

# GRANDROUNDS

Volume 01 ISSUE 03

## CODING & BILLING HELP DESK

Bridging the needs of the medical provider's office with expertise in coding and billing.

- Immediate turn-around for coding and documentation questions from certified coders
- Immediate billing support questions for billing of all medical organizations
- Denial Management support offered to medical practices and hospital groups
- Live-Chat
- Grand-Round Forum

## The Five Step Billing Process

1. Determine that the service is medically necessary.
2. Provide the service needed in order to properly meet the patient's needs.
3. Document the service provided.
4. Select the most appropriate CPT/HCPCS code for the medically necessary service that was provided and properly documented.
5. Submit the service to the Payer.

## OBSERVATION TO INPATIENT ADMIT RULE OF THUMB

If I admit a patient into observation one day & then admit them into in-patient the next day, does the patient's admit become retroactive to the first date?

It doesn't matter if a patient stays 23 hours, less than 23 hours, 48 hours or

72 hours. If the patient is out-patient (place of service 22), because THAT is where the doctor admitted the patient, then they are out-patient. To

retroactively admit the patient in-patient, when the doctor did not feel the patient met DRG requirements to be in-patient, could be considered by some

(including moi) to be fraudulent billing.

So - in answer to your question,

use 99218, 99219 or 99220 on the first date (regardless if the patient is admitted at 6:15am or 11:47pm). Then, on the second date, bill out-patient codes 99211-99215 (continued page 4)



# PRACTICE MANAGEMENT



There has never been a more pressing need for the health care provider to capture every dollar and to receive payments as quickly as possible. The price of money has increased, and costs have risen so that more pressure is on the billing team to resolve open accounts more quickly.

The billing team must work unresolved accounts as soon as the denial comes to the office. Here are the steps to effective denial management:

- Review EOB denial within 24 hours of notification.
- Review EOB for unpaid or incorrectly paid claims from the payer.
- Note the denial in your "Denial Tracking Log."
- Research the denial.
- Note the error, corrections, and action in the "notes" section of the billing system.
- If you are unable to determine the correction required, then contact the Payer directly for guidance.

**DO NOT LET THE DENIALS GO LONGER THAN 1 WEEK WITHOUT WORKING THE ISSUE.**

## DON'T LOSE REVENUE BECAUSE OF UNTIMELY FILING

If your Office needs a second pair of hands to work your denials please consider our team.

We will deploy our "S.W.A.T." team to aggressively work your receivables.

## 10 Questions for any EMR Vendor

1. How long has your company been in the EMR business and are you CCHIT certified?
2. How is the product licensed and what does that license provide?
3. Is your product sold as a complete package or can modules be purchased separately?
4. What is your operating platform: ASP vs. server?
5. What limitations does the system have and can it be customized? What is the cost to customize?
6. Can your product interface with my current practice management system, lab system, e-prescribing or imaging system? Do these interfaces currently exist?
7. How many charts can I open at one time? Can more than one person work in the same chart?
8. What does the price include?
  - ✓Software
  - ✓Hardware
  - ✓Training
  - ✓Technical Support
  - ✓Maintenance
  - ✓Upgrades
  - ✓Travel
9. What is included in the implementation? How and where is training conducted?
10. What are the names of practices that are my size that are currently using your product that I may contact for an on-site visit?

# MEDICAL CODING



## TIMELY FILING REQUIREMENTS FOR MEDICARE FEE-FOR-SERVICE CLAIMS APRIL 01, 2010

On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act (PPACA), which amended the time period for filing Medicare fee-for-service (FFS) claims as one of many provisions aimed at curbing fraud, waste, and abuse in the Medicare program.

The time period for filing Medicare FFS claims is specified in Sections 1814(a), 1835(a)(1), and 1842(b)(3) of the Social Security Act and in the Code of Federal Regulations (CFR), 42 CFR Section 424.44. Section 6404 of the PPACA amended the timely filing requirements to reduce the maximum time period for submission of all Medicare FFS claims to one calendar year after the date of service.

