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# The Insider News

May 2009

Volume 1, Number 7

## In This Issue

- Recovery Audit Contractors Update
- E/M Coding: History: Additional Medicare Guidelines
- Professional Courtesy
- Update: Red Flag Rules

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## Recovery Audit Contractors Update

The new Recovery Audit Contractors (RACs) are in place and are starting their audits.

We expect that the RACs will be much more aggressive than other examiners because they are private companies that will only be paid a contingent fee equal to about 10% of the funds they recover.

The four RACS and the states they currently cover are:

- Diversified Collection Services, Inc. of Livermore, California, 866-201-0585 in **Region A**, initially working in **Maine, New Hampshire, Vermont, Massachusetts, Rhode Island and New York.**
- CGI Technologies and Solutions, Inc. of Fairfax, Virginia, 877-316-7222 in **Region B**, initially working in **Michigan, Indiana and Minnesota.**
- Connolly Consulting Associates, Inc. of Wilton, Connecticut, 1-866-360-2507 in **Region C**, initially working in **South Carolina, Florida, Colorado and New Mexico.**
- HealthDataInsights, Inc. of Las Vegas, Nevada, 866-376-2319 in **Region D**, initially working in **Montana, Wyoming, North Dakota, South Dakota, Utah and Arizona.**

Additional states will be added to each RAC region in the near future.

RACs have the following limits on the number of medical records that can be requested from physicians (for FY 2009):

- Solo Practitioner: 10 medical records per 45 days
- Partnership of 2-5 individuals: 20 medical records per 45 days
- Group of 6-15 individuals: 30 medical records per 45 days
- Large Group (16+ individuals): 50 medical records per 45 days

Providers must respond within 45 calendar days to a RAC request for medical records, but may request an extension at any time prior to the 45th day by contacting the RAC.

The Medicare appeals process will apply to RAC appeals.

RACs will not replace current review entities. Other entities, such as Medicare carriers and the OIG, will continue to review claims. However, RACs cannot review a claim that has previously been reviewed by another entity.

## E/M Coding: History - Additional Medicare Guidelines

*Editors Note: This is an extension of our 3-part series on tips for documenting E/M codes. We began in the last edition by providing tips on documenting history. This article addresses additional documentation guidelines for the history component – specifically documentation responsibility per Medicare requirements.*

The ROS and PFSH elements of the History can be recorded by someone other than the provider, if there is documentation that the provider reviewed this information and indicates agreement with it or amends it.

This does not extend to the HPI documentation – according to Medicare, the HPI component must be documented by the billing provider. The HPI cannot be documented by staff and then referenced by the provider (i.e., its NOT okay to state “reviewed and agree with above” for the HPI component).

In a clarification statement, Noridian also extends this to the chief complaint, indicating that documentation of this element is also the responsibility of the billing provider.

To accommodate the chief complaint documentation requirement, many practices have added a line to their forms or templates called “Reason for Visit” which is filled out by the staff as the patient is roomed, and then the actual line for chief complaint, as well as the HPI is documented by the provider.

Most intermediaries and MACs have published specific direction for history documentation. If you are unfamiliar with guidelines from your specific intermediary or MAC, check their guidelines to make sure you are in compliance.

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## Professional Courtesy

Professional courtesy is the practice of waiving all or a part of the fee for services provided by the physician office when the patient is a physician or family member of a physician.

Per the OIG, whether a professional courtesy arrangement runs afoul of the fraud and abuse laws is determined by two factors:

- (i) how the recipients of the professional courtesy are selected; and
- (ii) how the professional courtesy is extended

If recipients are selected in a manner that directly or indirectly takes into account their ability to affect past or future referrals, the anti-kickback statute—which prohibits giving anything of value to generate Federal health care program business—may be implicated.

Any practice that provides professional courtesy should have and follow specific policies in place that are in accordance with OIG compliance guidelines as noted in the OIG Compliance Plan for Individual and Small Group Physician Practices.

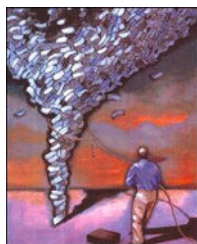
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## Update: Red Flag Rules

The FTC will delay the implementation of the Red Flag Rules until August 1, 2009 to give covered entities more time to develop/implement required policies and procedures.

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## Industry News



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