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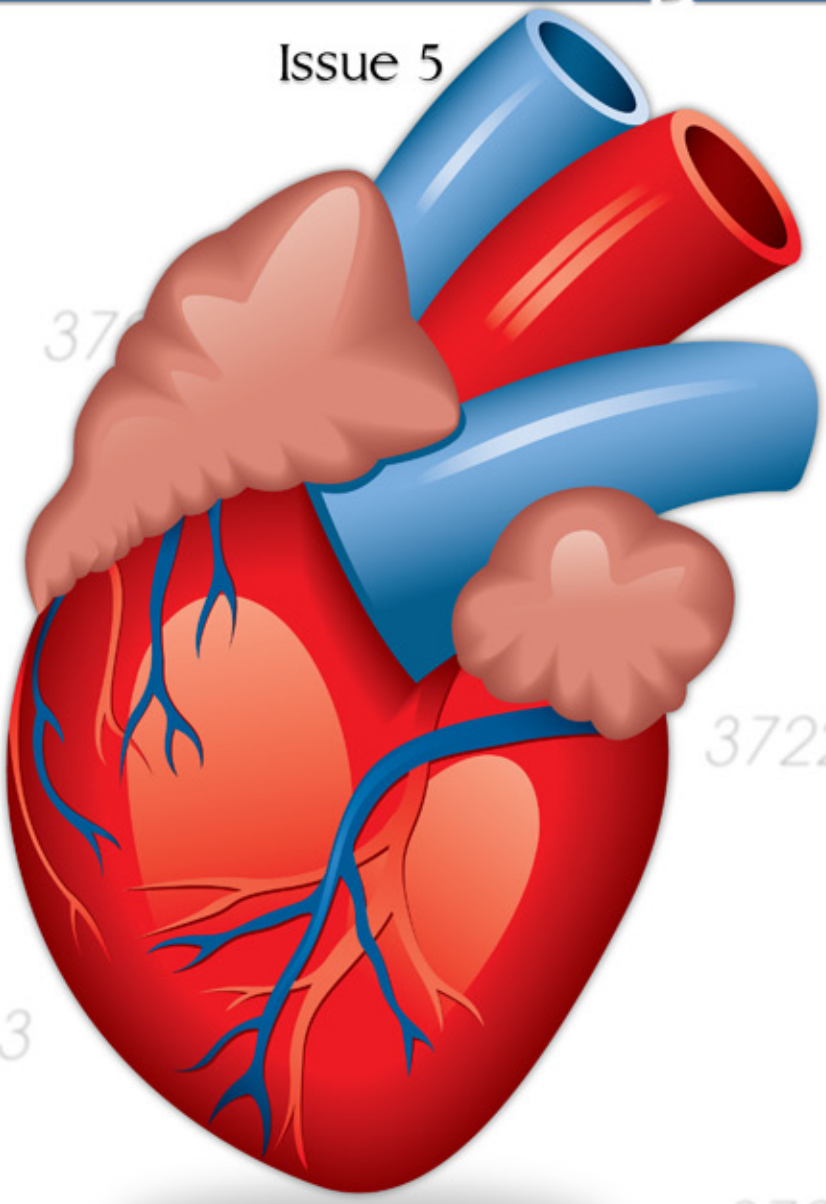

CARDIOVASCULAR Statistics and Code Changes

+ Transparency Measures in 2012
+ Navigating a Sea of Information

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Medical Business Journal
ISSUE 5, VOLUME 2, MAY 2011

Letter from the Editor

Dear Readers,

Let's cut straight to the heart of the matter: getting incentive payments. Electronic Health Record (EHR) incentive payments have begun to trickle out, and it's time to get your fair share. Before you get ahead of yourself, you need both 90 days of consecutive reporting and to register using the proper attestation process. The process is outlined in detail in our article, "April 18th Commence the Attestation Process." Also in this issue, you can find a preview of Stage 2 Meaningful Use rules.

This month's Navigating a Sea of Information tackles the monolith that is the Department of Health and Human Services and their website. This one is the grand-pappy of all healthcare regulation websites. If you can navigate HHs.gov, you can figure out almost any website.

Also, www.MBJonline.com now has archives of old MBJ issues. You can also access our Podcast straight from the site. Please feel free to contact the MBJ with any questions, concerns, or comments at news@mbjonline.com.