Under the new law, claims for services furnished on or after January 1, 2010, must be filed within one calendar year after the date of service. In addition, Section 6404 mandates that claims for services furnished before January 1,

2010, must be filed no later than December 31, 2010. The following rules apply to claims with dates of service prior to January 1, 2010. Claims with dates of service before October 1, 2009, must follow the pre-PPACA timely filing rules. Claims with dates of service October 1, 2009, through December 31, 2009, must be submitted by December 31, 2010.

Section 6404 of the PPACA also permits the Secretary to make certain exceptions to the one-year filing deadline. At this time, no exceptions have been established. However, proposals for exceptions will be specified in future proposed rulemaking. *(continued page 4)*



## Medical Home Care Potentials

Recently the Obama administration informed Medicare that they will help to fund pilot projects in states that use primary-care physicians and teams of healthcare coordinators that will manage the patient care and should reduce costs.

In the "medical home" model, that was a focus of Vermont's health care revisions that physicians could be paid more for coordinating the care of their patients. Their goal is to help chronically ill patients stay healthy and avoid or significantly reduce trips to the hospitals for outpatient or expensive inpatient stay. Ultimately the project would offer significant saving to the state. Health and Human Services commented that the plan would be better for the patient, the providers and the government.

The plan would be to fund a pool that would pay salaries and expenses to the coordinating team. This may include social workers, dieticians and nutritionists and nurse practitioners. The recent announcement means Vermont may soon be able to add Medicare, the federal health care program for the elderly and disabled, to the mix.

There are five bills in Congress to reengineer the country's health-care system and would open the door to increased use of the medical homes programs. In addition there would be bonus payments for Medicare plans that *(continued on page 4)*

## KEY ISSUE

### Coding Venipuncture for Medicare

### Medicare changed the G0001 code -Are you getting denials?

**As of January 1st, 2005, the correct code to use is 36415.**



# MEDICAL CODING



CONT'D Page 1 (still with POS 22). UNLESS the doc either admits the pt into IN-PT status or sends the patient home (or they kick off as Greg House MD phrased it last week). In the case of the admit into IN-PT status, use the 99221 or 99222 on the 2nd day with the POS 21 (and the AI modifier to show who the admitting physician is).

Yes, it's conceivable a 99223 could be used on that admit - but doubtful since most doctors will not do a completely NEW history, exam & mdm on the patient, but rather they would use the data from the admit into obs the previous day to dictate an in-pt admit.

Do NOT use an out-patient visit code 99211-99215 on that date. In the case of discharging the patient home (or to the morgue, if patient expired), use a 99217 that date, again - not billing any 99211-99215 that date.



coordinate the care, expand medical homes into Medicaid, the state-federal health insurance program for the state's poor.

There will be a solicitation process that begins in the fall and it is intended to be implemented in early 2011. The States that want to get the extra funding from Medicare must demonstrate that their programs will "actually produce better results with lower health care costs," Ms. Sebelius said.

We intend to guide physicians through the Medical Home process.

## STRUGGLING WITH WHEN TO CODE & BILL 99211 CONTINUED

Rules for claims prior to October 1, 2009

Service dates for claims 10-01-08 through 9-30-2009 must be filed by 12-31-2010

Please be on the alert for more information pertaining to the Patient Protection and Affordable Care Act.

## HIPAA AUDIT PROCESS - WWW.HIPAAAUDIT.COM

If you are part of a covered entity (medical practice, hospital, billing agency, etc), you need to be doing an annual HIPAA Audit. This HIPAA Audit Process is very important. It must be well documented and well structured.

A systematic approach to your HIPAA Audit Process is exactly what will save you business in the long run.

Like any audits a business incurs—financial, inventory or HIPAA, the more structured and systematic the process is, the less painful the process.

There are 2 sides to a HIPAA Audit. There is the front office “paperwork” audit that ensures coding, etc, is being done correctly. Then there is the technical side of HIPAA. This includes all computer, fax, email and employee policies. HIPAA regulations require a dizzying array of requirements when it comes to the technical side of things.

