

# SELF'S TIPS AND TIDINGS

Don Self & Associates, Inc.

Working with MSI

PO Box 2610, Lindale, TX 75771  
903 882-4023 Fax 903 882-4027  
DONSELF@DONSELF.COM

JULY 2008

JULY 2008

## WHAT HAPPENED TO THE 10.6% REDUCTION?

As you probably know, the law required for there to be a 10.6% reduction in Medicare allowed amount this year, but similar to what has happened in the past few years, Congress each year made a temporary fix. This year was no different, except that the temporary fix this year became a political victory for the Democrats in the Congress. Here is the timeline for what happened with the bill to prevent the doctors from having a 10.6% reduction on July 1<sup>st</sup>.

- 6/20/2008 HR 6331 Introduced in House
- 6/24/2008 Agreed to in House: On motion to suspend the rules and pass the bill, as amended by the Yeas and Nays: (2/3 required): 355 - 59
- 6/27/2008 Failed on a vote in the Senate.
- 6/27/2008 Senate Majority refused to discuss proposal by Sen. Kay Hutchison (R-TX) for a 30 day continuance of current MFS to give Senate time to finish discussions.
- 7/9/2008 Passed/agreed to in Senate: Passed Senate without amendment
- 7/9/2008 Cleared for White House.
- 7/10/2008 Presented to President.
- 7/15/2008 Vetoed by President.
- 7/15/2008 Passed House over veto: 383 - 41
- 7/15/2008 Passed Senate over veto: Passed Senate over veto by 70 yeas to 26 nays

If you believe the moronic foolishness being discussed by a lot of state and national medical associations, you probably think that the Democratic House and Senate just did you a favor by pushing through bill 6331. They (the associations run by idiots) don't tell you that the ONLY reason the majority party refused to allow a 30 day continuance was so they could give a HUGE black eye to the Republicans by making you believe they were thinking of the physicians and geriatrics foremost. That is beyond stupidity. Yet – it is amazing how many state and national MD associations blindly believed it. This was the biggest home-run by a major political party that I've seen in my lifetime – yet the majority of Americans was blind to what really transpired.

OK – the result is that instead of trying to get the private sector (that is much better at controlling costs than the Federal Government), to help with the Medicare plans, the Democrats bullied the minority parties into not allowing ANY discussion or amendments, which resulted in them taking money from MA Plans run by private companies to put into the Medicare carriers (whom have a terrible reputation on managing it) so if you think you've had problems with the Medicare Advantage plans in the past – expect a lot more in the future.

So – the result is that the American physician community is clapping like Paula Abdul on American Idol because they received a 0.5% (half of 1%) increase in the Medicare Fee Schedule this year and a 1% increase next year. This while fuel has increased, expenses have increased, malpractice has increased, salaries of employees has increased, CME costs have increased, etc.... Remember this in November!

## E.D. & CRITICAL CARE BILLING

The Emergency Department (ED) is now included as a site where one may bill critical care services after a regular E&M service, with a 25 modifier. CMS came out with a 24 page long transmittal that has new, rigid documentation requirements when family counseling is part of the critical care time, for those E.R. coders.

## HISTORY OF PRESENT ILLNESS

As everyone knows, one of the 3 basic components of an E&M is the HPI. Although it is possible to bill an established patient visit while only documenting the Exam and MDM, all 3 components are required for a new patient. Dianne Wilkinson had some fun applying song titles to the different elements of the HPI to demonstrate what each is:

- **LOCATION:** "All My Exes Live in Texas" (George Strait)
- **SEVERITY:** "I'm So Lonesome I Could Cry" (Hank Williams, Sr.)
- **ASSOC.S&S:** "Bewitched, Bothered, and Bewildered" (Frank Sinatra)
- **CONTEXT:** "Singing in the Rain" (Gene Kelly)
- **TIMING:** "I Go Out Walkin' After Midnight" (Patsy Cline)
- **DURATION:** "Endless Love" (Diana Ross/Lionel Ritchie)
- **QUALITY:** "Achy-Breaky Heart" (Billy Ray Cyrus)
- **MODIFYING FACTORS:** "D-I-V-O-R-C-E" (Tammy Wynette...something she did MORE THAN ONCE to "make it better")!!

Thank you Dianne for helping us, with humor, to better understand HPI.

## WASTED DRUGS - \$\$\$

If you feel like you've been losing money on some of the drugs and injectables you're providing – you may be right. Medicare does allow for the wastage, as found in Medicare Claims Processing Manual Chapter 17:

"...The CMS encourages physicians, hospitals and other providers to schedule patients in such a way that they can use drugs or biologicals most efficiently, in a clinically appropriate manner. However, if a physician, hospital or other provider must discard the remainder of a single use vial or other single use package after administering a dose/quantity of the drug or biological to a Medicare patient, the program provides payment for the amount of drug or biological discarded along with the amount administered, up to the amount of the drug or biological as indicated on the vial or package label..."