Enjoy your new issue,

Christopher Myers
Editor-in-Chief, *Medical Business Journal*

Medical Business Journal
Issue 5, Volume 2, May 2011

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TRANSPARENCY MEASURES IN 2012

Preparing for the Physician Payment Sunshine Provisions

Starting January 1, 2012, all U.S. manufacturers of drugs, devices, biological and medical supplies will have to record, and later report, all payments (in any form) to physicians or teaching hospitals. That means that those free lunches and fruit baskets gifted by pharmaceutical representatives will become public record in 2013.

Sections 6002-6005 of the Patient Protection and Affordable Care Act (PPACA), which are commonly referred to as the Physician Payment Sunshine provisions, will require public disclosure of the above mentioned payments. The regulation gives a lot of administrative discretion to the Secretary of the Department of Health and Human Services (HHS).

Under the new regulation, any transfer of value would be considered a payment. These are broken down into the following specific categories:

- Cash or cash equivalent;
- In-Kind items or services;
- Stock, a stock option, or any other ownership interest, dividend, profit, or other return on investment;
- Any other form of payment or other transfer of value (as defined by the Secretary).

The report would have to include all information concerning the recipient, except for their National Provider Identifier. This includes name, amount of payment (or value), the date of transfer, description of the payment type, description of the nature of the payment (consulting fees, gift, entertainment, etc.), whether the payment is related to marketing, education, etc. and any other information the Secretary deems appropriate.

The first report must be filed by March 31, 2013, and will be made public by HHS no later than September 30, 2013. The report will include information for the entire 2012 year and will be filed annually thereafter.

There are a few exceptions to the rule. Any payment under $10 does not have to be reported, until the aggregate payments for one "covered recipient" from one manufacturer exceeds $100. Then all payments must be reported.

Additionally, educational material provided for patient benefit is exempt, as well as loans of covered devices, items provided under warranty, dividends/investments in publicly traded securities or mutual funds, and payments made to a physician who is also (and acting as) a patient or employee of the reporting company.

Any payments related to research and product development may be delayed. In the case of a clinical trial or other development agreement, the manufacturer will not have to report until the product is approved, or four years after payments are made (whichever comes first). At this point all payments must be reported. This also applies to new applications of existing products.

Penalties for noncompliance will start at $1,000 and cap at $10,000 per failure to report, not exceeding $150,000 annually. Knowing failure to report will start at $10,000 and cap at $100,000 per failure, not to exceed $1,000,000 annually.

April 18th Commence the Attestation Process

REPORT MEANINGFUL USE, GET BONUS MONEY

CMS requires you to use a website, maintained by them, to register your providers for the Electronic Health Record Incentive Program. You must then use the same website to "attest" to having met the specific criteria for meaningful use in order to receive your bonus money, up to $18,000 per provider for your first year of successful attestation. April 18th marked the day Eligible Professionals (EPs) gained the ability to sign into the website (aka. The EHR Incentive Program Registration Attestation System), and use it. The EHR Incentive Programs website launched complete with the new attestation page for information on the process and how to actually attest to compliance with meaningful use criteria. The site appears to be a series of simple, point-n-click pages with the occasional requirement to enter numerator and denominator information for specific measures.

