



THE MHS COMMUNICATOR

Medical Healthcare Solutions, Inc.: Complete Healthcare Management & Billing Services

WINTER 2009



OFF THE TOP ...

*To our valued
clients and
friends*

The New Year will no doubt usher in many changes in the health-care business. Whether it is in the form of new technology or day to day operations, MHS looks forward to working together with you to assess and effectively manage any challenges as they arise. Through our commitment to customer service, we will make every effort to keep our practices apprised of any revisions in order to maintain the highest possible levels of reimbursement.

Best wishes for a prosperous New Year!

Stephen P. Brighton, President/CEO

PROVIDER REQUIRED FRAUD TRAINING

CMS requires all providers and employees who provide administrative or health care services to a Medicare Advantage patient, to complete a Fraud, Waste and Abuse training program. This is an annual training program that began with calendar year 2009. If your office has not already completed the training, it must be done as soon as possible as the original information distributed to participating providers in July indicates a December 31, 2009 deadline. The training is done online and may be accessed at www.hcasma.org, and then by choosing the "Medicare Training" tab at the top of the home page.

Medicare Advantage programs include Blue Cross Blue Shield of Massachusetts, Fallon Community Health Plan, Harvard Pilgrim Health Care, Health New England, and Tufts Health Plan.

SOURCE: BCBSMA PROVIDER TRANSMITTAL, JULY 20, 2009
PROVIDER FOCUS, DECEMBER 2009

MEDICARE PAYMENTS ON HOLD THROUGH JANUARY 15, 2010

CMS will ring in the New Year with a temporary payment hold for the dates of January 1 to January 15, 2010. Payments are expected to resume processing after that 10 day period.

SOURCE: PARTNEWS, DECEMBER 30, 2009

MASSHEALTH REFERRAL DEADLINE EXTENSION

Masshealth has extended the 11/30/09 deadline and will continue to accept legacy PCC referral numbers until further notice.

SOURCE: MASSHEALTH TRANSMITTAL, DECEMBER 15, 2009

CONTRACTED RATES

As a participating provider, you have the ability to negotiate preferable reimbursement rates with many of your carriers. By submitting your signed contracts to MHS, those rates can be loaded into your directory to insure the highest possible reimbursements. Medicare allowable rates are the default amounts, however, if you have obtained a different rate, please submit your contract to your MHS Sr. Billing Manager so that your directory may be brought up to date.

BC/BS MASSACHUSETTS REFERRAL REMINDER

Effective October 21, 2009, BC/BSMA reduced the 180 day retroactive referral request allowance to 90 days. This further urges Providers to enter or seek referrals/authorizations prior to rendering care. The time allowed to "catch-up" with a service has been cut in half, however, technology allows for requests and approval confirmations to be done online, reducing office staff phone calls and administrative time.

SOURCE: FYIBCBSMA, JULY 1, 2009

W.B. MASON NEW SUPPLIER

Tufts Healthplan recently named W.B. Mason as their supplier for both referral and claims forms. Effective January 1, 2010, Moore Wallace is no longer the vendor to be used. More information can be found online at: www.tuftshealthplan.com/providers and may be fax'd to W.B. Mason at 800-738-3272.



WHAT IS PECOS/UPD AND WHAT DOES IT MEAN TO YOUR PRACTICE?

CMS/Medicare Provider Enrollment Chain Ownership System (PECOS) is a free and secure provider registry and has recently been joined by Universal Provider Datasource (UPD), the equivalent for private payers. Office administrative costs are reduced by these two databases as once information is added, it can be accessed by outside carriers to obtain practice information to perform contracting tasks. It is the Provider's responsibility to initially enter and periodically update the system to maintain accuracy. The council for Affordable Healthcare (CAQH) maintains the UPD in a manner similar to the CMS-855 enrollment process. They are hopeful that technology updates will soon allow the sharing of information from PECOS to UPD, allowing the provider to access one of the two systems and the automatic crossing of information to the other system. Why is registration important? As early as April 2010, CMS will require any provider listed in the referring/supplying doctor fields be a registered provider. This includes both electronic and paper claims submissions. If a referring/supplying provider is not registered, any claim submitted will be denied payment to the servicing provider. This may appear to be a benign issue to a provider outside the PCP circle. However that is deceptive as there are many practitioners who are currently eligible to order items or refer Medicare recipients to other Medicare providers or suppliers and yet do not have current enrollment records on file at Medicare. In addition, there are situations where the servicing provider information is used to fill a blank field for claims processing, those claims too will deny for payment without proper registration. This registration will affect many areas of healthcare services, including specialists and DME services. CMS urges providers to maintain accurate enrollment information through PECOS or effective April 5, 2010 they will receive written notification in accordance with the Medicare Program Integrity Manual. This is a revised implementation date, however early registration is advised. Additionally, CMS policy dictates that if a letter is returned due to invalid address, the Provider's billing rights may be deactivated. Outside agencies and billers are not allowed to enroll or update provider information. PECOS registration may be done online at www.pecos.cms.hhs.gov. UPD updates can be recorded at

www.upd.caqh.org.

