Medic Incorporated

The M.E.D.I.C. News Quarterly

VOLUME II, ISSUES 3&4 SUMMER/FALL 2007

SPECIAL POINTS OF INTEREST:

- **Medicare Fee Schedule Cuts? (pages 1 & 3)**
- **NPI Issues (pages 1 & 6)**
- **Prescription News (page 2)**
- **2008 PQRI (page 2, 5 & 7)**
- **The –25 Modifier (page 4)**
- **Collections Statutes of Limitations (page 5)**
- **M.E.D.I.C. Going Paperless (page 8)**
- **New HMO Class Action (page 8)**

The Good, The Bad & The Ugly Of The 2008 Medicare Physician Fee Schedule

10.1 Percent?!?!? The now yearly controversy over cuts to Medicare payments has again begun, and this year, absent Congressional action, there will be a 10.1% reduction in the physician fee schedule! Why so high? If you recall, the 2007 physician fee schedule cut was set at 4-5%. Congress acted to delay this cut, but in doing so, folded it into the 2008 fee schedule. So, in essence, we are seeing two years of cuts at once.

Why More Cuts? Congress establishes Medicare expenditures for each coming year. In the event that actual expenses exceed those estimated expenses, then Congress has statutory obligations (as mandated by the sustainable growth rate (SGR) governing Medicare payments and budget neutrality requirements) to make up that difference — to account for that discrepancy in the estimated and actual expenses. This is done by adjusting the physician fee schedule.

Is Relief In Sight? Yes. Congress has been

Con't. on p. 3

NPI—The Dim Light at the End of the Tunnel

Contingency Plans: The Centers for Medicare & Medicaid Services (CMS) announced earlier in 2007 that it was initiating a contingency plan which extended the compliance date for the National Provider Identifier (NPI) from May 23, 2007 to May 23, 2008. Physician practices, covered under the Health Insurance Portability and Accountability Act (HIPAA), were still required to get individual and organizational NPIs, as necessary, and to submit those numbers on all HIPAA electronic standard transactions, including claims. Further, Medicare has been requiring use of the NPI on the revised paper 1500 claim forms.

This NPI contingency plan has permitted Medicare and commercial insurers to continue accepting legacy provider identification numbers until May 23, 2008. However, each payer has determined the specifics of its contingency plan, and as such, there are as many contingency plans as there are payers. Further, while such contingency plans may not extend beyond May 23, 2008, entities ***may elect to end their contingency plans sooner***.

Upcoming Deadlines: As the ultimate compliance date for NPI-only billing is looming, it behooves us all to review the key dates on the horizon:

1/1/08—all institutional claims filed on UB-04 paper claims or 837P electronic claims must contain NPIs (may still have legacy numbers as well)

3/1/08 — all physician claims filed on 1500 paper forms or 837P electronic claims must contain NPIs (may still have legacy numbers as well)

5/23/08 — only the NPI will be accepted for ALL paper and electronic claims… claims containing legacy numbers will be rejected. Also, CMS will stop providing legacy identifiers in crossover claims as of this date.

What Needs to be Done?

1. As of now, all of M.E.D.I.C., Inc.'s clients should have received their individual NPIs (and

Con't. on p. 6

Writing Prescriptions in the 21st Century

E-Prescriptions: There has been increased discussion regarding the E-prescribing Initiative during the close of 2007. Most relevant to M.E.D.I.C., Inc.'s clients is the theory that in the future, Medicare will pay only for prescriptions written and issued via an e-prescribing protocol. The thought is that standardizing prescriptions via e-prescribing will enhance a) patient safety (since there will be no questions as to the prescribing physician's handwritten instructions); b) societal safety (since it will be vastly more difficult to steal or falsify a prescription); and c) and financial savings to the Medicare program . The push to universally move to e-prescribing is so strong that there is even talk of providing funding to physicians who cannot afford to obtain the technology. Look for further discussion in 2008!

