VEI
Indianapolis Medical Management
7330 Shadeland Station #200
Indianapolis, IN 46256

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BRING ON SPRING!!

IMM INSIGHT NEWSLETTER

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ATTENTION!!

New Authentication Requirements for Medicare Telephone and Written Inquiries

Effective April 6, 2009, when you call either the Medicare IVR system, or a Medicare Customer Service Representative (CSR), the Centers for Medicare & Medicaid Services (CMS) will require you to provide three data elements for authentication:

1) Your National Provider Identifier (NPI);

2) Your Provider Transaction Access Number (PTAN); and

3) The last 5-digits of your tax identification number (TIN).

Make sure that your staffs are aware of this requirement for provider authentication.

Source CR6139

EFT Concerns with Bank Mergers and Closures

At our recent Medicaid seminar, Maureen Hoffmeyer shared an important reminder regarding EFT's. When a bank merger or closure occurs, it is important to inform the insurance companies who pay via EFT so there is not an interruption in payments.

For Medicaid reimbursement, EDS must have an updated, signed IHCP Electronic Funds Transfer Addendum from the provider to update or change the account information. If the provider does not update their information with EDS, the EFT account will be canceled and a paper check will be sent to the "Pay to" address that is listed on the provider file. If the "Pay to" address has not been updated the payment will be sent to the wrong address.

To make sure the provider file is correct go to Web InterChange and check under the Provider Profile link:
http://www.indianamedicaid.com/ihcp/index.asp

Thank you to Maureen Hoffmeyer for bringing this to our attention!

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UPDATE ON PQRI CODING ISSUE

A technical problem has caused line items containing any of the QDCs listed below to reject/return as unprocessable. In those circumstances the eligible professional (EP) received a message other than N365 indicating that the procedure code not accepted for reporting proposes. Since this is an issue that affects claims-based PQRI reporting only, the reporting of quality measures through registries is not affected.

CPT II Code	Measure #	Measure
3250F	99	Breast Cancer Resection Pathology Reporting: pT Category (Primary Tumor) and pN Category (Regional Lymph Nodes) with Histologic Grade
3250F	100	Colorectal Cancer Resection Pathology Reporting: pT Category (Primary Tumor) and pN Category (Regional Lymph Nodes) with Histologic Grade
3570F	147	Nuclear Medicine: Correlation with Existing Imaging Studies for All Patients Undergoing Bone Scintigraphy
3016F	173	Preventive Care and Screening: Unhealthy Alcohol Use – Screening
3455F	176	Rheumatoid Arthritis (RA): Tuberculosis Screening
4195F	176	Rheumatoid Arthritis (RA): Tuberculosis Screening
4196F	176	Rheumatoid Arthritis (RA): Tuberculosis Screening
3470F	177	Rheumatoid Arthritis (RA): Periodic Assessment of Disease Activity
3471F	177	Rheumatoid Arthritis (RA): Periodic Assessment of Disease Activity
3472F	177	Rheumatoid Arthritis (RA): Periodic Assessment of Disease Activity
1170F	178	Rheumatoid Arthritis (RA): Functional Status Assessment
3475F	179	Rheumatoid Arthritis (RA): Assessment and Classification of Disease Prognosis
3476F	179	Rheumatoid Arthritis (RA): Assessment and Classification of Disease Prognosis
0540F	180	Rheumatoid Arthritis (RA): Glucocorticoid Management
4192F	180	Rheumatoid Arthritis (RA): Glucocorticoid Management
4193F	180	Rheumatoid Arthritis (RA): Glucocorticoid Management
4194F	180	Rheumatoid Arthritis (RA): Glucocorticoid Management
4148F	183	Hepatitis C: Hepatitis A Vaccination in Patients with HCV
4149F	184	Hepatitis C: Hepatitis B Vaccination in Patients with HCV
0529F	185	Endoscopy & Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps – Avoidance of Inappropriate Use
4267F	186	Wound Care: Use of Compression System in Patients with Venous Ulcers

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STATUS UPDATE ON CPT II CODING ISSUE (continued)…

CMS is actively working with the carriers/AB MACs to address this issue. All carriers/AB MACs will be able to accept the affected codes **by April 1, 2009**. Once this has been accomplished, submission of the affected CPT II codes will result in the normal N365 message on the remittance advice indicating that the code has been accepted for reporting purposes.

In order to minimize any adverse impact on EPs for determination of satisfactory reporting for affected measures, CMS will exclude from the reporting denominator all cases for dates before which the carriers/AB MACs could accept the affected CPT II codes, unless inclusion of cases for such dates is more favorable to the EP. In view of this, EPs have the option to seek correction of first quarter QDC submissions which were returned as unprocessed if desired, but EPs would not be required to seek correction for the affected codes.
The two basic options for EPs are:

- Do not seek correction of the submitted codes which were returned unprocessed.

As indicated above, CMS will exclude from the determination of satisfactory reporting cases for dates prior to the date the carriers/AB MACs can process the relevant codes. Thus, EPs are not required to seek correction of claims. On the other hand, EPs who have begun to submit codes for the affected measures should continue to submit such codes. The beginning of acceptance of the codes will be apparent when the N365 message is noted on the remittance advice. The 2009 reporting period will not be changed and the EP who qualifies for the incentive based on the listed or affected measures will receive the 2% incentive payment with respect to the entire reporting period.

