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November 3, 2010

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President's Message

Howdy all! I figured this would be an appropriate greeting given the CMA Awards for 2010 will occur later this month. This edition of our newsletter has some very important and timely information for our medical practices and operations. We also have a new feature column titled "Healthcare Newsline". At this time of year we have such a cornucopia of healthcare updates, news and regulations. Happy Thanksgiving!!

Some other noteworthy news to pass along include:

MLN Matters Article MM7133: Counseling to Prevent Tobacco Use which details Medicare's coverage for this service.

The Certified HIT Product List (CHPL) is now available on the Office of the National Coordinator for Health Information Technology's (ONC) Web site. Go here: http://onc-chpl.force.com/ehrcert

Did you know: The Taxpayers Against Fraud Education Fund calculates that the U.S. Justice Dept. recovered more than $3.16 billion from fraudulent False Claims Act settlements, with pharmaceutical companies topping the list.

One in five medical claims is processed inaccurately by health insurers, according to the AMA's National Health Insurer Report Card.

In October, 2010, CMS began publishing a newsletter, called the Medicare Quarterly Provider Compliance Newsletter. The stated goal of this publication is to advise physicians, suppliers, and other [fee for service] providers about how to avoid common billing errors and other erroneous activities. Here is the URL for the first edition: http://www4.cms.gov/MLNProducts/downloads/MedQtrlyComp_Newsletter_ICN904943.pdf.

Enjoy!
Debbie

BREAKING NEWS!
Health and Human Services Releases Proposed Rule

To read the proposed rule that includes a 30% cut in the Medicare Conversion Factor go to

http://www.ofr.gov/OFRUpload/OFRData/2010-27969_PI.pdf

If this proposed rule is adopted you will likely see an increase in the unemployment of billing and coding professionals (non-revenue producing positions). A 30% reduction in Medicare revenue is catastrophic and will cause physicians to not take Medicare patients.

PPACA and RAC

CMS' recovery audit contractor (RAC) program, now operating permanently under fee-for-service Medicare (Plans A and B) nationwide, will next expand to find improper payments under Medicaid and additional Medicare Plans. Provisions under the Patient Protection and Affordable Care Act (PPACA) also call for a permanent expansion of the RAC program to Medicare Advantage (Plan C) and the Medicare drug benefit (Plan D), in addition to Medicaid, by the end of the year.

The 12/31/2010 deadline may be problematic for CMS. Expansion of the RAC program to Medicaid will be challenging because it involves coordination with 50 different state programs. Recently, a CMS spokesperson reported the agency is furthest along with implementing a RAC component to oversee Medicare Part D, the prescription drug program for seniors.

PPACA

Other provisions of the Patient Protection and Affordable Care Act (PPACA) of special note include:

Expansion of False Claims Act (FCA)

Prohibits the submission of false or fraudulent claims in order to receive payment from the government plus civil fines of $5,500 to $11,000 per claim plus treble damages.

PPACA expands upon Fraud Enforcement and Recovery Act of 2009 (FERA) changes and makes other changes.

FERA amendments made the knowing retention of overpayments actionable.

PPACA establishes parameters governing the return of overpayments.

Defines Overpayments:

Funds that a person receives or retains under title XVIII or XIX to which the person, after applicable reconciliation, is not entitled under such title.

Establishes timeframe: An overpayment must be reported and returned to the applicable entity, by the later of:

the date which is 60 days after the date on which the overpayment was identified; or

the date any corresponding cost report is due, if applicable.

Mandatory Compliance Programs

All Medicare, Medicaid and CHIP providers and suppliers must maintain compliance programs that satisfy standards developed by the Secretary. CMS is to issue regulations specifying required elements of compliance, timeliness and other details regarding

implementation. When establishing implementation timeline, CMS is to consider the extent to which compliance programs are already in widespread use within a specific provider or supplier segment.

CMS likely to focus first on provider or supplier types where adoption of compliance programs is less widespread (e.g., DME suppliers).

Medical-data breach said to be major

A computer flash drive containing the names, addresses, and personal health information of 280,000 people is missing - one of the largest recent security breaches of personal health data in the nation.

"We deeply regret this unfortunate incident," said Jay Feldstein, the president of the two affiliated Philadelphia companies, Keystone Mercy Health Plan and AmeriHealth Mercy Health Plan.

The breach, which involves the records of Medicaid recipients, is the first such Medicaid data breach in Pennsylvania since at least 1997, according to the state's Department of Welfare, which has oversight.

"We take compliance [with federal privacy laws] very seriously," department spokeswoman said.

The security failure, one of the several largest in nearly two years, involves nearly two-thirds of the insurers' subscribers. It became known only after The Inquirer requested information Tuesday evening. The insurers said the drive was missing from the corporate offices on Stevens Drive in Southwest Philadelphia. It noted that the same flash drive was used at community health fairs.