Tamper Resistant Prescription Pads: Until the exclusive use of e-prescriptions occurs, CMS has addressed the issue of prescription safety by as pertains to Medicaid payments. Specifically, CMS has provided guidance to state Medicaid programs to define and implement tamper-resistant prescription pads.

CMS' guidance on the tamper-resistant law, set forth in an August 17, 2007 State Medicaid Director letter, contains two phases. For the first, which must be implemented by April 1, 2008, a prescription must contain at least one of the three tamper-resistant characteristics listed below in order to be considered "tamper resistant." October 1, 2008, marks the second phase, by which prescriptions must contain all three characteristics of the tamper-resistant pad:

1. It must prevent the unauthorized copying of a completed or blank prescription form (ex: a "VOID" watermark will appear when copied)
2. It must prevent the erasure or modification of information written on a prescription form by the prescriber (ex: background ink will appear showing attempts to erase or alter a prescription)
3. It must prevent the use of counterfeit forms (ex: use of penetrating ink will prevent chemical "lifting" of the prescription information)

President Bush has accepted this measure, which was initially slated to go into effect October 1, 2007, through his September 29th execution of the "Extenders Law."

2008 PQRI — Is That Still Around?

As you will recall, 2007 marked the first step of CMS's move toward "pay for performance," with the Physicians Quality Reporting Initiative. The end of 2007 marks the end of the inaugural year of PQRI, however, the program has been renewed for 2008, with some modifications.

What remains the same?

- the core focus of PQRI has not changed – the focused is still on quality of patient care
- Still based on the reporting of a minimum of 3 measures with an 80% reporting rate
- Bonus is still 1.5% of the total Medicare claims filed, and still paid to the holder of the TIN. Still distributed mid-year following end of PQRI (so mid-2009 for 2008 PQRI)
- The cap is still in place, with the same formulation/principles as used in the 2007 PQRI
- Validation plan will remain unchanged from 2007 PQRI
- Formula for determining sufficient participation remains unchanged
- Performance and reporting modifiers are the same
- Claims must still be received by the end of February for inclusion in the PQRI (so, filed by 2/28/2009 for 2008 PQRI)
- Most importantly — it is still a **voluntary** program

Congressional Modifications to PQRI

As 2007 draws to a close, the Senate has passed legislation that the House and the President are expected to sign off on as well, which makes some changes to the Physician Quality Reporting Initiative:

- PQRI will continue in 2008 ***with payment bonuses***, however, rather than the bonuses coming from the new Physician Assistance and Quality Improvement Fund (which CMS had planned), the payments will come from Medicare Part B Trust Fund, as in 2007
- Cap may be eliminated in 2008 Senate-passed provision
- Reporting period is now 12-months (2007 it was 6 months)
- Requires that CMS continue to review and establish measures for 2009, but does not give a payment source or give authority for 2009 bonuses…. The thought is that when Congress reconvenes in 2009 to look at physician payments (pre-6/30/08), then it may reconsider at that time the funding and authority re: 2009 bonuses.

Client Memo Follow Up

In the last issue of The M.E.D.I.C. News Quarterly, M.E.D.I.C. provided a "top 10 list" of ways to reduce the size of client memos. M.E.D.I.C. would like to propose an other option for reducing the size of memos: use M.E.D.I.C.'s services to take care of the memo for you. For a fee of $75 per hour (including travel time), M.E.D.I.C. will send a member of its staff to your office to pull and copy all relevant patient documents, office notes, op reports, etc… whatever necessary to respond to memo requests. If interested, contact Yvonne Wills at 540-662-9250 or via e-mail at yvonne@medicbizservices.com so that she can coordinate these services for you.

The Good, The Bad & The Ugly…

Con't. from p. 1

diligently working toward a solution to this ever-recurring issue. The expectation is that Congress will in fact arrive at an agreed solution, and present to the President for execution. The overwhelming belief and understanding as of December 18, 2007, is that this Congressional "fix" will *only delay the fee schedule cuts for six months* (until June 30, 2008).

