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In This Issue

- Medicare Incentives and Bonuses
- Q2 Update: CPT Changes
- Countdown to ICD-10
- *Worker's Compensation Corner*

*Starting next month!
E/M Coding Corner: A
monthly case study
review using an actual
chart note*

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Medicare Incentives and Bonuses

Medicare is currently offering a number of incentives and bonuses. But there are so many, and the rules are so varied, it's difficult to keep them all straight! The following is a list of bonuses and incentives and basic guidelines for each:

Medicare Risk Adjustment

This incentive has been available to Medicare HMO plans since 2000. Medicare pays the HMO a capitated dollar amount that is based on the patient's age. Medicare has also defined a list of about 3300 diagnosis codes that are considered high acuity and weighted per level of acuity. If any of those diagnoses are submitted during a calendar year, there is additional capitation paid to the health plan. The diagnosis coding information utilized is based on physician claims. Whether or not a portion of the capitation "bonus" is paid to the physician depends on whether the physician has a risk-sharing contract with the health plan.

Medicare Risk Adjustment has been the motivation for many Medicare HMOs setting up "data mining" projects where a coder representing the health plan reviews medical records to validate that all applicable diagnoses have been submitted.

For more information, go to:

https://www.cms.gov/MedicareAdvtgSpecRateStats/01_Overview.asp#TopOfPage

E-Prescribe

The E-Prescribe program rewards providers who submit prescriptions by approved electronic methods. The system can either be a stand-alone system for e-prescribing only, or it can be accomplished within an EHR system capable of e-prescribing functionality.

In order to qualify for the bonus, at least 10% of billing to Medicare must be from the list of defined eligible codes. These include office E/M codes. With a few exceptions, both physicians and most nonphysician providers are eligible to participate.

Registration is not required. To report e-prescribing, the provider includes the Medicare specific HCPCS code G8553 (*At least one prescription created during the encounter was generated and transmitted electronically using a qualified e-Rx system*) on claim forms.

Incentive payment for 2011 and 2012 is 1% of the provider's allowable claims. In 2013 the incentive will be 0.5%. For most providers who are not E-prescribing by 2012, there will be a penalty in the form of claims payment reduction.

For more information, go to:

http://www.cms.gov/ERxIncentive/01_Overview.asp#TopOfPage

PQRS

PQRS is an abbreviation for Physician Quality Reporting System (formerly known as PQRI). This program involves quality measure reporting based on defined measures identified by Medicare and represented by specific HCPCS codes. With a few exceptions, both physicians and nonphysician providers are eligible to participate.

To participate, providers are generally required to submit information on the performance of at least three of the defined measures.

There is no sign-up or registration required and performance of the measures may be reported either via claims submission or through registries defined for that purpose.

PQRS and E-Rx are separate incentive programs. A provider may participate in one or both of them.

Incentive bonus for 2011 is 1% of allowed charges. Beginning 2011, physicians have the opportunity to earn an additional incentive of 0.5% by "more frequently" participating in a "Maintenance of Certification" Program.

For more information, go to:

https://www.cms.gov/PQRS/01_Overview.asp#TopOfPage

Meaningful Use Incentive

This incentive is available for providers who use or implement an electronic health record meeting Medicare's meaningful use requirements. There are two programs: one for Medicare and one for Medicaid.

Eligible providers for the Medicare program include doctors of medicine, osteopathy, podiatry, dentistry, optometry, and chiropractors who are not hospital-based. It does not currently include non-physician providers.

The Medicaid program includes physicians, nurse practitioners, certified nurse-midwives, dentists, and physician assistant who furnishes services in a Federally Qualified Health Center or Rural Health Clinic that is led by a physician assistant.

In addition, to qualify for an incentive payment under the Medicaid EHR Incentive Program, an eligible professional must meet one of the following criteria:

- Have a minimum 30% Medicaid patient volume
- Have a minimum 20% Medicaid patient volume, and is a pediatrician
- Practice predominantly in a Federally Qualified Health Center or Rural Health Center and have a minimum 30% patient volume attributable to needy individuals

Program registration is required, and an eligible provider may participate in either program, but not both. A physician participating in the EHR incentive program may also participate in the PQRS program, but may not collect an E-Rx bonus and EHR incentive bonus in the same year.

Based on when qualified EHR implementation occurs, the eligible provider may earn up to \$44,000 in incentive bonus in the Medicare program. If the provider does not participate by 2015, there will be a penalty in the form of claims payment reduction.

