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# The Insider News

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## In This Issue

- Update on e-Prescribe
- Reminder: New Patient Definition
- Countdown to ICD-10
- Worker's Comp Corner
- E/M Case Study

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## Update on e-Prescribe

The CMS e-Prescribe program offers additional payment incentive when providers use electronic methodology to provide patient prescriptions. CMS has encouraged participation for the last several years, but beginning in January 2012, compliance is mandatory.

Unless a practice experiences "significant hardship" in complying with the e-Prescribing program, Medicare will begin to penalize providers for noncompliance.

The penalty consists of a reduction in the Medicare Physician Fee Schedule of 1% beginning January 2012. This escalates to 1.5% in January 2013, and then to 2% in January 2014 if the provider is still noncompliant.

To put the penalty into perspective, using the current year (2011) conversion factor, the code 99213 is reimbursed at \$52.95. If the conversion factor would stay the same in 2012, and the provider faced a 1% penalty for noncompliance in e-Prescribe, that payment would be reimbursed at \$52.42, a reduction of \$.53 per each 99213 reported. For a provider reporting fifty 99213 services per week, over the course of a year, the reduction would be \$1,378. If the provider continued to be noncompliant, this figure would double in 2014.

In its final rule, CMS allows providers who are otherwise eligible for the e-Prescribe program to request a "hardship exception" from the 2012 penalties if they were unable to submit the minimum required 10 Medicare prescriptions by 6/30/11.

Hardship exceptions include:

- Providers in rural health areas with limited high speed internet access
- Providers in rural health areas with pharmacies that have limited high speed internet access
- Inability to e-Prescribe due to local, state, or federal regulation (eg, the majority of the prescriptions are for controlled substances and must be written)
- Limited prescribing activity because the majority of prescribing activity occurs during other than the specified CPT codes (i.e., post op encounters)
- Insufficient prescribing opportunity (i.e., mid-level practitioners not writing prescriptions under their own NPI number)

In order to apply for a hardship exception, the provider must apply by November 1, 2011. Instructions are available on the CMS website [www.cms.gov/ERXincentive](http://www.cms.gov/ERXincentive). If application is not made by that date, payment reductions will begin for services dated January 1, 2012 and later.

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## Reminder: New Patient Definition: CPT versus California WC

Based on CPT guidelines, a new patient is a patient who either has never been seen in the practice before or has not received professional (face to face) services from a provider in the practice of the same specialty for the past three years.

If a physician joins the practice, existing patients of the provider who transferred from the previous practice to the new practice are considered established at their first encounter in the new practice.

When a patient is seen under California Work Comp guidelines, the definition of new patient is different. Under California Work Comp, a patient is considered “new” at the initial encounter for a new injury occurrence.

For example, if the patient was seen in 2010 by the provider for a WC injury involving a right wrist sprain, the first encounter with the same provider, or provider in the group of the same specialty, is considered new when presenting for the first time for new onset of a different WC injury.

Note that this variation is specific to California WC – many other states follow the CPT definition.

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## Countdown to ICD-10: Productivity Reduction Predictions

One of the biggest concerns about the implementation of ICD-10-CM is the potential for reduced productivity. This may be experienced both internally and externally. For example, internal delay might occur when it takes more time to assign the codes because of the high degree of specificity required and the basic unfamiliarity with the code sets. An example of external delay is delayed claims payments and/or increase in claims queries, of which both are predicted to occur.

When ICD-10 was implemented in Canada, coders experienced a 50% reduction at the time of implementation, and recovered to 80% of pre-implementation levels two years later.

When Australia implemented ICD-10, a 25% productivity reduction was experienced, with a return to 100% of pre-implementation levels in 6-12 months.

For the United States, the Nolan report predicts a 5-10% reduction in productivity for providers for the first three months after implementation. The report also predicts a 20% coder productivity reduction during that same time frame.

Other experts predict as much as a 50% productivity reduction.

The reality is that a productivity loss is very likely to occur, but its extent is going to be based on each practice itself. Much depends on workflow and preparation, and may also be specialty specific. For example, specialties like behavioral health will have a fairly limited number of codes to choose from. But orthopedics, where the codes are extremely site-specific, including laterality, and whether the encounter is a first or subsequent encounter for the problem, will have by far a greater number of code options.