Agreement in sum and substance will, among other things:

- rescind the 10.1% cut and replace it with a .5% increase in the fee schedule for 6 months… in the first half of 2008, Congress will work to finalize a long-term solution to the SGR (Sustainable Growth Rate) issue;
- extend PQRI;
- Extend therapy cap exception process

Why Only A 6-Month Fix? To avoid the administrative nightmare of 2 years ago when claims had to be refiled to accommodate the Congressional action made retroactive to January 1st.

How does Congress plan on recouping this financial shortfall? While this remains to be seen, one proposal being floated is to reduce Medicare Advantage Plan payments. Currently, Medicare Advantage is paying at approximately 120% of Medicare allowable, and it is deemed that this should be reduced. Even if this is not addressed in 2008, we should look for an attempt to cut the Medicare Advantage payments in 2009, after the change in administration, when physicians and hospitals will join forces to prevent fee schedule payments , and redirect such cuts to Medicare Advantage.

Med·ic™
Incorporated

Modifiers 101: The –25 Modifier

It is not uncommon for M.E.D.I.C. to see coding that either lacks a modifier, or implements an incorrect modifier. Failure to use, or improper use of modifiers, can result in a reduction in income for practices and M.E.D.I.C., Inc., alike, and in extreme circumstances, can trigger audits by Medicare or other third party payers. As such, this is the first in a series of articles focusing on the proper use of modifiers.

Definition of the –25 Modifier: Perhaps one of the most common modifiers used is the –25 modifier. The –25 modifier is defined by the AMA's CPT as "Significant, Separately Identifiable Evaluation and Management Service by the Same Provider [which includes physicians in a group practice who are in the same specialty and subspecialty] on the Same Day of the Procedure or Other Service." The CPT elaborates that the modifier was created to "situations when the physician needs to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/ service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. The E/M service may be prompted by the symptom or condition for which the other procedure and/or service was provided. As such, different diagnosis codes are not required for reporting of the E/M services in the same date."

In essence, as long as the procedure that is performed *is for a reason other than that for the office visit*, then both may legitimately be charged. Why? Because every procedure is deemed to have an inherent E/M component, which may not be separately billed.

Further, the Office of the Inspector General of DHHS has asserted that, in general, "a provider should not bill E/M codes on the same day as a procedure or other service ***unless*** the E/M service is unrelated to such procedure or service," although they may sometimes arise from the same diagnosis.

So, to code accurately and effectively using the –25 modifier: be sure that the record is clear regarding the patient complaint, circumstance, finding, result or diagnostic testing, complication, etc… that supports the need for a second E/M service. When the diagnoses on the same date of service differ, the OIG will generally agree with the use of the –25 modifier. However, if the diagnosis is the same for both services, more attention is required. Carefully document and record the events that transpired — including the time of services — to create the need for the second, significant, separately identifiable E/M visit.

In summary, it is critical to use these modifiers appropriately, for non-use will cause providers to miss out on a significant amount of money otherwise earned and owed to them. However, misuse could expose providers to governmental scrutiny – it is a fine balance that must be maintained!

Helpful Hints To Proper -25 Modifier Usage:

- Be sure that you are reporting both a procedure code and an E/M code.
- Be sure that the modifier is appended to the E/M code, NOT the procedure.
- Do not append the -25 modifier if the services were performed by two separate physicians, or two physicians in a group practicing differing specialties.
- Be sure that documentation supports the -25 modifier, and does not reflect that the amount of work conducted was consistent with that normally performed with that procedure. Furthermore, be sure that the documentation for the two visits is clearly separated.
- Do not use the –25 modifier to an E/M visit that results in the decision to perform surgery in the next 24-hours — this situation calls for the –57 modifier.

What is the "Timely Filing" For Collections ?