So – make sure you bill for the correct number of units. More than half of the offices we perform analysis on are NOT using the right number of units – even though the office manager and physician believe they are. You may wish to check on this in YOUR office.

## HOSPITAL COMMITTING BILLING FRAUD

I received a question from a coder at a hospital asking how to convince the management at the hospital that they were committing fraud. The ER doctor will put a splint on a patient with a fracture and send the patient to an Orthopedic Surgeon in town for care of that fracture. The hospital wants to bill for fracture care instead of splinting. I told the coder to just copy the information on CMS' website about Qui Tam regarding billing fraud. That should get their attention. If they don't abide – then quit and consider filing a Qui Tam. That money they are stealing is YOURS and MINE we pay in taxes.

## MODIFIER 52 & 53

There appears to be quite a bit of confusion as to when a practice should use modifier 52 instead of 53 or vice-versa.

**Modifier 52: Reduced Services:** Under certain circumstances, a service or procedure is partially reduced or eliminated **at the physician's discretion**. Under these circumstances, the service provided can be identified by its usual procedure number and the addition of the modifier '52', signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. This also means that the physician is not doing all of what the CPT code designates.

**-53 Discontinued Procedure:**

Under certain circumstances, the physician may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the well being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. This modifier is not used to report the elective cancellation of a procedure prior to the patient's anesthesia induction and/or surgical preparation in the operating suite.

You CANNOT use either of these with a patient that doesn't show up for the service. You also cannot use 53 unless the procedure or anesthesia has been initiated. Initiated does not mean that the nurses have obtained the vitals. Initiated means that the physician has initiated services.

## DON'T ROUTINELY WAIVE CO-INSURANCE

Medicare, CMS and the HHS frown on and prohibit physicians from routinely waiving deductibles and co-insurance. They have been known to prosecute too. An OIG transmittal that would be appropriate for this is <http://oig.hhs.gov/fraud/dosc/alertsandbulletins/121994.html>.

If your office is routinely doing it – you may wish to read this link. If you only do it once in a great while and it's not routine, you may not be too worried about it.

## REMOVED WRONG LUNG – BILLING?

I received an email from a hospital professional coder that wanted to know what diagnosis to use on the claim for the surgeon's services when they removed a healthy lung from a patient. She was afraid to use the diagnosis for the lung they were supposed to remove. I replied that they should NOT bill for removing the incorrect lung (which subsequently caused the death of the patient), yet her doctor felt that they should. I replied that this would be similar to you taking your car in to have your alternator replaced – which was not working – and the mechanic replacing your radiator without permission and wanting to bill you for the new radiator. Of course, no one would expect to pay for that and the family (in my opinion) shouldn't be billed for the surgeon removing the incorrect lung either.

# SCREENING PELVIC EXAM – G0101

As you will find on CMS' site at:

<http://www.cms.hhs.gov/MLN MattersArticles/downloads/MM6085.pdf>

A screening pelvic examination with or without specimen collection for smears and cultures, should include at least seven of the following eleven elements:

1. Inspection and palpation of breasts for masses or lumps, tenderness, symmetry, or nipple discharge; and
2. Digital rectal examination including sphincter tone, presence of hemorrhoids, and rectal masses.
3. External genitalia (for example, general appearance, hair distribution, or lesions);
4. Urethral meatus (for example, size, location, lesions, or prolapse);
5. Urethra (for example, masses, tenderness, or scarring);
6. Bladder (for example, fullness, masses, or tenderness);
7. Vagina (for example, general appearance, estrogen effect, discharge, lesions, pelvic support, cystocele, or rectocele);
8. Cervix (for example, general appearance, lesions or discharge)
9. Uterus (for example, size, contour, position, mobility, tenderness, consistency, descent, or support);
10. Adnexa/parametria (for example, masses, tenderness, organomegaly, or nodularity); and
11. Anus and perineum.

**Please note that CR 6085 does not provide any change in policy. It simply clarifies unclear information in the manual as stated above.**

## **THE LAST LECTURE**

If you haven't read the book written by **Randy Pausch**, who was a professor at Carnegie-Mellon in Pittsburgh, let me encourage you to spend the \$16 at Wal-Mart on the book. It is an amazing story of how to live each day as if it might be your last. I bought a copy for each of my sons and my dad. It was Randy's last lecture. This 47 year old passed this past week. His lecture has been seen by more than 6 million on the internet. Check it out.