For more information, go to:

https://www.cms.gov/EHRIncentivePrograms/01_Overview.asp#TopOfPage

Primary Care Bonus

There is an insufficient number of primary care providers in the United States. As part of the health care reform package passed last year, Medicare has implemented a primary care bonus. Effective January of this year, for all primary care providers (including non-physician providers) where 60% or greater of their Medicare-submitted claims are specific E/M services, there will be a 10% bonus paid for each year beginning in 2011 and going through 2015. Bonus payments will be based on the total amount paid to a physician for an entire year for CPT codes 99201-99215 and 99304-99350. For 2011, the bonus amount is determined on the provider's 2009 claims data. However, for new physicians, the bonus will be based on 2010 data. Bonus payments will be made on a quarterly basis. If the provider practices solo, the bonus will be paid directly to the provider. If the provider is in a group, the bonus is paid to the group's NPI number. Included designations are family medicine, internal medicine, geriatric medicine, and pediatric medicine. No enrollment is necessary.

For more information, go to:

<http://www.cms.gov/MLN MattersArticles/Downloads/SE1109.pdf>

Q2 Update: CPT Changes

64613 and 64614: The bilateral procedure payment indicator for chemodenevation codes will no longer be recognized for codes 64613 and 64614. Codes 64613 and 64614 may only be charged once per day whether unilateral, bilateral or performed at different sites.

77071: The bilateral procedure payment formula for manual application of stress performed

by physicians for joint radiography has changed from 3 (base organ payment) to 2. Do not report 77071 bilaterally as the code includes examination of contralateral joint.

Countdown to ICD-10

Where to start? At this point in the timeline, you should be developing more than a “passing acquaintance” with ICD-10 coding. There are two beginning pieces of this puzzle you can be simultaneously developing.

Your first action is identifying the potential impact to your specialty. Either purchase a draft ICD-10-CM book (available from the AMA and other coding publishers) or download it from the CMS website. (Purchasing the book is actually easier and far less time consuming). Also purchase a mapping book. (Ingenix has published a mapping book that mirrors the CMS GEMs work). The mapping book is a side-by-side comparison of each ICD-9-CM code to its ICD-10-CM counterparts. This will show you, based on codes used most frequently in your type of practice, the potential impact of ICD-10.

Your second action is to identify all technical computer applications that use or process diagnosis codes. This should include any interfaces you are using to map between applications. Each vendor responsible for the applications and interfaces should be able to assure you of their ICD-10 readiness by the implementation date of 10/1/13. Their plan should include a timeline, testing plans, and plan for implementation support.

Coming next month: Additional readiness steps

Worker's Comp Corner:

The WCAB has rendered a decision that may help prevent non-MPN physician's reports from being admissible. The issue of whether non-MPN physicians' reports should be allowed into the record has been a subject of much argument, and the WCAB's decision in *Scudder v. Verizon California* is sure to add to the maelstrom. The WCAB ruled that reports by two separate physicians who were not part of the MPN were inadmissible. The defense attorney on this case, R. Mitchell Mays, said that the decision may help the defense stop reports from non-MPN physicians from being admitted into evidence.

What happened in this case is that the applicant, Terry Scudder, received treatment from his pre-designated physician, Dr. Eric Feldman. Dr. Feldman ultimately referred him to Dr. Douglas Jackson and Dr. Stanley Majcher. Ultimately, Scudder saw Dr. Philip Sobol (not in MPN) who referred him to Dr. Arthur Lipper (also not in MPN). The original decision by the worker's compensation judge ruled that Sobol and Lipper's reports were admissible. However, the defense filed for reconsideration, and this time the WCAB panel took the employer's side and found that neither report was admissible.

Commissioner Deidra Lowe wrote, "Labor Code Section 4600c provides that an employee may be treated by a physician of his or her choice 30 days after the date of injury is reported only where the employer does not have an MPN... Here, the employer does have an MPN. For this reason, applicant had no right to change his treatment to physicians outside the MPN 30 days after he reported his injury." Although the WCAB found that Scudder was entitled to medically appropriate referrals by Dr. Feldman, he said that the referral to Dr. Sobol was made by the applicant attorney, and therefore not valid under LC section 4600 (d) (6).

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For coding questions, contact Gladys Ross, CPC, CCS-P, ACS-EM at gross@grmed.com

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