On several occasions, M.E.D.I.C., Inc.'s clients have requested information as to the statute of limitation on sending delinquent patient accounts to a collection agency. As an initial matter, this is an issue that is dictated by state law, and there are variations among the 50 states! That being said, the following is a summary of Virginia's statutes of limitations:

Signed Agreement: If a Virginia patient (i.e., he or she resides in Virginia — state of residency as opposed to state of treatment) has signed a treatment agreement, which includes an acknowledgement of the patient's obligation to pay for treatment, the time limit in which to file claims for payment on an open account is five (5) years from the date of the last payment OR five (5) years from the date that services were last provided (if no payments have been made yet).

No Signed Agreement: If a Virginia patient has NOT signed a treatment agreement, the time limit in which to file claims for payment on an open account is three (3) years from the date of the last payment OR three (3) years from the date that services were last provided (if no payments have been made yet).

The following are some practical examples of situations in which the patient did NOT sign a treatment/payment agreement:

1. If a patient is seen for treatment on June 1, 2000, and never makes a payment, then the debt claim must be filed by June 1, 2003.
2. If the same patient, seen on June 1, 2000, does not make his first payment until June 1, 2002, then the deadline for filing a debt claim is no longer June 1, 2003, but now June 1, 2005 — three (3) years from the date of the last payment.
3. If the same patient is seen on June 1, 2000, and then again on June 1, 2001, then the claim for the first visit must be filed by June 1, 2003, but the claim for the 2nd visit has until June 1, 2004 to be filed (and to make matters more complex, if the patient makes a payment on either of those bills, then the filing date is changed again, as described in EX 2).

Hopefully this helps to clarify some of the timing issues with regard to making decisions regarding referring patients to collection agencies. Please contact Larissa LPC Sneathern should you have any additional questions.

2008 PQRI— Is That Still Around?

Con't from page 2

What Has Changed? With so much seemingly unchanged from the 20087 PQRI, one might ask what has changed! There are several significant changes:

- Additional 2008 reporting options. While 2007 PQRI codes was reported solely on claim forms, there are 2 additional mechanisms for submitting quality codes in 2008: EHR-based reporting and Registry-based reporting. Each have detailed requirements and provisions which must be met in order to submit in such manners, the specifics of which can be found on the CMS website. M.E.D.I.C. predicts that use of these reporting mechanisms will be somewhat stunted, for they have been established merely for testing purposes. In other words, quality codes submitted via EHR or Registries will not be considered for bonus payments — *only codes submitted via traditional claims forms (either on paper or electronically) will be eligible for bonus payments!*
- New reporting measures. There are many new measures available in the program, in addition to refinements to and some inactivations of the measure sets from 2007, all of which necessitate a careful review of the newly published 2008 measures, which can be found on the CMS website at 222.cms.hhs.gov/PQRI
- Structural measure codes. These are high priority for the

Con't. on page 7

NPI—The Dim Light at the End of the Tunnel

Con't. from p. 1

group NPIs, if necessary — i.e., if your practice is incorporated and payments are funneled through the corporation, then the group NPI, which serves as the billing provider, is required). **If you have not obtained the required NPIs, please contact M.E.D.I.C., Inc. immediately, so that we can assist you in obtaining these important numbers — failure to do so will result in payment delays!**

2. To facilitate billing,, practices should send their NPIs to all industry partners requiring NPI reporting/ registration. M.E.D.I.C., Inc. has been working on this for its clients.
3. Make sure that your NPI registration is complete and accurate. It is important to note that the Medicare crosswalk only uses numbers listed in the "Other Provider Identification Numbers" section of the NPPES application, so please be sure that ant UPIN, OSCAR, Medicare numbers, etc… are listed on that page field to ensure successful claims submission and payment. On a similar note, be sure that all Medicare numbers, including Railroad PINs, are listed as Medicare PINs — not as "Other" identifiers.
4. Ensure that if you have both an individual and group NPI, that you have corresponding group and individual Medicare numbers (i.e., that both you as an individual and your corporation are enrolled in Medicare and have received PINs). We have seen this issue crop up with some providers who have been practicing for many years, since prior to Medicare's issuance of group numbers. They never had a need for the group number, until the NPIs began to be used, and Medicare rejecting claims in which the NPI/legacy identifier combination used in claims could not be validated against the NPI crosswalk (because there was no group Medicare number).
5. Make changes to the NPPES database within 30 days of the change's effective date. This includes changes to addresses, e-mail addresses, phone numbers, addition of other issuer PINs, etc….

