



IMM INSIGHT NEWSLETTER

IN THIS ISSUE:

- ❖ PQRI UPDATE
- ❖ UNCLAIMED MONEY
- ❖ MEDICARE SCAM
- ❖ COLLECTION AGENCY FEES
- ❖ PAYING FOR INTERPRETERS
- ❖ ANNUAL SAFETY TRAINING
- ❖ DUPLICATE CLAIMS ON MEDICARE'S RADAR
- ❖ GOVERNMENT INCENTIVES
- ❖ PROOF OF MD ORDERS
- ❖ NEW TEAM MEMBER

PQRI UPDATE FROM CMS LEARN RESOURCE: 200906-19

The 2007 Physician Quality Reporting Initiative (PQRI) feedback reports that have been posted since July 2008 on www.qualitynet.org/pqri will be archived effective June 30, 2009 and will no longer be available to eligible professionals (EPs) who participated in the 2007 PQRI.

Archiving is required to create server space for new feedback reports related to the 2008 PQRI and the 2007 PQRI rerun participation. Only those EPs who previously did not qualify by submitting at least one quality data code successfully, but are newly qualified following the back-end system analysis and re-run of 2007 PQRI data, will receive a 2007 PQRI re-run feedback report.

All eligible professionals who successfully submitted at least one quality data code for the 2008 PQRI will receive a feedback report. These reports should be available in October 2009.

The 2008 PQRI incentive payment will be distributed by the Carrier and/or A/B MAC in **October 2009**. The 2007 PQRI re-run incentive payments will be distributed by the Carrier and/or A/BMAC in **November 2009**.

Additional information about the 2007 PQRI feedback reports can be found in the "2007PQRIprogram" section page at <http://www.cms.hhs.gov/pqri> on the CMS Web site. Posted 06/12/2009

PQRI BEGINS A NEW HALF-YEAR REPORTING PERIOD IN JULY

Beginning July 1st there are two ways to begin PQRI reporting to achieve incentive payments for 2009.

1. Report three individual 2009 PQRI measures for at least 80% of applicable Medicare Part B FFS patients seen between July 1, 2009 and December 31, 2009 through a qualified 2009 PQRI registry. (Some registries will allow the practice to submit data to them from the start of 2009 allowing the practice to report for the entire year.)
2. Report a measures group through claims or a qualified 2009 PQRI registry; depending on the sample method selected for a measures group, you could qualify for:
 - A half year incentive by reporting the measures group on 80% of applicable Medicare Part B FFS patients seen between July1, 2009 and December 31, 2009 or
 - A full-year incentive by reporting the measures group on 30-consecutive patients.

A list of qualified registries for the 2009 PQRI can be found on the CMS PQRI "Reporting" section page at <http://cms.hhs.gov/PQRI>

* * * *



IMM SERVICES

Leisa Hills
Executive Director, IMM
621-7318

Dave Mooney
Sr. Director of Finance, IMM
621-7494

Account Mgrs/Consultants

Betty Boester	621-7766
Debbie Bopp	621-7196
Tim Gee	621-9580
Lindsay Gross	621-7738
Anita Huse	621-4090
Linda Hutchens	621-9772
Jason Keller	621-9750
Kathleen McAllen	621-7460
Amy Miller	621-7790
Ellen Stancil	621-9374
Betsy Walter	621-9361
Richard Zenor	621-5139

Billing and Coding

Carol Hoppe	621-7555
Jan Hooker	621-1644
Lita Jones	621-1889
Judy Odum	621-1645
Charleen Porter	621-9743
Ann Silvia	621-9783

TPPECC

Carol Hoppe	621-7555
Darlene Gebhart	621-9312
Michelle Hayes	621-1647
Pat Schmitter	621-7187

Regulatory Compliance

Brenda Chapelle	621-9782
Beth Wilhelm	621-9751

UNCLAIMED MONEY AT IndianaUnclaimed.com

Please check this site for any unclaimed checks that your office may have and follow the instructions on the website to file a claim. There are several Community Hospital of Indiana claims listed. Also check by practice name and by provider name. The website is: IndianaUnclaimed.com.

* * * *

MEDICARE SCAM

CMS has become aware of a scam targeting physician practices. Faxes are sent to medical offices posing as a Medicare carrier or MAC. The fax instructs the office to respond to a questionnaire within 48 hours to update account information. **The fax has the CMS or MAC logo and appears authentic.** CMS advises offices to "be wary." If your office receives such a request, contact your Medicare carrier or MAC before responding.

* * * *

COLLECTION AGENCY FEES

Practices employed by **Community Health Network** should **NOT** be charging collection agency fees to the patient due to the hospitals' not-for-profit status. **For-profit entities can pass this cost back to the patient if they have been notified in the Patient Financial Policy.** Any office who has questions about **collection agency fees** should contact their Billing/Coding consultant.

* * * *

PAYING FOR INTERPRETERS

Practices have had difficulty figuring out how to pay for interpreters for their patients for years. There are sources available to practices that will help offset those costs.

1. Medicaid – Managed Care Organizations are required to provide free oral interpretation to their members when seeking health care. A contracted physician can contact the MCO in advance at the numbers below:
 - MHS – 800-414-5849
 - MDwise – Contact the delivery system provider relations staff
 - Anthem – 866-408-6132
2. HMOs – Indiana state law requires the HMOs to show that they have developed an access plan for their non-English speaking participants. Contact the HMO for information on this.
3. Medical Practice Carrier – Sometimes discounted rates are available through the malpractice insurance.
4. Community Resources – There are several community foundations that provide assistance, such as St. Joseph Community Health Foundation and Blue Cross Blue Shield Foundation. Some even provide grants for staff training.
5. Interpreter Alternatives – There are also alternatives to face-to-face interpreting such as telephone and video interpretation services. For instance, Relay Indiana is a free service for communication with the deaf.
6. IRS Tax Credit – Contact your health care accountant to see if you are eligible for the disabled access tax credit for small business. This helps offset the cost of the expenditures.