- Seek correction of the submitted codes that were returned unprocessed.

In certain circumstances, EPs may desire to seek correction of the unprocessed claims. To accomplish this, EPs who have already billed and included any of the listed QDCs for dates of service January 1, 2009 and after and received a message other than N365 on their remittance advice, can call their Carrier/AB MAC contractor and request a correction beginning 4/1/09. In this case the EP should be prepared to give specific claim information to the carrier/AB MAC contractor, such as, the internal control number (ICN), the beneficiary's health insurance claim number (HIC), dates of service and the QDCs. EPs who began reporting the affected measures using the Measures Group Consecutive Method during the first three months of 2009 may find that it is worthwhile to pursue correction.

Note: PQRI reporting and performance rate analysis for ONLY the affected measures will initially be performed after excluding cases for the first three months of 2009. If an EP does not qualify based on this calculation, then the EP's claims without excluding claims for the first three months of 2009 will be evaluated. Thus, the determination of satisfactory reporting will be evaluated both ways for all EPs who report on the relevant measures.

Acronyms Used in this report:

- *Quality-data codes (QDCs)*
- *Physician Quality Reporting Initiative (PQRI)*
- *Eligible professional (EP)*
- Medicare Administrative Contractor (MAC)
- Center for Medicare & Medicaid Services (CMS)

Source: Status Update on CPT II Coding Issue for the 2009 PQRI and Options for Eligible Professionals (EPs) CMS Website 2/18/09

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I M M I N S I G H T

MODIFIER 79 – BE PREPARED FOR AUDIT

According to the Medicare transmittal 442 the Office of the Inspector General is investigating the misuse of the modifier 79. The transmittal is telling contractors to strengthen their program safeguards to prevent improper payment for modifier 79. CMS established **modifier 79** to simplify billing for services provided to a patient during the post-operative period that was unrelated to the surgery originally performed. If the procedures are related, **modifier 78** should be used.

What should you do?

1. Run a CPT frequency report for this year as well as all of last year to see how many times modifier 79 was appended to a surgical procedure. The higher the frequency, the more likely an audit will occur.
2. Check to see if the appropriate modifier was used. If it was related to a previous surgery and within the global period, submit a corrected claim with modifier 78. If you have the documentation to support an unrelated procedure, modifier 79 should stand up under audit.

Audits are not something to fear if the documentation supports what is billed. Be prepared by double checking the documentation and correct anything billed in error

FIRE DRILLS

We have all been doing fire drills since we were in grammar school. But in a modern medical office there is a lot more to consider than just marching students down the hall. Fires can happen anywhere. A fire in a large building creates an enormous risk to everyone. Other reasons for evacuating buildings include natural gas leaks, earthquakes, hazardous materials spills and storms. Knowing what to do is the key to surviving a fire emergency. Conducting regular fire drills will give you the confidence to escape a fire safely. There are two steps for a good evacuation program – planning and practice.

Your Safety Manual provides the fire evacuation plan in policy EOP: 4 RESPONSE: FIRE – CODE RED. Be sure to establish responsibilities for staff members using the RACE acronym to assist you. Review fire extinguisher use using the acronym PASS. Annual online VEI OSHA training includes these two elements but it is also important to review these topics with staff during your annual fire drill as well. When reviewing a fire drill plan be sure to include everyone and during the planning phase have employees walk to all escape exits so they know which exit to use in case one is blocked during a real emergency. In situations where patients of poor mobility are to be physically moved by staff, you must ensure that the staff have received the appropriate training to do so. Another very important aspect of evacuations is the accounting of personnel. You must have a designated meeting place and a quick and accurate method of accounting for all personnel including patients, visitors, and vendors.

Once the emergency plan has been developed and training given, you will need to evaluate its effectiveness. The best way to do this is to perform a fire drill, which should be carried out annually or as determined by your manager. For example if you have a high staff turnover, you may need to carry them out more often. A well-planned and executed fire drill will confirm understanding of the training and provide helpful

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FIRE DRILLS (continued)…

information for future training. Whatever training you decide is necessary to support your fire safety strategy and emergency plan (i.e. a table top drill or a walk through drill), it should be verifiable. Records should be kept of any training held and should include: the date, the duration, name of the person giving the training, names of the people receiving the training, and the nature of the training. Any conclusions and remedial actions should be recorded and implemented.

Evacuation drills serve a very important role in responding to an emergency, building employees' familiarity with company policies, and keeping the work environment safe. And, if employees feel safe at work, they will work more effectively.

Contact your IMM Clinical/Regulatory Consultants with questions:

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APRIL CALENDAR OF HEALTH OBSERVANCE DATES

World Health Day (April 7th)

Alcohol Awareness Month

Autism Awareness Month, National

STD Awareness Month, National

Volunteer Week, National (3rd full week)

WalkAmerica March of Dimes (4th Weekend)

Women's Eye Health and Safety Month

Youth Sports Safety Month, National

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