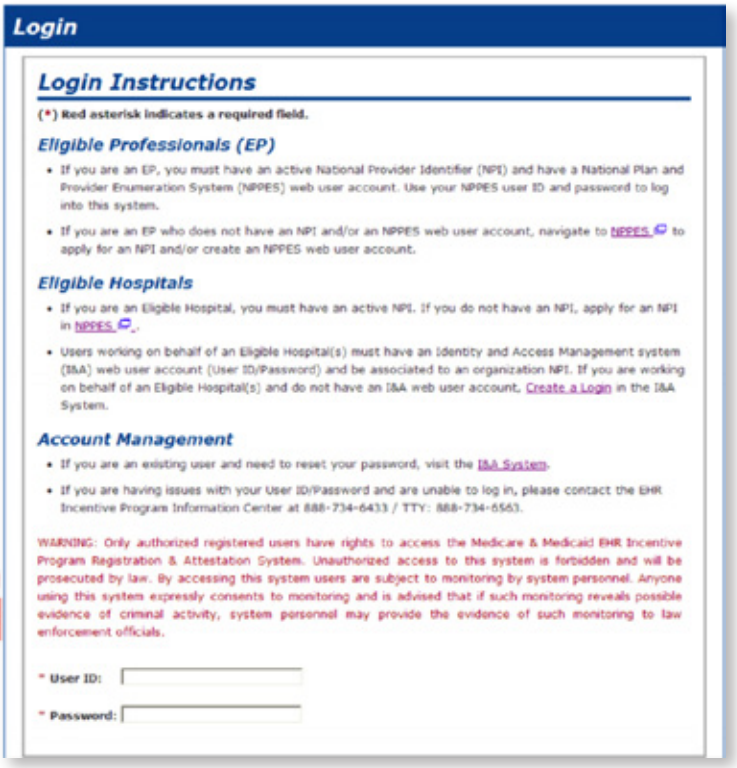
The site also includes a meaningful use attestation calculator that enables providers to confirm that they meet criteria before attesting to it, and print a summary for their records. EP and hospital user guides provided on the site, walk providers through the attestation system prior to attesting.

Enhancements are on the horizon to include worksheets that enable providers to complete meaningful use measure values and have the values at-hand while attesting. CMS also plans to include videos on the site to show providers completing the attestation process.

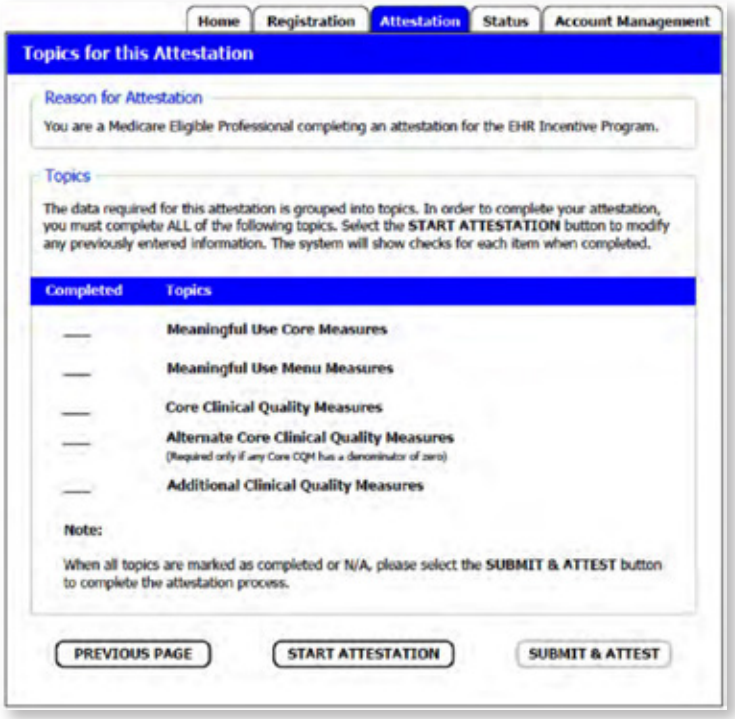
Be sure you begin your 90-day reporting period in time to attest and receive a Medicare payment in 2011. The last day to begin your 90-day reporting period for 2011 incentive payments is July 3, 2011 for eligible hospitals (EHs) and critical access hospitals (CAHs), and October 1, 2011 for EPs.

The following is an overview of how the online attestation pages work:

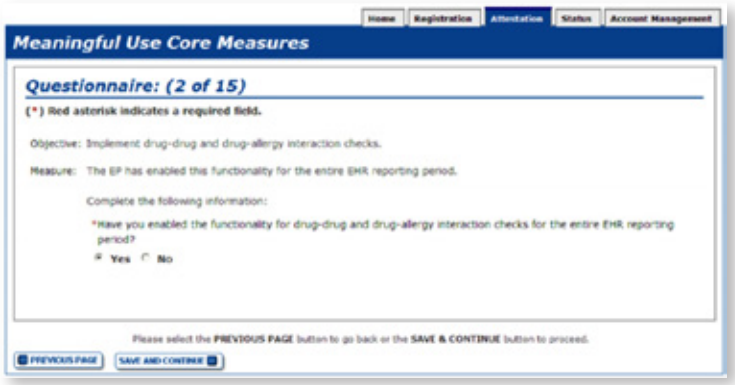
1) Sign in to the site – Remember, your provider must be registered to use the attestation website. Currently only the provider is supposed to be registering – third party registration is not allowed until CMS adds new functionality to the site in May.



