(continued from pg. 1)

who partners with the free EHR vendor. Even so, the cost is low (see pg. 5) compared to mainstream EHR packages from vendors such as McKesson, eClinicalWorks and NextGen.

While free EHRs can work well and are certified to meet meaningful use, they must still pass the basic test of being able to meet your unique clinical needs, Tate says. "Specialists who need specialty specific features like the right diagnostic tests and templates might want a specialty EHR that charges money," he says.

Here are some pros and cons to consider with free EHR systems.

1. You will deal with ads. On most of the windows, toolbars and menus of the free EHR, your physicians will see ads from drug companies, device manufacturers, specialty societies, computer and supply companies and even local practice management consultants. These ads are aimed at clinicians, says Robert Rowley, MD, a practicing family physician and chief medical officer for Practice Fusion, a free EHR vendor based in San Francisco.

2. Patient data is not sold. Free EHR vendors have a pretty good incentive not to violate HIPAA, as they are on the hook for patient breaches caused by their own advertising systems, says Andre Vovan, MD, a critical care physician who is also the founder of Mitochon Systems, a free EHR vendor based in Newport Beach, Calif. In the case of Mitochon, "broad disease categories" are given to ad purchasers, but no patient-specific data, statistics or exact diseases are disclosed, Dr. Vovan says. "We tell them, if you have a cardiac product, we will show the ad to our users who treat cardiac diseases," he explains. At Practice Fusion, the ad purchasers get specialty information instead, Dr. Rowley says. "It is targeted based on the specialty of our physician users, so they know we will show ads to doctors of a certain specialty."

3. Free, but there are possible fees. Both Practice Fusion and Mitochon do not charge for their EHR product, or for remote technical support and training done via webinars and phone calls. But their products are not a

complete package. **Example:** Practice Fusion can integrate with most existing practice management systems, but the best integration is had with a PMS by Kareo, a Practice Fusion partner who does happen to charge a fee, ranging from $69 per provider, per month up to $299 per provider, per month based on features.

4. Your data can be migrated, but it won't be easy. If a free EHR vendor goes under, or decides that a free model isn't sustainable and starts charging money, you may want to switch to another vendor, Tate says. There is some precedent for free business tools becoming paid tools; a small business accounting program called Outright went from a free web tool to a subscription service charging $9.95 a month. Free EHR vendors say they offer the same data migration abilities as any conventional EHR. Both Practice Fusion and Mitochon can export patient data and demographic data in standardized formats (continuity of care document or CCD, continuity of care record or CCR, PDFs of scanned test results or notes, CSV files for demographics). But the reality of migrating data is that "it's very onerous," admits Dr. Rowley, the Practice Fusion medical officer.

5. Do the same homework for free EHRs as you would for paid systems. "Just because something's free doesn't mean it's the best software for your practice," says Robert Tennant, senior policy advisor for the Medical Group Management Association (MGMA) in Washington. You must consider the clinical abilities of a free EHR system and whether it includes a PMS that you like, Tennant says. Don't rush into signing up with a free EHR because once your data is in, it's tough to get out, he says. The advice on free EHRs is similar to buying advice for any big purchase – "see a demo, talk to other clients and

(continued on pg. 6)

At a glance: 3 free or alternative-pay EHR systems

Vendor	User base	EHR features	Fees
Practice Fusion (*www.practicefusion.com*)	60,000 unique practices nationwide; no clients have received incentive money so far	▸ Ad-driven model that targets clinicians based on user specialty ▸ Certified by Drummond for meaningful use, though full certification only became available in July ▸ Cloud-based data storage by vendor ▸ Free remote training and support ▸ Supports data migration via CCD, CCR, PDF and CSV files	▸ Seamless practice management system (PMS) integration with Kareo for $69-$299 per provider/month ▸ Optional ad-free version for $100 per provider/month ▸ On-site support via consultants for $500 per incident
Mitochon Systems (*www.mitochonsystems.com*)	600 unique practices nationwide; no clients have received incentive money so far	▸ Ad-driven model that targets clinicians based on broad patient disease category ▸ Certified by Drummond for meaningful use ▸ Cloud-based data storage by vendor ▸ Free remote training and support, including meaningful use "coaches" ▸ Supports data migration via CCD, CCR, PDF and CSV files	▸ Seamless PMS integration with CollaborateMD for $149-$219 per provider/month ▸ Optional ad-free version for $200 per provider/month
MTBC PracticePro (*www.mtbc.com*)	Not disclosed; has users in 40 states, with some clients having received Medicaid bonus	▸ No ads ▸ Certified by CCHIT for meaningful use ▸ Cloud-based data storage by vendor ▸ Includes PMS with online eligibility verification, real-time claims adjudication, automated appointment reminder and patient balance reminder calls ▸ Financial analysis reports ▸ Free remote training and support ▸ Supports data migration via CCD, CCR, PDF and CSV files	▸ Charges 5% of practice collections ▸ $1,000 flat startup fee ▸ Optional EHR-only option for $295 per provider/month ▸ Vendor will store all data via "cloud" for additional $100 per provider/month