NPI Registry: One convenient tool has emerged from the NPI registration process — the NPI Registry. This is a database that has been made available to the public by CMS. The Registry is particularly useful for obtaining the requisite referring physician data for claims processing. To access this database, go to https://nppes.cms.hhs.gov/NPPES/Welcome.do. From that page, click on the hyperlink "Search the NPI Registry," and from there, begin your search. (An interesting point of information, as of October 30, 2007, there were 41,009 individual/Type 1 NPIs, and 12,440 group/Type 2 NPIs issued in Virginia)

To search this Registry, you need only know either the NPI, the provider name, or a city/state. Key data elements that can be ascertained through use of this database are as follows: NPI, Entity Type Code (1-Individual or 2-Organization), Replacement NPI; Provider Name; Provider Business Mailing Address; Provider Business Location Address; Telephone Number; Fax Number; Healthcare Provider Taxonomy Code (s); Other Provider Identifier(s); Other Provider Identifier Type Code; Provider Enumeration Date; Last Update Date; NPI Deactivation Reason Code; NPI Deactivation Date; NPI Reactivation Date; Provider Gender Code; Provider License Number; Provider License Number State Code; Authorized Official Contact Information.

Happy Holidays from M.E.D.I.C., Inc.!

The holiday season conjures up many memories, but perhaps one of the most poignant is coming in out of the opening the door to your home and coming in out of the cold, only to be welcomed by the scents of fresh baked-goods… We wanted to share one of our favorites with you this holiday season. Enjoy!!!

WINDMILL COOKIES — makes approx. 8 dozen

1 teaspoon baking soda
2 sticks (1 cup) unsalted butter, softened
4 cups all-purpose flour
1 teaspoon ground cinnamon
1/2 teaspoon ground mace
1 cup slivered almonds (4 oz)

1/2 cup hot water
2 cups packed dark brown sugar
1 teaspoon salt
1/2 teaspoon ground nutmeg
Pinch of ground cloves

- Stir together baking soda and water until baking soda is dissolved.
- Beat together butter, brown sugar, and baking soda mixture with an electric mixer until pale and fluffy.
- Whisk together flour, salt, and spices, then mix into butter mixture until combined well. Stir in almonds. Form dough into 3 (10- by 3-inch) logs and wrap tightly in plastic wrap. Freeze logs until firm, about 4 hours, or overnight.
- Preheat oven to 350°F.
- Keeping remaining logs frozen, cut 1 log crosswise into slices slightly less than 1/4 inch thick and arrange slices 1 inch apart on an ungreased baking sheet. Bake in middle of oven until set, 12 to 14 minutes, then transfer to racks to cool. Slice and bake remaining dough in same manner.

2008 PQRI— Is That Still Around?

Con't from page 5

agency, for the thought is that the automation will assist in the quality of patient care! These structural measures are also significant in that if they are used, they account for 2 of the 3 measures that providers must successfully report on to satisfy 2008 PQRI requirements.

1. The first structural measure code relates to e-prescribing, and calls for the practitioner to have e-prescribing in the office and be using it for patient care. There are some minimum elements that must be met for use of this measure: the system must be able to print out a complete and active medication list; the provider must be able to select medications, print them or electronically transmit them; the e-prescribing must provide information re: availability of lower cost therapeutically appropriate alternatives, if any; the system must provide info re; formulary or tiered-formulary medications; and the system must be able to conduct safety checks and offer the prescribing provider information re: drug being prescribed — such as potentially inappropriate dose, drug-to-drug interactions, allergy information — and provide warnings or cautions (since the e-prescribing system will interface with pharmacy databases, all medication information on a particular patient will be available for such cautionary actions).
2. The second structural measure code relates to Electronic Health Records, and again, there are a some prerequisites for use of the measure. The EHR system must be able to generate a problem list, a medication list and all entered lab data as discreet and searchable data fields. Specifically, CMS is looking for C-CHIT certified EHR programs, but understands that that may not always be possible, so CMS has developed a list of standards that they would look for in non-C-CHIT EHR programs that providers may have implemented and be using in trying to qualify for this measure. See CMS website for this list of specifications.