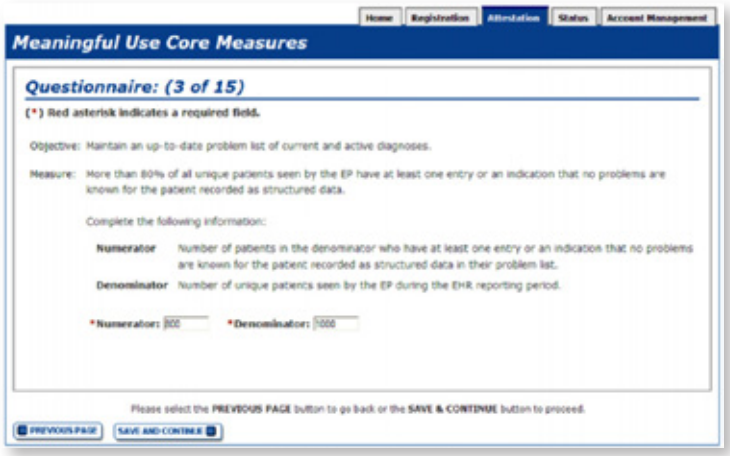
2) Enter the attestation module.
Once you are logged in, you will see a tab for 'attestation', click on it. The tab will then show you a checklist of tasks you must complete to enter attestation data and submit it.



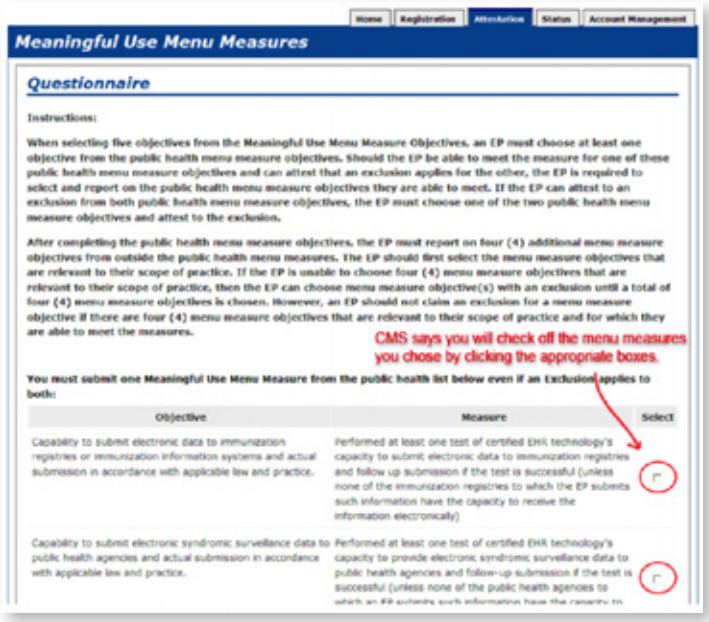
3) Answer core meaningful use measure questions.
You may note, most tasks are simply questionnaires that survey how you met various meaningful use measures, starting with the 15 mandatory or "core" measures. These questions appear to be straightforward and require a simple click of a button. When you complete the questionnaire, you move to the next measure.



4) TIP: Have data handy for more involved questions. Some measures require more information. For example, a measure may ask you to enter a value for the numerator (number of patients whom your provider maintained the problem list) and a value for the denominator (total number of unique patients during the EHR reporting period).



5) Select menu measures you will be reporting.
Upon completion of the core measures, you will be prompted to select the 10 "menu" measures you want to attest to.
Reminder: To meet stage 1 meaningful use, you must meet the 15 core measure and five of 10 menu measures. You must select the five that apply to your provider



6) Answer menu meaningful use measure questions.
Identical to the process for the core measures, you will point-n-click your way through the menu measures based on your selections.

7) Submit attestation and view summary.
Once you are done entering all the information, you will electronically submit through the website. Once submitted, you will be able to view a summary of the reported measures and see whether they were "accepted" or "rejected".

CMS has yet to state when you will get any other acceptance or rejection notification, and what to do in the case of rejections.