Source: **Part B News** *interviews with vendor officials and analysis of vendor pricing information*

do your full due diligence," Tennant says. — *Grant Huang (ghuang@decisionhealth.com)*

Modifiers now required when billing common services with annual wellness visits

You must be ready to use the right modifier when billing many common services in the same encounter as the new annual wellness visit (AWV), according to an exclusive **Part B News** analysis of the latest version of the National Correct Coding Initiative (CCI) edits.

The initial AWV code, **G0438** (initial wellness visit, $161.05), is now subject to more than 100 edits in CCI version 17.2, which went into effect July 1. Some of your peers have already been caught off-guard by the new edits, as routine services like **93000** (complete ECG, $19.71) were denied after contractors had been paying them without complaint since Jan. 1.

NOTE: Most of the edits that apply to G0438 also apply to its sister code, **G0439** (subsequent wellness visit, $107.37), but because this is the first year the AWV is effective, only G0438 can be billed for beneficiaries.

Here's an overview of the most commonly billed codes that now require a modifier to be billed in the same session as the initial AWV. **Warning:** While CMS has said that it expects separately billed E/Ms to be more common, the other edit pairs have very few realistic scenarios that would justify an override, says Margie Scalley Vaught, CPC, content coding specialist for DecisionHealth, the publisher of **Part B News**.

- The major E/M codes, **99201-99205** and **99211-99215,** as well as other E/Ms, including ER visits, **99281-99285** and nursing facility care, **99304-99310**, **99315-99318**. These codes can all be overridden with modifier **25** (significant, separate E/M, same physician/day).
- Numerous psychiatric diagnostic interviews, **90801-90822**. Can be overridden with modifier **59** (distinct procedural service).
- Eye exams, **92002**, **92004**, **92012**, **92014**. Can be overridden with modifier 59.
- ECGs, **93000**, **93005**, **93010**, **93040-93042**. Can be overridden with modifier 59.
- Manual limb muscle testing, **95831**, **95832**. Can be overridden with modifier 59.
- Range of motion measurements, **95851**, **95852**. Can be overridden with modifier 59.
- Health assessment and behavior intervention, **96150-96154**. These have a CCI indicator of "0" and cannot be overridden with any modifier, as their functions are intrinsic to the purpose of the AWV, Vaught says.
- Medical nutrition therapy (MNT), **97802-97804**. Cannot be overridden.
- Prostate screening **G0102**, and reassessment and subsequent MNT **G0270**, which cannot be overridden.