"That seems grossly irresponsible," said Dr. Deborah Peel, a Texas psychiatrist who heads Patient Privacy Rights, an advocacy group.

"Why would you be hauling around private patient information to a health fair," she said. "I can't imagine what they were thinking, taking this data out of a locked room at company headquarters.

"What's tragic is that this is a particularly vulnerable group of people," Peel said. "They tend to be vulnerable to identity theft, vulnerable to discrimination." Medicaid recipients are low-income people.

The companies said that as of Tuesday, there had been no reports of anyone trying to use the information stored on the drive.

The news of the breach comes at a time when there is more emphasis - and billions of dollars in federal funding - to develop protocols for electronic medical records, with information being shared among providers, insurers, and consumers.

The idea is to eliminate duplicated record-keeping and improve patient health by allowing doctors, hospitals, and others to be quickly informed about medical conditions, prescriptions, allergies, and treatments.

"It's scary when you think about electronic patient records, which have many potential benefits, but there's also the concern about loss," said Susan Grant, director of consumer protection for the Consumer Federation of America, an association of nearly 300 consumer groups.

The health data are very sensitive and may also contain payment information.

The most infamous security breach occurred in 2006, when records of 2.65 million veterans were stolen from a Veterans Administration employee working from his home.

The Privacy Rights Clearinghouse in California maintains a database of reports on breaches culled from the media and websites. It listed 184 medical data incidents in 2009 and 2010 involving the records of 5.2 million people.

The Keystone and AmeriHealth case, if it had been listed, would have been among the top five by number of people involved.

In the Keystone and AmeriHealth case, the company said that of the 280,000 people affected only seven members' Social Security numbers were included on the flash drive, along with the last four Social Security numbers of an additional 801 clients.

The affiliated companies have been tight-lipped about the breach, which they said occurred Sept. 20.

Until asked for information, the company had not disclosed the data breach to affected members, most of who live in Philadelphia and nearby counties.

Federal patient-privacy laws, which have been strengthened as the push toward electronic medical records advances, require that companies report major data breaches to the individuals, to the U.S. Secretary of Health and Human Resources, to the media, and to appropriate "business associates," in this case defined as the Pennsylvania Department of Public Welfare.

The federal website explaining the law says that breaches must be reported "without unreasonable delay and in no case later than 60 days."

Medicaid is funded jointly by federal and state governments. Pennsylvania's agreement appears to require a report within two days. Myers said it was unclear when the companies reported the incident. The federal government did not respond on time.

The companies refused to offer any explanation of how the incident happened.

They would not say how they know the computer drive was lost, not stolen. They would not comment on the riskiness of taking the drive to health fairs, nor would they say whether the data on the drive was encrypted.

The companies refused to say whether they reported the incident to the federal government, as required.

After many requests for follow-up information, the companies issued this statement:

"At Keystone Mercy Health Plan and AmeriHealth Mercy Health Plan, our number one priority is our members. Since reporting this unfortunate incident to the Department of Public Welfare, we have actively and responsibly executed a

multifaceted plan to inform those affected, while also evaluating and enhancing our security measures to ensure this does not happen again."

Keystone Mercy Health Plan provides insurance to 300,000 Medicaid members in Philadelphia, Bucks, Montgomery, Delaware, and Chester Counties. AmeriHealth serves 100,000 in a 15-county arc running from Harrisburg to northeastern Pennsylvania.

The two companies are jointly owned by Independence Blue Cross and the Mercy Health System.

Officials realized Sept. 20 that a portable drive containing the records of 285,691 Medicaid clients was missing.

Medicare Dispatch

Question: If a provider accepts assignment, can they make the decision not to accept new patients who have Medicare Coverage to their group?

Answer: In general, it's OK to close a practice to new Medicare beneficiaries while maintaining a participation status with Medicare for treating Medicare beneficiaries already in your practice. This is of course different from Opting Out of the Medicare Program.

Question: Is there a web address one may use to identify whether a provider is enrolled in PECOS?

Answer: Yes, go to http://www.oandp.com/pecos/

Question: Why is my practice receiving medical record requests for Level IV and V new patient visits?

Answer: Highmark Medicare has initiated a prepayment review for all claims with 99204 and 99205 in September 2010.

For any claims sent in, requests will be sent to the provider requesting copies of the medical record before any payment is made. They are looking for supporting content to justify these levels of services and signature legibility and meeting the "incident to" guidelines, among other things mentioned.
This is across the board - all specialties. Refer to their Medicare Bulletin 9/20/10.

HealthCare Newsline

One of the latest issues on the forefront of healthcare is the availability, use and terms of healthcare credit cards.

What are healthcare credit cards?

Healthcare credit cards are offered by lenders (such as GE Money and Citibank) to consumers who have large out-of-pocket medical expenses.

