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Superior Resources, Inc. *linking work and revenue*

20% of Insurance Claims Are Processed Wrong

The AMA issued the 2010 Health Insurer Report Card this week showing 20% of claims are processed incorrectly.

The AMA estimates over \$15 billion could be saved by the Healthcare Industry by simply cleaning up the claims processes, improving accuracy and transparency, and standardizing coverage.

Of the claim edits disclosed by Aetna this year, 66.7% were their own edits, not National Correct Coding Initiative, CPT, or any other national resource. Aetna used disclosed edits to reduce payment of 6.65% of the claim lines submitted to \$0. An additional 0.7% of submitted claim lines were reduced based on edits they did not disclose.

Aetna is not alone in these issues, either. Of the claim edits disclosed by Humana, 60.6% were their own. Humana took the prize for most claims denied with 8.22% of submitted claim lines reduced to \$0 payment. Of those reduced claim lines, 8.9% were reduced by undisclosed edits, which is less than any other carrier for reductions for undisclosed edits.

Do not count on your Electronic Remittance Advice helping with accuracy. Anthem Blue Cross and Blue Shield's ERA were

accurate a mere 73.98% of the time. The best carrier in this category was Coventry Health and their ERAs are only accurate 88.41% of the time.

This is the third annual check-up of national health insurers as part of the AMA's Heal The Claims Process campaign. In previous years, the AMA included Medicare in its Report Card. This year, 7 commercial carriers were reviewed.

Though an 80% accuracy rate is not good, categories previously highlighted have shown significant improvement. In 2008, only 62-84% of claims were paid

under the correct contracted rate. This year, that rate jumped to 78-94% with Anthem BCBS being the lowest.



Last year we told you 42.9% of claim lines reduced to \$0 payment by Medicare were reduced based on edits they did not disclose to physicians. Medicare did not participate this year, but the rates in that category this year range from 39.70% by HCSC to 8.9% by Humana. That shows a great improvement in communicating with physicians.

There is, of course, need for improvement on the physicians side of equation as well. The number one reason for claim denials by all carriers was invalid insurance information, showing the need for physician offices to check insurance at every single visit.

Diligence in reviewing claims both pre and post payment is obviously still needed by all physician offices. If your office needs help, let us know.

Coding Confidential

Welcome to Coding Confidential, where we answer your questions on how to code and bill to ensure you get fair payment for the services you've rendered.

Q: Do you recommend using DX V65.49 [*Other counseling, not elsewhere classified; unspecified reason for consultation,*] as primary when patient is post-op and coming in for treatment planning (Example: chemotherapy teaching/planning) or CA diagnosis?

A: The primary condition being treated is the cancer, so that would be the primary diagnosis. V65.49 would not show medical necessity for either chemo teaching or planning.



Coding Confidential is an informational resources provided to clients of Superior Resources.

Coding Confidential is written by Kathy Stull, CPC, CMRS. Ms. Stull is president of Superior Resources, Inc. and has over 23 years experience in coding and billing. She has been a Certified Professional Coder since 2004 and a Certified Medical Reimbursement Specialist since 2008. She obtained a specialty certificate in E&M coding from the American Academy of Professional Coders in 2006. Ms. Stull is a popular speaker on Coding, Billing and Compliance in the NW Ohio area.

If you have a question for Coding Confidential, e-mail it to KathyStull@superiorresources.info. We'll respond to you and, possibly, include your question here.

FTC's "Red Flag" Rules Face Suit

The Federal Trade Commission's "Red Flag" rules, first proposed in November 2007, have been delayed yet again, and the AMA is still unhappy with physician's inclusion in the law.

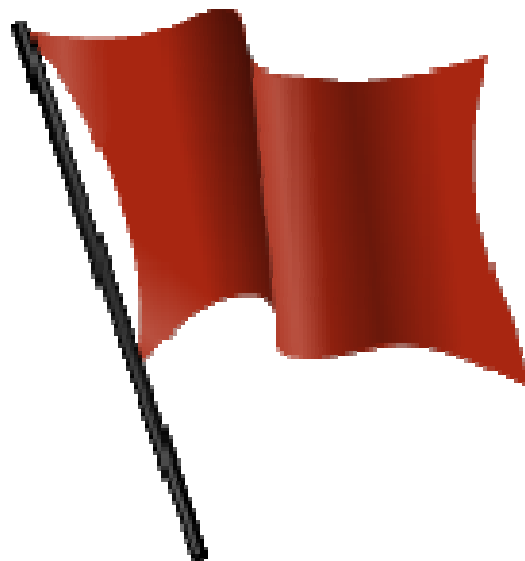
The AMA, the American Osteopathic Association, (AOA,) and the Medical Society of the District of Columbia, (MSDC,) jointly filed a lawsuit on May 21, alleging that the FTC has overstepped their regulatory power by defining physicians as "creditors" .