IMM INSIGHT NEWSLETTER

I
M
M
-
I
N
S
-
I
G
H
T

ANNUAL SAFETY AND COMPLIANCE TRAINING REQUIREMENTS

OSHA requires annual safety training for employees at the time of initial assignment and at least annually thereafter. If you are part of the Community Health Network, you are also required to complete annual NRCP and HIPAA compliance training. For those employees, log on to InComm and **complete all annual mandatory training by the deadline of July 31, 2009.**

* * * *

DUPLICATE CLAIMS ON MEDICARE'S RADAR

Resubmitting a claim before the original claim has been completed results in a duplicate claim. When this situation occurs, Medicare may send out duplicate requests for information to the provider costing Medicare time and dollars.

If an insufficient documentation denial is received, the claim must be corrected and resubmitted. This type of claim is considered "rejected" rather than denied. Resubmitting the claim without corrections will only delay the processing of the claim. This costs the provider time and dollars.

Any denial received on a claim is final. Resubmitting the claim and expecting a different outcome is not an efficient strategy for claim management. Often, the claim is past the timely filing limits by the time the denial is sent through the appeal process. This costs both the provider and Medicare time and dollars.

Medicare tracks duplicate claim denials. Some offenders are notified directly by NGS that they must eliminate their duplicate claim submissions. Other providers submitting duplicate claims may be targeted for audit by the RAC.

* * * *

GOVERNMENT INCENTIVES FOR INFORMATION TECHNOLOGY

The following web site is now available from CMS. On this site you can find information pertaining to the Medicare and Medicaid incentives for electronic health records adoption and important links to related sites at the Department of Health and Human Services.

http://www.cms.hhs.gov/Recovery/11_HealthIT.asp#TopOfPage

* * * *

PROOF OF M.D. ORDERS

Physicians must supply "proof of MD order" for CERT reviewers auditing labs, diagnostic and therapeutic procedures. The following items are acceptable as proof:

- Order or requisition form with physician signature and diagnoses that necessitate the services rendered.
- Physician progress note of visit in which procedure was ordered or the visit following the test procedures showing the physicians signature and medical necessity.
- Physician signature and diagnoses on test results.
- An electronic mail by the treating physician/practitioner or his/her office to the testing facility (including diagnoses).

I
M
M

I
N
S
I
G
H
T

PROOF OF M.D. ORDERS (CONTINUED)

- A screen print of an electronic request by the physician.

With electronic system requests, you must also include diagnoses and one of the following:

- ★ A copy of your protocol with a requirement that the physician must have a logon ID and password to order tests or procedures.
- ★ Evidence of physician entry into the system with individual logon ID and password such as an audit trail that proves the doctor entered the request for services electronically.

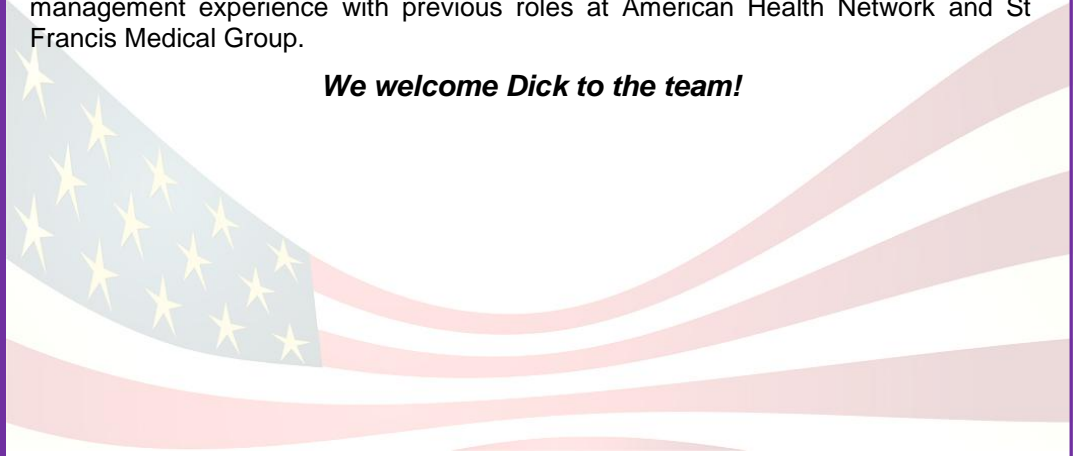
The starred items above are new to the list. The protocol can be sent in once per provider and the CERT contractor will keep a copy on file. You may submit this with any current medical record request with a CERT ID number. After the protocol is on file, each record request for labs and diagnostic procedures will require the screen print of the MD request, the diagnoses that necessitate the testing, and the results showing the testing was performed.

* * * *

IMM'S NEWEST BUSINESS CONSULTANT

IMM welcomes **Richard Zenor** to our team in the role of Business Consultant (Account Manager). Richard brings with him many years of physician practice management experience with previous roles at American Health Network and St Francis Medical Group.

We welcome Dick to the team!



JULY HEALTH OBSERVANCES & HEALTHCARE RECOGNITION DATES

Therapeutic Recreation Week, National (2nd Sunday)
Eye Injury Prevention Month
Hemochromatosis Screening Awareness Month
Light the Night for Sight
UV Safety Month