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## Worker's Comp Corner

### California: Governor Brown Signs Compound Drug Measure

On 10/07/11, Governor Brown signed several pieces of workers' compensation legislation, including Assembly Bill 378 which will now bring compound drugs under the state's pharmacy fee schedule.

The new law limits the amount payable for compound drugs prescribed in WC cases to 20% mark-up over documented acquisition cost for pharmacy goods dispensed by physicians.

## Coding Case Study: What's the Level of Service? GYN New Encounter

Chief Complaint: Heavy menses  
LMP: 08/03/2011  
PCP: Dr. Smith

### SUBJECTIVE:

Had heavy menses for about the last eight months. Had hot flashes before starting OCPs at that time for the heavy bleeding. Symptoms resolved on the OCPs for 2 mo. After stopping the OCPs she had q 3 wk cycles. Hot flashes and sweats have been present since stopping the OCPs.

MEDS: none currently

### GENERAL EXAM

Height (in): 67  
BP: 104/ 66mm Hg  
Weight: 130 lbs  
General Appearance: Well developed; well nourished female  
ENT: Grossly normal  
Abdomen: Soft; nontender; no masses or hepatomegaly

### GYN EXAM:

Vulva/External Genitalia: Normal female; no lesions; normal BUS  
Vagina: Normal rugae; no lesions  
Cervix: No lesions; no cervical motion tenderness  
Uterus: Small; mobile; nontender Anteverted  
Adnexae: No masses or pain on palpation bilaterally  
Anus & Perineum: Within normal limits

### ASSESSMENT:

1. Her hot flashes and nightsweats are suspicious for a hypo-estrogenic cause. She is obviously not in menopause.
2. Bleeding sounds like anovulation despite the q 3 wk cycles. Options are to put up with it, use progestin cycling, or resume OCPs.

### PLAN:

Check FSH, Estradiol.  
She would like to start OCPs. Increased risk of MI/Stroke/DVT with OCP and smoking in her age group reviewed.  
Rx Mircette

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### Coder's Audit:

*This is reported as a consult by a GYN*

*[Coder's note: does not support a consult – does not identify requesting source, nor the intent of the requesting source (i.e., evaluation and advice versus management of the problem). Also, even if the consultation guidelines had been met, whether or not a consultation code could be billed is dependent on whether the patient's carrier accepts consultation codes – many carriers, including Medicare, Medicaid, Medicare HMO's etc. no longer accept these codes]*

### Chief complaint is present

### 4 HPI elements are present:

- Location (menses)
- Duration (8 months)
- Modifying factors (Symptoms resolved on the OCPs)
- Timing (3 week cycles)

### 1 System Review present

Endocrine (hot flashes)

### PFSH:

Past History – no meds

*[Coder's Note: The history supports expanded problem focused.]*

Exam:

1995:

4 organ systems covered: Constitutional, ENT, GI, GU

*[Coder's Note: Based on 1995 guidelines, the exam would be considered expanded problem focused.]*

1997:

10 bullet points:

Vital signs, general appearance, GI exam for tenderness/masses, GI exam for HSM.

External genitalia, vagina, cervix, uterus, adnexa, anus/perineum

*[Coder's Note: exam is based on 1997 Single System Female GU Guidelines. No credit is given for HEENT – the statement is too vague and there are no HEENT bullet points in this particular single system exam. The exam would be considered expanded problem focused]*

Medical Decision Making

New problem to examiner/chronic exacerbated problem

Overall

History: Expanded problem focused

Exam: (1995) Expanded problem focused; (1997) Expanded problem focused

Medical Decision Making: Moderate Complexity

Using 1995 or 1997 guidelines:

Code 99202

Comments:

Since the patient is new to the practice, a new patient code is reported. The decision making supports moderate complexity (99204). While it's unlikely that the problem would have required a comprehensive history and exam, as is required by 99204, only one additional system review and two exam bullet points would have been necessary to support 99203.

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