The "Red Flag" rules attempt to put forward safeguards against identity theft and, in the case of physicians,

medical identity theft. This includes expanding on HIPAA regulations that are already in place to include:

- Credit card information
- Tax ID numbers: Including Social Security numbers and Employee IDs
- Insurance Claim information
- Background checks for employees and service providers

Despite the current lawsuit, the red flag rules will apply to physicians unless changes are passed. If you need assistance making sure your office is compliant, call Superior Resources.



Defining “Meaningful Use”

“Eligible professionals (EPs), who meaningfully use certified electronic health record technology as early as 2011 or 2012 may be eligible for up to \$44,000 in Medicare incentive payments spread out over five years (increased by 10 percent for EPs who predominantly furnish services in a health professional shortage area).” - <https://questions.cms.hhs.gov/>

Sounds like a great deal, right? You use an EHR, you get \$44,000. There’s just one problem; what exactly is “meaningful use”?

CMS has dedicated seven pages to what a computer system must do to qualify for the incentives. Included in the list:

Computer Provider Order Entry must be used for 80% of all physician orders, including medications, labs, radiology/imaging, and referrals.

The system must implement drug/allergy checks in real-time, including tracking the number of alerts users respond to.

Must maintain an up-to-date current problem list, active medication/allergy list, demographics, and changes in vital signs on at least 80% of patients. E-prescribing is used on at least 75% of applicable prescriptions.

Smoking status must be recorded on 80% of patients 13 years or older.

Clinical lab results must be incorporated into the EHR as structured data, not just scanned documents, on at least 50% of all test results.

The system must be able to generate at least one report listing patients with specific conditions.

Must be able to report ambulatory quality measures to CMS or the States.

Preventative/follow-up care reminders are automatically sent to at least 50% of all unique patients 50 years or older.

Five clinical decision support rules relevant to specialty or high clinical priority must be implemented, including automatically generating alerts and care suggestions.

The ability to check insurance eligibility and send claims electronically to both public and private payers on 80% of unique patients is required.

The provider must be able to supply a patient with an electronic copy of their health information, 80% of requests being fulfilled within 48 hours.

Provider must offer at least 10% of patients electronic access to their health information, within 96 hours of the information becoming available.



Must provide at least 80% of patients with a clinical summary of all office visits.

Provide a summary of care record for at least 80% of transitions of care and referrals, and perform at least on test of certified EHR technology’s capacity to electronically exchange key clinical information.

Must be able to perform medication reconciliation at relevant encounters and each transition of care on at least 80% of patients.

Able to submit electronic data to immunization registries and public health agencies.

Able to provide electronic syndromic (e.g., influenza like illness,) surveillance data to public health agencies. Must be able to protect electronic health information through the implementation of appropriate technical capabilities, including conducting or reviewing security risk analysis and implementing security updates as needed.

When looking to update your system, these are the features you need to have included to qualify for the stimulus reimbursement.

Opens and Ends

- RAC is requesting payment back on codes 33960 - *Prolonged extracorporeal circulation for cardiopulmonary insufficiency; initial 24 hours* and 33961 - *Each additional 24 hours (List separately in addition to code for primary procedure)*, previously paid by Medicare. 33961 is an add-on code which cannot be billed separately, even

though the codes is per 24 hours. Medicare had requested that all add-on codes be billed under the initial date of service, but RAC has come back and requested payment be returned. We have requested clarification on this policy. We will keep you updated as this develops.

- We have had multiple claims deny by Medicare Secondary Payer for invalid patient type. Please keep in mind that working spouse aged 65+ is MSP 12. Working spouse aged less than 65 is MSP 43
- UHC has reduced payment on the second of two E&M services on the same date to 50%, citing multiple surgery rules. This edit is not on their website. The rep we spoke to said it may be a processing error, but we will keep you updated.

Superior Resources, Inc offers expert medical coding and billing services and assistance. We specialize in specialists, so we understand the barriers you face. From full-service billing plans to auditing, consulting and credentialing, we tailor our services to fit your needs. For more information, visit us on the web at www.SuperiorResources.info or call 419 794 1006 or toll free at 866 731 0712.

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