## **NO BALANCE BILLING MEDICARE PATIENTS**

On the phone yesterday with a practice in New York, I discovered that a Medicare participating physician was balance billing his Medicare patients on injectables because "Medicare doesn't pay enough for injections".

That is highly illegal. Section 1866(2)(A) of the Social Security Act precludes participating physicians/suppliers from charging Medicare beneficiaries more than the deductible and coinsurance based upon the approved Medicare payment amount determination. Providers (par and non-par) who accept assignment must accept Medicare's payment and beneficiary copayment, referred to as the Medicare allowed amount, as payment in full for all covered services. Providers cannot "balance bill" beneficiaries for amounts in excess of the Medicare allowed amounts.

## INJECTION ADMIN AND MODIFIER 25

We've been getting calls from clients wondering why Medicare carriers have been bundling office visits into the injection administration and after some research, we discovered that a problem exists. Medicare carriers are supposed to follow Medicare Global Fee Guidelines, but at the same time, Medicare also uses the National Correct Coding Initiative (NCCI) edits.

CPT code 90772 has "XXX" global days which means it has no global period. That SHOULD mean that you do NOT need a 25 on the visit performed on the same day as this is different from a zero day global period which includes a minor E&M with the procedure. But, version 7.3 NCCI verbiage changed that in that it said xxx global period codes are considered like minor procedures and are considered to include a minor EM with the procedure. It is up to each Medicare carrier to adopt the verbiage in CCI, so it depends on the carrier or other third party payer as to whether you need a 25 modifier on your EM to indicate that it is significantly separately identifiable EM service. Remember, make sure the note supports a 25 modifier and it is not just that minor EM associate with the procedure.

To be safe, we recommend that you use the 25 modifier on the visit code if it is significant and separately identifiable in your progress notes, so that both will be paid.

## WHAT YOU DON'T KNOW ABOUT LAB **IS** HURTING YOU, YOUR PATIENTS and YOUR ANNUAL PROFITS

Since we started educating ourselves on the differences between CLIA Waived and Non-Waived clinical lab testing over the past year (thanks almost solely to our partner Keith LaBonte with Medical Source, Inc.), we've been astounded at how much misinformation there is in medical offices about lab. While I do not mean any offense to anyone reading this, it is usually well meaning employees that are causing a lot of the problems. I cannot tell you how many times I will hear an office manager tell me "we can't afford to be non waived" or "we can't afford to spend the money on the controls or equipment" or "we don't have the funds to pay someone to run tests in our office". Those 3 answers, without ANY doubt, are costing more than 90% of primary care physicians in private practice a minimum of **\$20,000 per month NET PROFIT**. That is almost ¼ of a \$Million per year in increased **NET PROFIT**. **(Ok – I just lost some of the readers and they won't read the rest of this article and they will miss out. Another percentage of the readers will think they already know it all – and they won't act on this either, and they'll miss out)** A few of you will think about this and then call me and we'll schedule a one hour FREE phone consult to go over the lab tests you are now doing in house, those that you are sending out and when you should be ordering lab and we'll show you how to increase net profits by \$20K per month.

## **LAB (Continued)**

No offense to your doctor – but many physicians are not ordering the lab tests when the carriers (including Medicare) WANT them to. Some office managers are not printing out a list of the tests that Medicare says they want ordered for specific diagnosis and giving them to their doctor, which results in the doctor not ordering CBCs, Panels, Thyroids, A1Cs, etc. as often as they should for the conditions their patients have.

**(OK – at this point, some physicians will suffer a defense mechanism and wonder why a non physician is trying to tell them how to practice medicine)** CMS, Medicare, HHS and every insurance carrier realizes that if you capture a disease or symptoms early enough, and make appropriate therapy changes – you can help alleviate catastrophic problems. That is why doctors order Cholesterol and triglyceride tests – so they can help prevent cardiovascular problems. But – how often does your doctor order CBCs? There is no doubt that more than 80% of primary care physicians do not order them on every patient they have on long term chronic medications – yet that is when they should be ordered.

Let's do some math. Your doctor sees 23 patients a day and what percentage of them are on long term medications for chronic conditions? Let's assume that only half. Are you ordering 11 CBCs a day? Maybe you should be? **(OK – I lost a few readers here as they don't want to approach their physician for fear the doctor may get upset that they are recommending how to practice medicine)**. Perhaps you are ordering those, but someone has convinced you that the only lab you should or can have in your office is CLIA Waived – so you're letting someone else make all the profits from it. How much profit is there? On this one test alone, perhaps not more than a few \$ Thousand a month – but when you consider the other tests that you should be doing in addition to the CBC – that can add up pretty quickly.

