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President's Message

Happy New Year to all! We have been blessed to have such a warm welcome to the New Year and this allows us to be hopeful the weather for our region will not be a repeat of last year's. It is now time to get back into the business of healthcare and begin to adjust to the changes the New Year brings. In this newsletter edition, we discuss some of the CPT and HCPCS coding changes, Medicare updates and noteworthy and/or newsworthy matters for healthcare and compliance. It promises to be another interesting year for our industry!

The Five Most Likely Places Where Your Identity Will Be Stolen According to USA Today

Colleges
Banks
Drs Offices
Hospital
Insurance Companies

This is why insurers and Medicare must STOP using SSNs as identifiers. Out of the top five, three are medically related.

S.3789 -- Social Security Number Protection Act of 2010 (Enrolled Bill [Final as Passed Both House and Senate] - ENR)

An Act to limit access to Social Security account numbers.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,
SECTION 1. SHORT TITLE.

This Act may be cited as the `Social Security Number Protection Act of 2010'.

SEC. 2. SOCIAL SECURITY NUMBER PROTECTION.

(a) Prohibition of Use of Social Security Account Numbers on Checks Issued for Payment by Governmental Agencies-

(1) IN GENERAL- Section 205(c)(2)(C) of the Social Security Act (42 U.S.C. 405(c)(2)(C)) is

amended by adding at the end the following:

`(x) No Federal, State, or local agency may display the Social Security account number of any individual, or any derivative of such number, on any check issued for any payment by the Federal, State, or local agency.'.

Does this mean Medicare EOMBs?

(2) EFFECTIVE DATE- The amendment made by this subsection shall apply with respect to checks issued after the date that is 3 years after the date of enactment of this Act.

(b) Prohibition of Inmate Access to Social Security Account Numbers-

(1) IN GENERAL- Section 205(c)(2)(C) of the Social Security Act (42 U.S.C. 405(c)(2)(C)) (as amended by subsection (a)) is amended by adding at the end the following:

`(xi) No Federal, State, or local agency may employ, or enter into a contract for the use or employment of, prisoners in any capacity that would allow such prisoners access to the Social Security account numbers of other individuals. For purposes of this clause, the term `prisoner' means an individual confined in a jail, prison, or other penal institution or correctional facility pursuant to such individual's conviction of a criminal offense.'.

(2) EFFECTIVE DATE- The amendment made by this subsection shall apply with respect to employment of prisoners, or entry into contract with prisoners, after the date that is 1 year after the date of enactment of this Act.

States get bonuses for boosting enrollment for uninsured children in Medicaid

States also cut red tape and simplified enrollment process.

HHS Secretary Kathleen Sebelius today awarded $206 million to 15 states for making significant progress in enrolling uninsured children in Medicaid. This year's bonuses are more than double the $75 million awarded to ten states last year.

"Today's announcement highlights the ongoing and committed efforts by states to improve access to health coverage programs and take the aggressive steps necessary to enroll eligible children," said Secretary Sebelius.

"Their actions reflect President Obama's serious commitment to assuring that our country's children get the health care they need. These performance bonuses demonstrate our support for the effective strategies these states have undertaken."

Medicare Details IT Modernization Plan

Agency aims to transform into an information-centric organization to improve its delivery of healthcare services and manage new programs and requirements outlined in federal law.

The Centers for Medicare & Medicaid Services (CMS) has revealed plans to modernize its computer systems as it reorganizes its IT infrastructure to break down information silos, support new data such as clinical records, and better manage data systems that can improve payment and other services to CMS beneficiaries, providers, and the general public.

The December 23 report, Modernizing CMS Computer and Data Systems to Support Improvements in Care Delivery, provides a detailed plan for updating CMS computer and data systems that support approximately 100 million beneficiaries and pay benefits totaling approximately $800 billion a year.