SOURCE: PARTBNEWS, AUGUST 10, 2009

PARTBNEWS, NOVEMBER 2, 2009

NHIC, CORP. SPECIAL NOTICE, J14 A/B MAC, NOVEMBER 24, 2009

MANAGEMENT IMPACT ON BOTTOM LINE

Crestcom, Inc. believes management and leadership development is a process that results in new skills, abilities and attitudes. The Crestcom program pledges to increase efficiency, motivate employees, avoid workplace conflicts and exceed customer expectations. Systematic delivery of knowledge to office supervisors and managers is considered to have significant impact on the practice bottom line. For more information please refer to www.crestcomtraining.com or contact Heather Rosenfeld at (978)475-9755 or heather.rosenfeld@crestcom.com.

MODIFIER "PC" DEFINED

"PC" is one of three modifiers which identify "never events". Specifically, "PC" indicates wrong surgery performed on a patient. This modifier automatically triggers a denial of the claim. It is often misunderstood to mean "professional component" which is correctly reported as "26".



SOCIAL NETWORKING CAUTIONS

Many physicians are utilizing social media options to communicate beyond the confines of an office. Ed Bennett, Director of Web Strategy at the University of Maryland Medical System, advises, though these sites can assist with recruiting staff, communicating with patients and serve to easily advertise your business, they may also leave your practice vulnerable to unexpected risks. Most obviously, HIPPA violations can easily occur whenever protected health information is discussed in any forum. To a lesser extent, social networks can expose office computers to viruses, hackers and other

security compromises. Often forgotten or overlooked are the unintentional violations. A Milwaukee practice broadcasted a surgical procedure for training purposes, taking care to shield the patient's face. However, they neglected to remember the implant used was printed with the patient's name, which was clearly visible. Any posting made by the Provider, can be used at a later date to document personal beliefs and prejudices, raising concern about the standard of care performed by the poster. This is especially difficult when a practice employee posts information relative to a current or past patient. Though governed locally, employee comments have been linked to the practice in several states. A physician's public voice projected under a pseudonym or through an employee may appear anonymous but that is not always the case. One Texas physician regularly posted under a blog name and later found himself admitting to that name under oath. Malpractice can be an unfortunate side-effect of comments or general statements posted online. However, also damaging is the negative attention given as a result of such comments, even if they were made within legal guidelines. Unflattering publicity affects the practice bottom line, whether or not it is accurate. Mr. Bennett summed it up stating that being a part of a local or extended community can be advantageous, but any activities intentional or not, may leave a practice open to risks.

SOURCE: PHYSICIAN OFFICE AND TECHNOLOGY REPORT, OCT 2009

DISCOUNT GROUP INSURANCE PROGRAM

HUB International has created a group Auto/Home discounted rate program for MHS employees. They are willing to do the same for MHS clients as well. For more information regarding possible savings for your practice, please contact Mary Ellen McIver, Account Executive, at (978) 661-6816 or maryellen.mciver@hubinternational.com



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Your comments and suggestions are welcome!



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[2010 FEE SCHEDULE DELETES CONSULT CPT CODES](#)

Despite opposition from specialty advocates, CMS has decided to permanently delete consultation codes from the 2010 Fee Schedule. Beginning January 1, 2010, E/M codes for both new and established patients will replace code ranges 99241-99245 and 99251-99255. E/M codes affected have received increased allowable rates to compensate for the deleted codes which typically carried higher fees. Additionally, the relative value units (RVUs) for new and established office, as well as initial hospital and nursing facility, codes have been increased. CMS also promises revised global period bundled payments to assist in the transition away from consult billing. A new modifier designed to designate the coordinating care physician has been announced. All initial inpatient claims billed by the admitting or attending physician should be billed using the new modifier, "AI". This will designate the claim to the physician who is overseeing the patient's care in a situation where other providers are also seeing the patient during the same inpatient stay. Other physicians and specialists will not utilize this modifier and will not be eligible for modifier dependent services. Subsequent care codes will be used by providers not designated as the coordinating care physician, replacing the current consult codes. Medicare will not supply a clear guideline to convert consult codes to visit codes. However, they have developed a crosswalk for the purpose of establishing budget neutrality between dates of service prior to 1/1/10 and dates of service subsequent to 01/10/10. It is predicted that providers rendering services outside of an office setting, may see an increase in reimbursement as the fee schedule typically favors a higher allowable for in-patient and nursing facility services. Consultants caution providers to consider the consult policies of other payors when coding, as it is not clear which carriers will adopt the CMS change. MHS has added a warning to be displayed during charge entry, alerting the user to this change for all claims entered into both Medicare and Harvard Pilgrim Freedom categories. As additional carriers adopt this change, the warning will be expanded as necessary. Should all carriers follow suit, the consult codes will be deleted and become unavailable for use.

SOURCE: PARTBNEWS, NOV. 5, 2009

PARTBNEWS, NOV. 9, 2009

PARTBNEWS, NOV. 16, 2009

PARTBNEWS, DEC. 17, 2009

HPFREEDOM UPDATE, DEC. 2009