Doctors and dentists have begun to offer applications for these cards in their offices - like Best Buy who offers you a credit card in order to finance a new laptop. Or, as you leave your dentist's office instead of receiving a "Goodie Bag" with a toothbrush and toothpaste now fill these "Bags" with healthcare credit cards.

Patients about to undergo expensive elective operations, like LASIK or cosmetic surgery, may decide to use a healthcare credit card because it will offer 0% financing for 12 months. In addition, healthcare credit cards are convenient for doctors and dentists because they can automatically bill the card and receive payment for services. No more waiting for the patient to pay the portion they owe.

New York's Attorney General, Andrew Cuomo, launched in August an industry-wide investigation into CareCredit, a healthcare credit card offered by GE, whose terms the AG found amount to "predatory lending".

According to Cuomo's office healthcare providers pushed consumers to sign up for the CareCredit card to cover out-of-pocket costs and received kickbacks from CareCredit based on how much patients charged. Consumers signed on for the cards believing that they carried zero interest, when in fact they often carried retroactive interest of over 25% if not paid in full during a promotional period.

What are the pros and cons of using healthcare credit cards? Consider the following.

Pros of healthcare credit cards

- 0% introductory financing (usually for12 months)
- Limits can range anywhere from $1,000 to $25,000
- A way to pay for medical procedures for the patient and family
- Automatic billing means a streamlined payment process

Cons of healthcare credit cards

- Interest rate could jump to 30% after the introductory period expires or if a payment is missed
- Like other credit cards, healthcare credit cards are just another way to accumulate debt
- A person can be tempted into adding extra services and procedures they can not really afford or don't really need
- Automatic billing means a dentist or doctor can charge the card immediately and in advance, leaving the patient to foot the bill before they have had the procedure or before the insurance company has decided how much it will cover
- Like other credit cards, healthcare credit cards can harm your credit score to varying degrees: applying for the card, being late or missing a payment, and maxing it out can slightly or seriously damage a person's credit score

Before simply charging healthcare costs to traditional or healthcare credit cards, one should take advantage of employer- and government-sponsored programs or consider communicating directly with the physician's office to figure out a payment plan that works for the patient.

ICD-9 CM Alert

Highlight ICD-9 CM Changes: Part I

Schwannomatosis

Code 237.73 was added to subcategory 237.7, Neurofibromatosis, to recognize Schwannomatosis. This is a genetic disorder that causes multiple tumors to grow on cranial, spinal, and peripheral nerves. Code 237.79 was also added to capture other neurofibromatosis conditions. The codes for Type 1 and 2: 237.71 - Neurofibromatosis, type 1 [von Recklinghausen's disease] and 237.72 Neurofibromatosis, Type 2.

There are three types of Neurofibromatosis, each of them resulting in bad symptoms (Type 1, Type 2, and Schwannomatosis). Type 1 neurofibromatosis also known as Von Recklinghausen or NF1 is the most common type of Neurofibromatosis. It is transmitted on chromosome number 17, and is caused mostly by mutation. This type causes multiple areas of hyper pigmentation (i.e. birthmarks). Type 2 has the same symptoms as NF1, and is caused the same way except for the fact that it is carried on chromosome 22, not 1. Schwannomatosis is different from the other types because it does not cause neurological disabilities or malignant tumors. Schwannomatosis causes chronic pain (which is possible to occur in any parts of the body) depending on the peripheral nerves are affected.

Obesity Hypoventilation Syndrome

Code 278.03 was added for obesity hypoventilation syndrome (OHS), also called Pickwickian Syndrome. OHS is a breathing problem that causes hypoventilation and produces decreased oxygen levels and elevated carbon dioxide.

The exact cause of OHS in not known. Most (but not all) patients with the syndrome have a form of sleep apnea. OHS is believed to result from both a defect in the brain's control over breathing, and excessive weight (due to obesity) against the chest wall, which makes it hard for a person to take a deep breath. As a result, the blood has too much carbon dioxide and not enough oxygen. People with OHS are often tired due to sleep loss, poor sleep quality, and chronic hypoxia.

Fluency Disorders

Code titles have been changed and new codes added to distinguish between childhood onset fluency disorder, adult onset fluency disorder, and fluency disorder subsequent to brain lesion or disease.

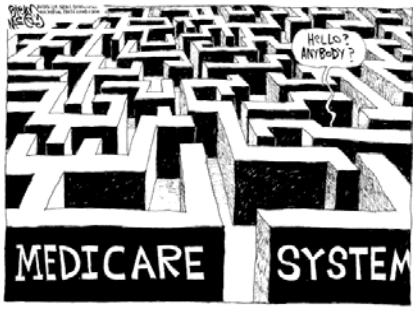
The title of code 307.0 was changed from "stuttering" to "adult onset fluency disorder." Code 315.35 was added for reporting childhood onset fluency disorder. New code 784.52, Fluency disorders in conditions classified elsewhere, is used as an additional code with conditions such as Parkinson's disease that produce the fluency problem.