- Confidential Feedback Reports – In 2007 there was no time to provide such reports, given the abbreviated nature of the program (6 months as opposed to 12), until after conclusion of the 2007 initiative. This reporting will be enhanced in 2008.
- Informal inquiry process. Because the legislation establishing the PQRI prohibits provider appeals, the informal inquiry process will be honed and established in Spring 2008.

In conclusion, the feedback from that CMS has received from participants of the 2007 PQRI has been positive. Those providers who implemented it are claiming to have found better & more efficient patient care… with such results, CMS is not likely to abandon the initiative anytime soon, and in fact may make it mandatory at some future date.

Med·ic™
Incorporated

Mailing Address: P.O. Box 742,
Winchester, VA 22604
Physical Address: 124 Amherst St.,
Winchester, VA 22601
M.E.D.I.C. Phone: 540-662-9250
M.E.D.I.C. Fax: 540-662-6334

TO:

M.E.D.I.C., Inc.'s 2008 New Year's Resolution

For the past few years, M.E.D.I.C., Inc. has tasked itself with various systemic restructurings and changes — the most notable of which have been the shift from client-based to task-based teams, and the purchase and implementation of the Ntierprise practice management system. So, what is in store for 2008? M.E.D.I.C., Inc. has resolved to go paperless!

We have begun to research and interview electronic document management systems, and are quite impressed and excited about the offerings and bells and whistles that are inherent in the process. For example, these systems would allow our clients to fax batches to us, as opposed to mailing, or physically transferring the documents. The faxed images then go directly into the scanning system — never creating any paper printouts — and are then accessible to M.E.D.I.C., Inc. staff online. This should significantly maximize the efficiency of M.E.D.I.C., Inc. employees — including Yvonne, who will no longer have to make weekly visits to client offices (don't worry, though — we'll institute regular meeting schedules so that clients can address questions or concerns in person)!

Among the other features of these scanning/document management systems are: the ability to fax images of EOBs directly from the system to the insurance carrier (for instantaneous receipt); fulsome searching and sorting tools to capture any combination of scanned documents; and the ability to eliminate documents containing *de minimus* data; the ability to remove colors, watermarks, etc… for improved quality and readability of the scanned image.

Please feel free to contact M.E.D.I.C., Inc. with any questions that you might have regarding this new technology! We are looking forward not only to eliminating the paper (and saving some trees), but also to simplifying and facilitating our communications with clients, patients and carriers.

New HMO Class Action Lawsuit

Over the past few years, there have been a spate of class action lawsuits resulting in settlements with various HMOs to which M.E.D.I.C., Inc.'s providers have been entitled to proceeds. On November 19, 2007, the latest settlement was preliminarily approved by the federal court. Following this approval, notices of the proposed settlement, along with claim forms and instructions for completing the claim forms were sent to potential class members on November 29, 2007.

This settlement is with the following defendants: Highmark Inc., Keystone Health Plan West, Inc., Highmark West Virginia, Inc. (d/b/a/ Mountain State Blue Cross Blue Shield), and Parker Benefits, Inc. (d/b/a/ Super Blue HMO). Note that Keystone Health Plan Central, Inc., is not a party to this settlement.

If you believe that you are entitled to proceeds from this settlement (i.e., if you have provided services to members of any of the above plans between 5/22/99-11/19/07), then please be sure to contact Larissa LPC Sneathern at M.E.D.I.C., Inc. (lsneathern@medicbizservices.com; 540-662-9250; 434-409-2412) so that your rights can be secured.

Please note that the deadline for submitting this claim form is February 27, 2008.