January 2010

Volume 8, Number 1

IMM Insight

The IMM Newsletter

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

IMM

INSIGHT

Important National City Bank Changes

Information has been received that National City Bank will be changing their name to their new owner PNC Financial Services Group Inc. It is probable that account numbers will change also. This process is to begin February 2010 and finalized by June 2010 with notification to account owners coming from PNC as to when the change happened to the account.

The bank should be advised of the impact that name and account number changes will have on Electronic Fund Transfer (EFT) payment agreements that are in place. Practices need this information before the transition as government revenue cannot be forwarded or "cross-walked" to a new account. Commercial EFT agreements in place will be limited by the payer's agreement. Once a crosswalk happens notification will be sent to Medicare and a Do Not Forward (DNF) flag will be placed on all revenue until an updated Form 588 EFT is received and processed by Medicare.

There is also the issue of whether or not the Medicare PTAN/NPI involved is in PECOS. If not, the PTAN/NPI will be required to revalidate before the new/updated EFT will be processed. Revalidation is accomplished via a complete Enrollment Form 855 that would need all supporting documentation (including IRS documentation that supports the legal business name) attached. Providers who are linked to the group that are not in PECOS will also need to revalidate with Medicare via a complete Form 855I and 855R before the new/updated EFT will be processed.

If you are banking with National City Bank please begin communicating with them your need to have this information prior to the change.

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Aetna Making it Easy to Estimate Patient's Out-Of-Pocket Costs

Aetna has a new on-line tool that will help estimate a patient's out-of-pocket costs before your patient arrives for services. Aetna's **PAYMENT ESTIMATOR** for providers is available through Aetna's secure provider website NaviNet.

How does it work: Prior to the patient's visit, staff can enter member information along with the diagnosis and procedure code into the online tool. The estimator will then supply Aetna payment amounts, and estimation of the patient's cost including deductible, copayment and coinsurance information.

For more information on how to get started and how this can help your practice, please visit the Aetna Payment Estimator website.

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Medicaid Spend-down

Beginning January 1, 2010 providers will be able to view the remaining amount of a patient's spend-down when eligibility is checked. EVS will display the remaining amount of spend-down obligation for the month however providers may not collect the spend-down obligation from the member at the time of service. Providers may bill the member for the amount applied to the patients spend-down after the claim is adjudicated. According to the Medicaid spend-down policy, a member's obligation to pay the spend-down begins upon receipt of the Monthly Spend-down Summary Notice, which is mailed to the member on the second business day of the following month.

The amount shown as patient spend-down is based on claims processed at the time eligibility is verified. This amount will change as claims continue to process in the system.

Providers must verify the amount applied to the patient's spend-down by reviewing the Remittance Advice (RA). Amounts credited to the patient's spend-down are identified on the RA by Adjustment Reason Code (ARC) 178.

The purpose of the IHCP providing this information when eligibility is verified is so that provider offices can help their Medicaid patients with making payment arrangements.

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2010 Changes to E-Prescribing Incentive Program

The Centers for Medicare and Medicaid Services (CMS) has simplified the Medicare E-Prescribing Incentive program for 2010. Some of the key program changes for 2010 include the following:

- In 2010, physicians must report an e-prescribing code only when a patient visit results in a prescription being generated and transmitted electronically using a qualified eRx system. The new e-prescribing code for 2010 is **G8553** which **replaces** the three codes reported in 2009 (G8443, G8445, G8446).
- Providers only need to report the new e-prescribing code (G8553) **25 times** in 2010 to be considered a successful electronic prescriber. This is a significant change from 2009 when the e-prescribing codes had to be reported for at least 50% of eligible patient visits.
- Prescriber may use qualified registries and qualified Electronic Health Record (EHR) products to submit data on the e-prescribing measure for 2010 in addition to claims-based reporting.
- Electronic prescriptions written for patients in skilled nursing facilities, domiciliary care, and home-care settings are now included in the program.

The eligible visit codes which qualify for the e-prescribing measure have changed for 2010 due to the elimination of consultation codes for CMS and the addition of the nursing facility, domiciliary care, and home services codes to the program. To be

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2010 Changes to E-Prescribing Incentive Program (continued)…

eligible for the e-prescribing incentive, at least 10% of the provider's total Medicare Part B allowed charges for the reporting period must be comprised of the following codes:

90801-90809, 90862, 92002, 92004, 92012, 92014, 96150-96152, 99201-99205, 99211-99215, 99304-99310, 99315, 99316, 99324-99328, 99334-99337, 99341-99350, G0101, G0108, G0109

The incentive for eligible, successful e-prescribers in 2010 remains at 2% of their total allowed charges for all covered professional services furnished during the reporting period. Feedback reports and incentive payments for the 2010 reporting period will be available in late 2011.

Additional information regarding the E-Prescribing Incentive Program can be found at: http://www.cms.hhs.gov/ERXIncentive.

IMM's Newest Team Member

We are pleased to announce **Joanne Komari** will be joining our team, **Monday, January 11th,** as a **Regulatory Compliance Consultant.** Please extend a heartfelt welcome to Joanne.

* * * *

HIPAA Q & A

May physician offices use patient sign-in sheets or call out the names of patients in their waiting rooms?

Yes. Covered entities, such as physician's offices, may use patient sign-in sheets or call out patient names in waiting rooms, so long as the information disclosed is appropriately limited. The HIPAA Privacy Rule permits the incidental disclosures that may result from this practice. However, these incidental disclosures are permitted only when reasonable safeguards and the minimum necessary standard have been implemented. For example, the sign-in sheet may not display personal information or medical information that is not necessary for the purpose of signing in (i.e. medical problem for which the patient is seeing the physician, home address, and phone numbers.)

Is it okay to email patients copies of lab results, immunizations records and/or other medical information the patient has specifically requested via email?

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HIPAA Q & A (CONTINUED)…

Yes, if the information is encrypted or protected by an alternative method. An intranet (a private computer network that uses internet technologies to securely share an organization's information between employees) is an alternative method for securing information instead of encryption. Essentially, an intranet is a private version of the Internet, one which is accessible only to the practice's staff members. Another form of secure transmission would involve the use of a virtual private network (VPN).

Community Health Network email account users, should always type the keywords **PHI:** or **SECURE:** as the first words in the email subject line. The system will recognize the keyword and send a message to the recipient that you have sent a secure message.

We recommend when emailing patients; you obtain a written request from the patient stating that he/she would like to communicate with him/her via email. Also, have the patient provide their email address to you in writing. This will show that you took reasonable steps to safeguard the information, and will also demonstrate that you have the patient's authorization to communicate via email. It is also recommended to limit the amount of PHI to what the person "needs to know" or the minimum necessary information to accomplish the purpose of release of the PHI.

The bottom line is that email messages must be secure to prevent any inappropriate or unintended disclosure of patient information.

For questions or concerns, please contact your Clinical Regulatory Consultant.

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Do you have questions we can help with? Please submit questions to be answered in a future IMM Insight Newsletter – contact us at http://imm.ecommunity.com/.

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SOME HEALTHCARE RECOGNITION DATES FOR JANUARY

Blood Donor Month, National
Birth Defects Prevention Month
Cervical Cancer Screening Month
Glaucoma Awareness Month, National
Medical Group Management Week, National **(4th work week)**
Thyroid Awareness Month