Mandated by the Patient Protection and Affordable Care Act, CMS said its IT modernization program will allow it to establish capabilities to achieve the following goals:

Improved Business Operations: CMS must transition to flexible payment methods that integrate administrative claim, encounter, clinical, payment, and outcome data while maintaining its fee for service (FFS) and Medicare Advantage and prescription drug (MAPD) operations.

Enhanced Public Accountability: CMS must streamline its program, billing, and eligibility information to make these systems and processes as informative as possible while reducing burdensome procedures, such as enrollment and claim processing, for providers.

In addition, improving health outcomes involves promoting a patient-centered focus on prevention and wellness, chronic care management, and individual health responsibility. All three depend on the beneficiary's and provider's timely access to critical information about coverage, eligibility, and quality of care.

The agency also outlined the difficulties it faces, and said its systems are unable to provide 360-degree views of patient and provider information.

-- CMS' healthcare role is changing from a passive payer of claims to a purchaser of quality healthcare outcomes. CMS is implementing programs for assuring healthcare quality and is progressing toward new payment models based on the quality of care.

According to CMS, it will take 5 to 10 years to implement the plan in incremental development cycles. CMS also predicts that its data governance and enterprise data management policies will spawn significant cost savings. Among the areas identified as benefiting from potential administrative cost savings/cost avoidance are:

-- Reduced risk of systemic failure due to overly complex, customized systems;

-- Simplified infrastructure through the retirement of hardware, applications, and databases;

-- Retirement of systems reducing the burden of maintaining product licenses and support costs (monitoring, upgrades, and patches) of retired systems;

-- Reduced labor activities related to the legacy hardware, applications, and databases (acquisition, storage, analysis, enhancement, maintenance, troubleshooting, archival, and distribution); and

-- Negotiation of better rates for resources that do not require special domain knowledge or expertise, which is presently required for complicated infrastructure or legacy assets.

Maryland Medical Record Law Update - Fees

The adjusted rates for medical record copying are as follows:

A preparation fee of $22.0911 (This fee may not be charged for records provided directly to patients),

plus a copying charge of $.73637 per page;

plus the actual cost of shipping and handling. .

Republicans:"Forget Obama Care"

Republican leaders and rank and file Republicans have stated that job #1 is to get rid of Obama care and job #2 is get rid of Obama. While some small provisioms took effect January 1, such as no pre-existing conditions for children and death panels - Republicans say they will stop the rest from taking effect. Especially, having to buy health insurance as a mandatory fact of life.

Medicare Dispatch

Question and Answer

Question: Is it ok to have a patient sign an ABN for the new Annual Wellness Visit (AWV) if the patient indicates they already had a wellness visit with another physician approximately 10 months ago?

Answer: Medicare appears to be silent on this issue so far. In past communications regarding the Initial Preventive Physical Examination (IPPE), Medicare had instructed a provider may obtain an ABN when the provider has questions about the patient's length of

eligibility or if the IPPE had already been billed. However, it would be consistent with Medicare thinking if you obtain an ABN for the AWV if you have sufficient questions about the patient's eligibility to have the encounter reimbursed by Medicare since they already had one previously provided in the calendar year. This service has a frequency limit and Medicare routinely has advised in past services an ABN is appropriate to obtain as long as you have sufficient reason to believe your service will not meet the requirements, state what is the service and explain what the frequency limit is for the said service.

Medicare Lab Requisition Signature Requirement Update

CMS will not require signatures on lab requisitions until April 2011, a three-month reprieve from the original January 1, 2011 deadline. This is in response to a letter received by CMS dated December 3, 2010 from numerous healthcare organizations including the American Hospital Association. The healthcare organizations requested a one year delay in the requirement.

However, this was not what CMS decided they would do. CMS will spend the first quarter of 2011 educating providers regarding the signature requirement. The biggest benefit for providers is having more time for education. The delay also provides facilities with additional time to re-develop forms.

CMS is remains adamant about requiring all lab requisitions to be signed if the lab receives them, even when a signed order is on file at the lab or in the physician's office.

CMS seems to be trying to resolve a problem with the location of signed orders. A signed order is often on file at the physician's office and not readily available to the hospital that performs the lab service based on a requisition.

