BILLING BITS

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INSURANCE & MEDICAL BILLING SERVICES

Preparing For RAC Audits– What you need to know.

The RAC (Recovery Audit Contractor) Program's mission is to reduce Medicare improper payments through the efficient detection and collection of overpayments, the identification of underpayments and the implementation of actions that will prevent future improper payments. The identification of underpayments, overpayments, and the recoupment of overpayments will occur for claims paid under the Medicare program for services for which payment is made under part A or B. By identification of the errors, providers can avoid submitting non-compliant claims, CMS can lower error rates, and taxpayers and future Medicare patients will be protected.

Connolly Healthcare has been assigned the CMS contract for the state of Virginia among others. According to their website these are among the approved audit issues for providers:

Add-on Codes- Certain CPT codes, by their definition (in each respective year of the CPT Manual) require billing to include both the primary and additional component codes. Providers are billing only the add-on codes without their respective primary codes resulting in overpayments.

Global Period (Major & Minor Surgery) - Additional/subsequent minor surgical procedures performed during the 10 or 90 day global postoperative period of the initial procedure are considered an overpayment when billed without modifiers "-58", "-78", or "-79".

Not a new patient- Medicare interprets the phrase "new patient" to mean a patient who has not received any professional services, i.e., E/M service or other face-to-face service (e.g., surgical procedure), from the physician or physician group practice (same physician specialty) within the previous 3 years. New patient CPT codes are only payable for beneficiaries without office based face-to-face services in the previous 3 years.

Once in a Lifetime- By virtue of the description of the CPT code, these codes can be performed only once per patient lifetime. Claims with modifier-58 will be excluded from your audit with dates of service starting 1/1/09. Starting 1/1/09 this code was allowed to be billed more than once if the provider used the modifier.

Untimed Codes– For CPT Codes (excluding modifiers KX, and 59) where the procedure is not defined by a specific timeframe (untimed codes), the provider should enter a one (1) in the units billed column per date of service.

Internal audits can be performed using the issues listed above. Practices will be able to see firsthand where their individual problem area's are and begin to take steps to correct the areas before they are processed by insurance.

Inside this issue:

Cloning Notes in your EHR

"The art of medicine consists in amusing the patient while nature cures the disease."
~ Voltaire

Even though some physicians struggle to implement new EHR systems into their practice, they eventually become proficient and start taking advantage of some of the shortcuts that the new software systems offer. Using templates and carrying forward information from previous visits should cut down on the providers charting time, and at the same time, benefit patient care. The down fall of this process is that, according to Recovery Audit contractors, many patients notes are looking identical from one visit to the next and are even carried over from one physician to the next. This is becoming so much of an issue that the office of inspector general (OIG) included "identical notes" as an area of interest in its 2011 work plan.

The guidelines for what is appropriate to copy from note to note were developed in 1995 and revised in 1997, before EHRs were common, but they are still in effect today. They serve as guidance for what may be recorded by someone other than the physician and what can be clones, or carried forward, from a previous note. Some of the key points of these guidelines of these guidelines are that if someone other than the provider documents the patient's history it needs to be reviewed with the patient by the provider and if a note is carried forward from a previous visit, it also needs to be reviewed with the patient, not just dropped into the current note. Only the billing provider can document the history of the present illness (HPI). According to Betsy Nicoletti, founder of codapedia.com, a frequent complaint of physicians with referred patients is that they have no clue why the patient was sent to them because the progress note does not tell a story about the patients condition and the treatment plan or clinical thinking.

(Here is a useful exercise. Remove the patient names from a sampling of notes and ask your clinicians to review their own and other's notes. Can the clinician treat the patient based only on the note? Does the note tell the whole story?.

Tips to enjoying the benefits of EHR while avoiding the mistakes of cloned or identical notes:

- Always document the history of the present illness based on the patients description that day and never copy from a previous note.
- Only use review of systems categories that are relevant to that day's visit. Avoid copying everything from a previous visit
- Only use past medical, family, and social history from a previous note if it is reviewed with the patient and relevant to that day's visit.
- Use templates with care, and edit them thoroughly

Change is Coming in 2013.

ICD-10- New formats- Are you aware?

Common Diagnosis in ICD-9 Vs. ICD-10

By Erin Carter

If a new patient was seen for a sprain of the left wrist today and the joint was not specified, ICD-9 code 842.00 would be appropriate. 842.00 would also be used on each encounter the patient was seen for that same injury. Using ICD-10 that same patient's diagnosis for today would be S63.502A. If the patient has a follow-up visit for the injury, the ICD-10 code that would be used is S63.502D. Each injury code in ICD-10 will have a 7th character specifying; A- initial encounter, D- subsequent encounter, or S- sequela (late effect of).

Example- Sprain Wrist

ICD-9

842 Sprains and strains of wrist and hand

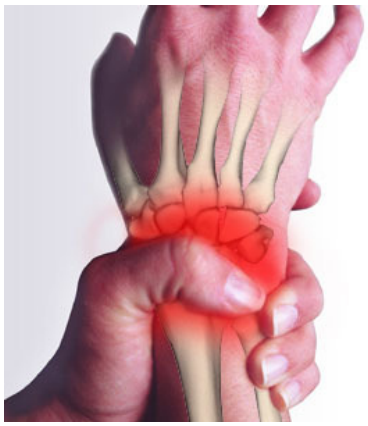
842.0 Wrist

842.00 Unspecified site

842.01 Carpal (joint)

842.02 Radiocarpal (joint) (ligament)

842.09 Other



ICD-10

The appropriate 7th character is to be added to each code from category **S63**

A initial encounter

D subsequent encounter

S sequela

S63 Dislocation and sprain of joints and ligaments at wrist and hand level

S63.5 Other and unspecified sprain of wrist

S63.50 Unspecified sprain of wrist

S63.501_ Unspecified sprain of right wrist

S63.502_ Unspecified sprain of left wrist

S63.509_Unspecified sprain of unspecified wrist

S63.51 Sprain of carpal (joint)

S63.511_ Sprain of carpal joint of right wrist

S63.512_ Sprain of carpal joint of left wrist

S63.519_ Sprain of carpal joint of unspecified wrist

S63.52 Sprain of radiocarpal joint

S63.521_ Sprain of radiocarpal joint of right wrist

S63.522_ Sprain of radiocarpal joint of left wrist

S63.529_ Sprain of radiocarpal joint of unspecified wrist

S63.59 Other sprain of wrist

S63.591_ Other sprain of right wrist

S63.592_ Other sprain of left wrist

S63.599_ Other sprain of wrist unspecified

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