At the very foundation of any office is the employee computer use policy. Every employee in an office should know exactly what they can and can't do on a computer., which websites they are allowed to visit and what the limits of email are. Not only should every employee know what is required of them on the computer system, they need to know where they can find answers to questions they may have (answers should be in the employee handbook).

Each employee should be required to read and sign the employee computer use policy.

The HIPAA Audit Process has multiple layers, but the first layer, the foundation, is extremely important and will help steer the other layers in your policy.

# PRACTICE BILLING

## What is a RAC Audit Anyway?

What is a RAC Audit?

The Medicare Modernization Act of 2003 established the Medicare Recovery Audit Contractor (RAC) program as a demonstration program to identify improper Medicare payments – both overpayments and underpayments. RACs were paid on a contingency fee basis, receiving a percentage of the improper overpayments and underpayments they collect from providers.

Stop the RAC Audit Madness!

You want the plain English version, right? Here it is:

RAC Audits are a way for Medicare to take money back from you.

Yes, it is that simple.

Here are some scary facts:

RAC auditors work on commission only (they get anywhere from 9% to 12.5% of

everything they collect from you).

RAC auditors can go back as many as 36 months.

The burden of proof is on you!

Why Do You Care?

As mentioned above, RAC Auditor's incentive is to find fault in your files.

Additionally, once they find one bad file, think they'll start digging deeper into your history? Ever hear the term "low hanging fruit"?

You have to do everything you can to protect yourself.

As one would expect, the RAC audit process is complicated.

There are many deadlines that YOU have to meet. One slip up and you lose.

RACGuru is here to help you trudge through the crazy RAC process with information, tips and tools to give you every advantage you need to win.

[www.RACGuru.com](http://www.RACGuru.com)

## OIG Launches HOTLINE!

### Fraud report on enforcement released

Fraud Hotline Website launched May 12, 2010.

Medicare Office of Inspector General sets up online forms to report complaints for the FIRST TIME!

OIG invites the public to help combat fraud, waste and abuse, see <http://www.oig.hhs.gov>.

OIG releases "Health Care Fraud and Abuse Control Program Report" May 13.

Report produced by Department of Health & Human Services and the Department of Justice highlighted new enforcement tools created from the *Patient Protection and Affordable Care Act*.

- ✓ **Easier prosecution of healthcare providers**
- ✓ **Larger fines**
- ✓ **Higher penalties**

## How do I bill for prolonged physician services, procedure code 99354?

Procedure code 99354 must be billed in conjunction with E/M codes 99201-99215, 99241-99245, or 99301-99350. Prolonged services can be billed only if the total duration of all physician direct face-to-face

services (including visit) equals or exceeds the threshold time for the E/M service the physician provided (typical time plus 30 minutes). If the total duration of direct face-to-face time does not equal or exceed the threshold time for the level of E/M service the physician provided, the physician may not bill for prolonged services.

# TRAINING WORKSHOP

Documentation Compliance- 1-hour, Instructor lead web-base class for physicians, CNP, PA. **\$169**

Essentials of Coding for the Medical Biller- 5 hour workshop (over 4 days). Designed for the novice or inexperienced biller. Covering the use of all the coding books, code assignment **\$255**

Modifiers- when and how to use modifiers in billing **\$99**

How to Audit for your Provider- 4 hr (1hr for 4 days) course designed for the clinical nursing staff. **\$265**

Advanced Billing Fundamentals - 4 hr (2-2hour courses) **\$275**

Contact Atlantic Financial Consulting at 888-428-2555 to Register.  
Use reference code: GRAND ROUNDS  
Visa, Mastercard, Discover & Paypal accepted



**ATLANTIC**  
FINANCIAL CONSULTING  
Helping business owners improve cash flow.

Ph: 1 888 428-2555 Ext. 200  
[www.atlanticfinancial.us](http://www.atlanticfinancial.us) • [info@atlanticfinancial.us](mailto:info@atlanticfinancial.us)