Almost every physician that is on the one hour free call with Keith and I are astounded at how much money they are losing on their lab. About 15% of them have a Phlebotomist in their office, who is an employee of Quest or Lab Corps. They do not realize that the fact that one of these huge profit making labs have invested in their own employee to put into your clinic says that you are NOW ordering enough clinical lab tests that you are making them \$ TENS OF THOUSANDS per month in profit. Otherwise – they wouldn't put that employee into YOUR practice. Think about it. Other than the Oil companies, is there any industry that is reporting higher net profits each quarter than these lab companies? The reason is simple. The carriers want you to order lab so they can find the problems with the patient early enough to save them \$Millions in long term care. Many believe that the carriers will ONLY pay the large labs – but that is not true most of the time. Oh – you can flippantly say “It is with the carriers we deal with” and cost yourself \$20,000 a month – but that is stupidity. Especially at a time when you just received only a 0.5% increase (that is LESS than 1%, yet your costs have increased at least 5% during the same period). The labs are more than willing to let you make them money every single day – and some doctors are happily letting them do it.

It's up to you. You have nothing to lose by calling us today and schedule a one hour call.

## WHERE IS YOUR DATA GOING?

A report released in June 2006 by the Veterans Affairs Department's inspector general revealed that a transcription subcontractor in India threatened to release the medical records of 30,000 veterans over the Internet in 2005, amid a dispute over payments. The report came on the heels of a department data breach last month that compromised the personal information, including Social Security numbers, of 26.5 million people."....

Have you seen the GAO report at <http://www.gao.gov/new.items/d06676.pdf> that stated **40%** of government agencies surveyed (Medicare, Medicaid, Tricare) said they have experienced security breaches involving PHI (both domestic and offshore outsourcing).

And you wonder why, when you call UHC or other carriers that someone named Bob answers the phone with a Phillipino, Indian or Pakistani accent so strong that you can't understand them?

Be careful folks, because if YOU are using a billing or transcription service located in this country that sends the data overseas, it will be YOU that gets prosecuted under the HIPAA laws. YOU are the one that is charged with protecting your patients' PHI.

## PHONE CODES – ARE YOU BEING PAID?

Even though we know that Medicare doesn't touch these codes with a 10 foot pole, we're asking whether you're being paid for these codes or whether you're billing them to private/managed carriers at all. We have heard that a few carriers are paying for these (it's a wise move since it's less expensive to pay for a phone call than an office visit), but we would like your input. If you are billing these and being paid, please let us know who is paying for them:

- **99441:** Telephone evaluation and management services provided by a physician to an established patient, parent or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment: 5-10 minutes of medical discussion.
- **99442:** ... 11-20 minutes of medical discussion.
- **99443:** ... 21-30 minutes of medical discussion

## PQRI – PAY FOR REPORTING or \$\$\$

Is all of the work that physicians and clinics are doing to comply with the pay for Reporting portion of PQRI paying off? Part B News ([www.partbnews.com](http://www.partbnews.com)), which is published by Decision Health (<http://www.decisionhealth.com>) says that only 52% of the physicians participating in the reporting of PQRI received any bonus from it. Some of those received minor amounts, which they cannot even appeal, since no appeal rights are part of PQRI. So – instead of concentrating on the elusive 1.5% you MIGHT get – why not take this entire thing seriously and restructure your practice to Really take advantage of PQRI by \$ TENS OF THOUSANDS per month. Give me a call today and we'll schedule a one hour free phone consult with you about how to use PQRI to make a change in your income.

## CODING FOR DIAGNOSTIC TESTS

CMS and Medicare have been very clear since 2001 about how to code for diagnostic tests.

Transmittal AB-01-144 (September 26, 2001) clearly states: *“The ICD-9-CM Coding Guidelines for Outpatient Services (hospital-based and physician office) have instructed physicians to report diagnoses based on test results. If the physician has confirmed a diagnosis based on the results of the diagnostic test, the physician interpreting the test should code that diagnosis. The signs and/or symptoms that prompted ordering the test may be reported as additional diagnoses if they are not fully explained or related to the confirmed diagnosis.”*

With this said, let's be careful. I have heard that at least one equipment person told a physician to test everyone with a diagnostic test and only bill those that come back with a covered diagnosis. That is extremely dangerous and contrary to Medicare policy and regulations. You should only be ordering the test if there is medical necessity for it, such as a symptom or because the patient is on long term chronic medications, etc...

Be careful where you get your coding advice. Just because someone sounds like they have your best interest at heart – that doesn't mean they actually know what they are talking about – and you are the one that will be accountable.

**DON SELF & ASSOCIATES, INC**  
**PO BOX 2610**  
**LINDALE, TX 75771**  
**Address Correction Requested**

**JULY 2008**