HealthCare Newsline

Physician Usage of Electronic Medical Record (EMR)

The CDC's annual National Ambulatory Medical Care Survey recently completed shows that 50.7 percent of the 7,000 physicians surveyed and who practice in ambulatory practice have at least a partial EMR in place in 2010. The same survey showed only 48.3 percent in 2009.

A partial system is considered to be less than a "Basic EMR". A "Basic EMR" is defined to be capable of recording patient history and demographic information, problem lists, clinical notes and medication lists along with E-prescribing and displaying lab and imaging results. To have a "Fully Functional EMR" the system includes the "Basic EMR" capabilities and includes medical histories, CPOE, drug-drug interaction checking and guideline-based interventions.

The 2010 survey revealed that of the 7,000 respondents, only 10.1 percent currently has a Fully Functional EMR". This figure is also slightly up over last year.

Modifier 33

CPT introduced a new modifier for calendar year 2011. The new modifier is 33 Preventive Service. CPT modifier 33 is to be used by providers to alert insurers the service was preventive under applicable laws, and the patient cost sharing should not apply.

This new modifier was created because of the new healthcare legislation passed this past summer. The Patient Protection and Affordable Care Act (PPACA) requires all health care insurance plans to begin covering preventive services and immunizations without any cost sharing, The regulation states health plans can not impose cost sharing requirements (i.e. co-pays, deductibles) for specified preventive services.

So what coding advice does the AMA provide? When the primary reason of the service is the delivery of a service in accordance with a "US Preventive Services Task Force A or B rating" and other preventive services identified in mandates (legislative or regulatory), the service should be identified by appending modifier 33 Preventive Service.

However, a separately reported service specifically identified as preventive, this modifier should not be appended. Basically, the services for which modifier 33 is appropriate will fall into four (4) categories.

Services rated "A" or "B" by the US Preventive Services Task Force. http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm

Immunizations for routine use in children, adolescents, and adults as recommended by the Advisory Committee on Immunization Practices of the CDC.

Preventive care and screenings for children as recommended by Bright Futures (American Academy of Pediatrics) and Newborn Testing (American College of Medical Genetics)

Preventive care and screenings provided for women (not included in the Task Force recommendations) in the comprehensive guidelines supported by the Health Resources and Services Administration.

Integumentary Highlights

With the 2011 CPT code revisions the debridement code range 11042-11044 involve, at a minimum, the full thickness of the skin plus subcutaneous tissue. The partial thickness and full thickness debridement procedures are coded using the revised CPT codes 97597 and 97598. The descriptions for 11042-11044 also are changed to now describe square centimeters. Codes 11045-11047 which are new in 2011 represent add-on codes to report for greater debridement dimension than the primary CPT code represents.

11042 (Debridement subcutaneous tissue (includes epidermis and dermis, if performed); first 20 square centimeters or less.

11043 (Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); first 20 square centimeters or less .

11044 (Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); first 20 square centimeters or less.

11045 (Debridement subcutaneous tissue (includes epidermis and dermis, if performed); each additional 20 square centimeters.

11046 (Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); each additional 20 square centimeters.

11047 (Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); each additional 20 square centimeters, or part thereof).

97597 (Debridement (eg, high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), open wound, (eg, fibrin, devitalized epidermis and/or dermis, exudate, debris, biofilm), including topical application(s), wound assessment, use of a whirlpool, when performed and instruction(s) for ongoing care, per session, total wound(s) surface area; first 20 square centimeters or less) .

97598 (Debridement (eg, high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), open wound, (eg, fibrin, devitalized epidermis and/or dermis, exudate, debris, biofilm), including topical application(s), wound assessment, use of a whirlpool, when performed and instruction(s) for ongoing care, per session, total wound(s) surface area; each additional 20 square centimeters, or part thereof (List separately in addition to code for primary procedure).