— *Grant Huang (ghuang@decisionhealth.com)*

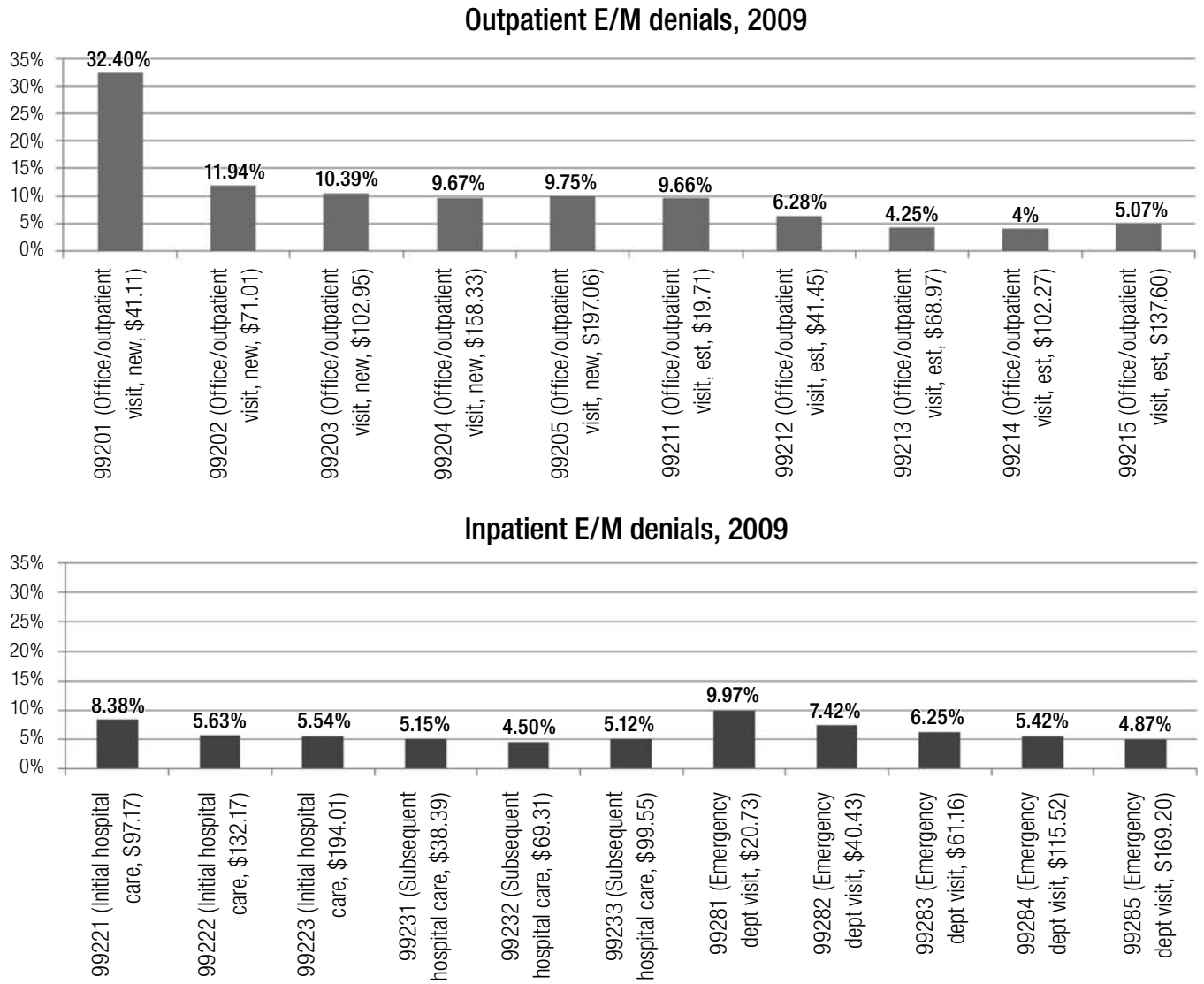
TIP: Download a complete table of all 107 CCI edits that now affect AWVs from the Part B News website at *http://pbn.decisionhealth.com/Articles/Detail.aspx?id=500947.*

Benchmark of the Week: Outpatient vs. inpatient E/M denials, 2009

Summary: Twice as many E/M codes are billed in the outpatient setting than inpatient, but the average denial rate is higher in the outpatient setting. This chart compares the E/M codes on a level-by-level basis in the two settings to examine where the denials are happening. **NOTE:** The "outpatient" setting is a combination of CMS claims data for place of service (POS) codes **11** (office) and **22** (outpatient hospital), while the "inpatient" setting is a combination of POS codes **21** (inpatient hospital) and **23** (emergency room).

Breakdown: A single code, **99201** (office/outpatient visit, new, $41.11), far outstrips all others in terms of denials in 2009. As the lowest-level new-patient E/M code, 99201 was denied 32% of the time, compared to 9.6% for the equivalent established visit (**99211**). On the outpatient side, denials are clearly higher for new patient visits than established visits. On the inpatient side, the five-level emergency department codes (**99281-99285**) are denied slightly more often on average than the three-level initial and subsequent hospital care codes (**99221-99223** and **99231-99233**).