Fluency refers to the smoothness with which sounds and syllables, as well as words and phrases, are joined together while speaking. A fluency disorder is a speech disorder in which the normal flow of speech is disrupted by frequent repetitions or prolongations of speech

sounds, syllables, or words or by an individual's inability to start a word. The speech disruptions may be accompanied by rapid eye blinks, tremors of the lips and/or jaw or other struggle behaviors that a person who stutters may use in an attempt to speak. Certain situations, such as speaking before a large group of people or talking on the telephone, tend to make stuttering more severe, whereas other situations, such as singing or speaking alone, often improve stuttering. There are no clear-cut answers to questions about the causes of stuttering, but experts have learned much about the factors that contribute to its development including: genetics, neurophysiology, child development, and family dynamics.

Influenza Due to Certain Influenza Viruses

Subcategories 488.0, Influenza due to identified avian influenza virus, and 488.1, Influenza due to novel H1N1 influenza virus, were expanded to the fifth-digit level to identify the following: pneumonia, other respiratory manifestations, and other manifestations that occur as a result of the virus infection.
Codes 488.01, Influenza due to identified avian influenza virus with pneumonia, and 488.11, Influenza due to identified novel H1N1 influenza virus with pneumonia, require an additional code to identify the type of pneumonia.



Who is eligible for Medicare?

Most people know that in the U.S., all Americans (i.e., citizens or permanent residents) are eligible for Medicare once they turn 65. However, the benefits are not the same for all individuals. For instance, the following groups can receive Part A Medicare coverage without paying a premium:

Individuals who already get retirement benefits from Social Security or the Railroad Retirement Board.
Individuals who are eligible to get Social Security or Railroad benefits but haven't yet filed for them.

Individuals who either themselves or their spouse has Medicare-covered government employment.
Some individuals qualify for both Medicare (for the elderly) and Medicaid (for the poor). These dual-eligible beneficiaries receive reduced cost sharing burdens as well.

There are two groups of Americans who can qualify for Medicare before they reach age 65. These include:

Individuals who have received Social Security or Railroad Retirement Board disability benefits for 24 months.
Most individuals with End-Stage Renal Disease

Monthly Quiz

Coding Mini-Quiz – ICD-9

1. An elderly patient is admitted to the inpatient unit of the hospital with shortness of breath and fever. She is found to have influenza and pneumonia and is treated accordingly. She also has flaccid hemiplegia due to old CVA. Which of the following would be the appropriate diagnosis code(s) selection?

   a. 487.1, 486, 438.20
   b. 486, 487.1, 438.20
   c. 487.0, 438.20
   d. 487, V12.59

2. Patient was admitted with a diagnosis of subacute and chronic pyelonephritis. He has underlying conditions that include proliferative diabetic retinopathy, COPD and a traumatic arthritis of the ankle, S/P ankle fracture two years ago. Which of the following would be the appropriate diagnosis code(s) selection?

   a. 590.00, 590.80, 250.50, 362.02, 496, 716.17, 905.4
   b. 590.10, 590.00, 250.50, 362.02, 496, 716.17, 905.4
   c. 590.80, 250.51, 362.02, 496, 716.17, 824.8
   d. 590.10, 590.00, 250.51, 362.02, 496, 716.17, 905.4

3. A patient is diagnosed with congestive heart failure due to diastolic dysfunction due to hypertension. The appropriate diagnosis code(s) assignment is:

   a. 402.91
   b. 402.91, 428.0
   c. 401.9, 428.30, 428.0
   d. 402.91, 428.30, 428.0

4. An AIDS patient is admitted for treatment of congestive heart failure (CHF). He has a history of coronary artery bypass graft (CABG) and was found to have HIV infection from a blood transfusion given at that time. His HIV was diagnosed one year ago, when he was found to have Kaposi's sarcoma of the skin, which is still present. He was treated with Lasix for the CHF and discharged. The appropriate codes include:

   a. 042, 176.0, 428.0, V45.81
   b. 428.0, V08, 176.0, V45.81
   c. 428.0, 042, 176.0, V45.81
   d. V08, 428.0, V45,81

5. Patient is seen in the ED for a fractured wrist after being pushed to the ground by her husband during a fight. How would this case be coded?

   a. 814.00, 995.81, E960.0, E967.3
   b. 814.00, 995.81, E960.1
   c. 995.81, 814.00, E967.3, E960.0
   d. 995.81, 814.00, E96

For answers go to:

www.codingtrainer.com/answers110110.pdf

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- **CCS Certification course – January 2011**
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- **Call us to set up a class for you and your providers at your facility.**

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