CMS has developed new HCPCS Level II codes for payment under the MFS for the application of Apligraf or Dermagraft to the lower limb. These HCPCS Level II codes do not allow separate reporting for site preparation, debridement or the use of 58 modifier. [Previously, reported using codes 15340-15341; 15360-15361].

G0440 (Application of tissue cultured allogeneic skin substitute or dermal substitute; for use on lower limb, includes the site preparation and debridement if performed; first 25 sq cm or less) .

G0441 (Application of tissue cultured allogeneic skin substitute or dermal substitute; for use on lower limb, includes the site preparation and debridement if performed; each additional 25 sq cm)

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Recent Fraud and Abuse Case

In central Ohio a physician was found guilty of healthcare fraud along with illegal distribution of a controlled substance. The foundation of the fraud charge is based on billing Medicare and Medicaid for office visits when the physician was out of the country.

According to the case record, the office manager was seeing patients for the physician while out of the country and used pre-signed prescription pads to write and issue prescriptions for his patients while out of town.

New Technology for Medicare and Medicaid to Combat Fraud and Abuse

A company from South Dakota has presented the Federal Government with a solution that could save the federal government billions of dollars by preventing Medicare fraud.

The company, Hagan Benefits, has created a biometric device that scans fingers and palms and had the potential to be most useful in preventing health care fraud. It is viewed as an efficiency tool for health care clinics that will eliminate the need for insurance verification.

Instead of showing an insurance card, patients will scan their palm or finger, and the images are immediately sent to the insurance company for verification. The patient's policy information is then sent back to the clinic.

This technology is not futuristic. Three (3) states (Florida, Maryland and New York) have reportedly begun using the devices in approximately 100 health care facilities in mid-November as a way to prevent Medicaid fraud.

Local Group Fined

In case you missed this news, State health regulators disclosed they have fined the group, Baltimore Behavioral Health Inc., $90,000 for employing a psychiatrist who had been convicted several years earlier of Medicaid fraud.

The fine equals the salary and benefits that the nonprofit clinic paid the provider during the 14 months he worked as an administrator for the group. According to Maryland State officials the group should not have hired him because he was on a federal no-hire list because of his fraud conviction.

Health Care *Reform Benefits Taking Effect in 2011*

• Primary care bonus: Doctors will get a 10 percent Medicare bonus for primary care services, while general surgeons in underserved areas will also get a 10 percent bump through Dec. 2015.

• Preventive care: Medicare recipients can receive an annual wellness checkup and a personalized prevention plan with no cost-sharing; Medicare deductibles for colorectal cancer screening tests will also be waived.

• Donut hole: Medicare beneficiaries will receive a 50 percent discount on brand-name drugs whose manufacturers have signed agreements with the Centers for Medicare and Medicaid Services. Additional savings over the next 10 years will close the gap completely by 2020.

• Medical-loss ratio: Health insurance plans must provide rebates to customers if they spend less than 80 percent of premiums ((85 percent for large employer plans) on health care; the ratios will be measured in 2011, and the rebates delivered in 2012. Further, the "mini-med plans," or low-value plans, are now required to collect data so federal regulators can determine how to apply the medical-loss ratio to them in the future.

• Home care: The community care transitions program helps coordinate care for high-risk Medicare beneficiaries to avoid unnecessary re-hospitalizations

and connect them with resources in the community.

For information about the Affordable Care Act and its timeline, go to http://www.healthcare.gov.

Feds Seek Anti-Fraud Technologies to Nab Medicare Cheats

The Obama Administration is looking for sophisticated fraud-fighting tools which could enable federal agencies to catch illegal Medicare and Medicaid practices as they happen.

"Many companies in the private sector, as well as the Centers for Medicare and Medicaid Services, have been testing and using predictive modeling programs to help identify possible fraudulent providers and scams based on historical information about the individual or the company in which the individual is affiliated," the Health and Human Services Agency said in a statement.

As an example, the HHS said, CMS has already taken action to stop federal payments to so-called "false fronts" in Texas identified through sophisticated predictive modeling.