Takeaways: The total utilization for outpatient E/Ms in 2009 was more than 234.5 million codes billed, compared to 114.7 million for inpatient E/Ms. Despite the greater volume, the average denial rate for all outpatient codes examined is 10.3% compared to 6.2% for inpatient. Even when the huge outlier, 99201, is removed, the average outpatient E/M denial rate is 7.9%, nearly 2% higher than the inpatient rate. **TIP:** On the outpatient side, keep a close eye on low-level office E/M codes, specifically 99201 and 99211. The latter in particular is commonly denied when billed alongside injections, which bundle the E/M into them (PBN 10/14/10).



CMS updates claims reprocessing, clarifies advanced diagnostic imaging and PCIP

CMS took questions from your peers on the new advanced diagnostic imaging requirement, the Primary Care Incentive Payment (PCIP) program and the agency's ongoing efforts to reprocess claims, but the answers don't offer fast solutions.

Here's the rundown on the top issues CMS addressed during its latest Aug. 9 open door call for physicians and non-physician practitioners.

- **Claims reprocessing update**. More than 50% of claims that were overpaid or underpaid in 2010 have now been reprocessed and correctly adjusted, said Stewart Streimer, director of the CMS's Provider Billing Group. The agency hopes to have all claims reprocessed by Dec. 31, 2011, but can't guarantee that date. You can call your Medicare Administrative Contractor (MAC) directly to ask for an update, because each MAC will finish on their own timeframes, Streimer said. **TIP:** You could stand to recoup thousands of dollars on reprocessed claims due to corrections CMS is making in response to retroactive effective dates on provisions in health reform and fee schedule fixes (PBN 8/8/11).

- **Advanced diagnostic imaging** (ADI) rule for Medicare enrollment. CMS plans to update its 855 enrollment forms with fields to accept ADI information. The most recent forms dated July 11 "went out prematurely" and the next version of 855s will have spaces for ADI information "that will look very different," said Sandra Bastinelli, a CMS official. **Remember:** Various typos and bugs affect ADI for both paper 855 enrollment forms and the online CMS enrollment system, and CMS is looking into these (PBN 8/8/11). **NOTE:** While all providers who bill for the technical component (TC) of advanced imaging services must add ADI information to their Medicare enrollment records by Jan. 1, 2012, there is something called "provisional accreditation" that gives you a 120-day timeframe beyond Jan. 1 under certain conditions, Bastinelli said. You will continue to be paid for ADI services after Jan. 1, 2012 for up to 120 days if you buy new imaging equipment or expand services by adding a practice location or imaging modality. You must seek updated accreditation from one of the three CMS-approved accrediting bodies and update your ADI information with CMS within that timeframe.

- **PCIP remittance advices** will get easier to read, just not anytime soon. A top complaint among those getting the bonus cash is that the remittance advice accompanying the payments are too long and don't show provider-level payments by national provider identifier (NPI), said Stephanie Frilling, a CMS health insurance specialist. This makes it tough to identify how much PCIP money should go to each provider, she acknowledged. CMS will be changing the PCIP remittances to show total payments per NPI, but the change won't happen until April 2012, she said. — *Grant Huang (ghuang@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 Can primary care physicians (MDs) be paid by Medicare for CPT codes for health and behaviorial assessment services (**96150-96152**)? If not, are there any HCPCS codes they could use?

A Per CPT, the codes were created for use by non-physician providers. Typically these providers were unable to utilize E/M services for the work they were doing, or the services they rendered did not meet the requirements of an E/M, so these codes were created. If a physician treats a patient in a manner similar to this type of visit, they are still directed to use the E/M codes. They would most likely document their counseling time, and use time as their driving force for code selection.

CMS further clarifies that these codes cannot be used by social workers, as they can only treat patients with a known mental illness/condition. These codes were created to manage psychological, behavioral, emotional, cognitive and social factors that may constitue an acute or chronic illness, without the diagnosis of a mental illness/condition.

On the Internet:

- CMS coverage determination: *www.cms.gov/medicare-coverage-database/lcd_attachments/30514_1/L30514_031610_cbg.pdf*

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