HHS secretary Kathleen Sebelius and Attorney General Eric Holder made their comments at the fourth regional healthcare fraud prevention summit on Thursday at the University of Massachusetts in Boston.

As part of that summit, CMS said it is soliciting "state-of-the-art fraud fighting analytic tools to help the agency predict and prevent potentially wasteful, abusive or fraudulent payments before they occur." The tools would be used by the National Fraud Prevention Program as well as the Department of Justice Health Care Fraud Prevention and Enforcement Action Team (HEAT).

Geisinger notifies almost 3,000 patients of PHI disclosure

WILKES-BARRE PA – Geisinger Health System, a physician-led healthcare system of northeastern and central Pennsylvania, has notified approximately 2,928 patients that some of their protected health information (PHI) was disclosed in an unauthorized manner.

Officials at Geisinger became aware of the disclosure on Nov. 6, but believe the incident occurred on or about Nov. 3, when a former Geisinger Wyoming Valley Medical Center gastroenterologist e-mailed the PHI from a Geisinger computer to his home email account in an un-encrypted manner. The physician had sent this information to his home computer to complete an analysis of his procedures, said officials.

The information included patient names, Geisinger medical record numbers, procedures, indications and the physician's brief impressions regarding the care provided. It did not include addresses, telephone numbers, Social

Security numbers, patient account information or any financial information that could make affected patients vulnerable to financial identity theft, officials said.

"Immediately upon speaking with the physician, he contacted and authorized his home e-mail provider to delete the protected health information from its network and servers," said Geisinger Privacy Officer John Gildersleeve. "He also deleted this information from his home computer."

Officials have notified patients as part of Geisinger's health information security program and in compliance with the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009.

"We have reviewed our internal practices and taken appropriate action to avoid reoccurrence," said Gildersleeve. "With the short time frame and the doctor's forthright explanation, we believe there is little risk that the protected health information was seen by anyone other than the physician himself. We take our commitment to maintaining our patients' privacy seriously and regret any inconvenience this inadvertent disclosure may have caused."

Gildersleeve emphasized that affected patients have been contacted by mail. "If you did not receive a letter, your PHI was not included in the email disclosure," he said.

Monthly Quiz

Take our free quiz and see how you do!

Coding Mini-Quiz –

How well do you know using modifiers?

1. It is appropriate to append modifier 51 to specific nuclear medicine codes (i.e. 78306, 78320, 78802, 78803, 78806, 78807).

a. True
b. False

2. CMS and some other private payers accept modifier 58 appended to surgical procedures with Zero days associated with the procedure.

a. True
b. False

3. Which modifier does one use to report B-readings of chest X rays (views include anteroposterior, lateral, and oblique)?

a. 52
b. 22
c. none
d. 59 appended to a repeat of the radiology CPT code

4. If the procedure is performed and it is more extensive than it normally would be and no CPT code exists that describes the procedure as documented you would:

a. Use only unlisted CPT code
b. Use a closely related CPT code and append modifier 22
c. Use the unlisted CPT code with modifier 22
d. Use closely related CPT code with modifier 52

5. What is the main difference between the appropriate use of modifiers 58 and 78?

a. Only modifier 78 refers to both procedures as being related
b. Only modifier 78 can be appended to a major surgical procedure performed during the global period
c. One is planned and the other is an unplanned procedure
d. Both modifiers reset the postoperative period for Medicare

For answers go to:

www.codingtrainer.com/answers010111.pdf

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"Your Coding Resource"

CodingTrainer.com provides central Maryland's premier training for coders who want any of nine certifications. We have a fulltime training facility in Catonsville Maryland, one half mile from the beltway.

Our next class dates are as follows:

- **Coding certification class for *nine different certifications* – Wednesday February 16, 2011 and Saturday class begins February 26, 2011 for 23 weeks**
- **Certification class for previously certified coders to become CCS-Ps – Monday February 28, 2011 for 6 weeks**
- **CCS Certification course – Thursday July 7, 2011 for 20 weeks**
- **Call us to set up a class for you and your providers at your facility.**

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