Sneak Peek at Stage 2

MEANINGFUL USE

Meaningful Use Requirements, Stage 1 Final vs. Stage 2 Draft	
This chart compares the current stage 1 meaningful use requirements to the early statge 2 meaningful use draft requirements. Stage 2 draft was released as a request for information (RFI) by the HHS Office of the National Coordinator for Health Information Technology (ONC-HIT)	
Stage 1 Measure	Stage 2 (RFI Draft) Measure
Eligible professionals (Eps) must use computerized provider order entry (CPOE) to record at least one medication order for more than 30% of all unique patients with at least one medication in their medication list	Use CPOE for at least one medication and one lab or radiology order for 60% of unique patients who have at least one such order
Implement drug-drug and drug-allergy interaction checks	Employ drug-drug interaction checking and drug allergy checking on appropriate evidence-based interactions
Maintain an up-to-date problem list of current and active diagnoses	Continue stage 1
Electronically generate and transmit more than 40% of all permissible prescriptions written by EP	Electronically generate and transmit 50% of prescriptions
Record these demographics for more than 50% of patients: preferred language, gender, race, ethnicity, DOB	80% of patients have demographics recorded and can use them to produce stratified quality reports
Maintain an up-to-date problem list of current and active diagnoses for more than 80% of patients	Continue stage 1
Maintain active medication list for more than 80% of patients	Continue stage 1
Maintain active medication allergy list for more than 80% of patients	Continue stage 1
Record and chart changes in vital signs for more than 50% of patients over age 2: Height Weight Blood pressure Calculate and display body mass index (BMI) Plot and display growth charts for children 2-20 years, including BMI	80% of unique patiens have vital signs recorded
Record smoking status for more than 50% of patients 13 years old or older	80% of unique patiens have smoking status recorded
Implement one clinical decision support rule relevant to specialty or high clinical priority along with the ability to track compliance with that rule	Use CDS to improve performance on high-priority health conditions. Establish CDS attributes for purposes of certification: Authenticated (source cited); 2. Credible, evidence-based; Patient-context sensitive; Invokes relevant knowledge; Timely; Efficient workflow; Integrated with EHR; Presented to the appropriate party who can take action
Report ambulatory clinical quality measures to CMS to the states	Continue as per Quality Measures Workgroup and CMS (i.e., same as stage 1)
Provide more thatn 50% of patients with electronic copy of health information (including test results, problem list, medication list, allergies) upon request	Continue stage 1
Provide clinical summaries for patients for each office visit within 3 business days, for more than 50% of all office visits	At least 20% of patients have the ability (and use it at least once) to view and download relevant information about a clinical encounter within 24 hours. Follow-up tests that are linked to encounter, but not ready during encounter, should be included in future summaries of that encounter, within 4 days of becoming available.
Perform at least one test of EHR system's capacity to electronically exchange key clinical information	Connect to at least three external providers in primary referral network (but outside delivery system that uses the same EHR), or establish an ongoing bidirectional connection to at least one health information exchange
Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1) and implement security updates as necessary and correct identified deficiencies	Additional privacy and security objectives under consideration via the HIT Policy Committee's Privacy & Security Tiger Team
(Menu) Implement drug-formulary checks and have access to at least on formulary during meaningful use reporting period	Moved from menu to core
(Menu) Incorporate more than 40% of all clinical lab test results during the reporting period into EHR as structured data	Moved from menu to core
(Menu) Generate at least one report listing patients of the EP with a specific condition	Moved from menu to core and must generate patient lists for multiple specific conditions
(Menu) Send reminders to more than 20% of patients 65 and older or 5 years and younger, per patient preference for preventative/follow-up care	Moved from menu to core

(Menu) Provide at least 10% of patients with electronic access to health information within 4 business days of information being available to EP	(Menu) 20% of patients use portal to view and download (on demand) relevant information contained in the logitudinal record, which has been updated within 4 days of the information being available to the practice
(Menu) Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient, at least 10% of patients	(Menu) Continue stage 1
(Menu) The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation for more than 50% of care transitions	Moved from menu to core
(Menu) Perform at least one test of EHR system's capacity to submit electronic data to immunization registries and follow up submission if the test is successful (unless none of EP's relevant immunization registries has capability to receive it)	Moved from menu to core and some immunizations are submitted on an ongoing basis to Immunization Information System (IIS), if accepted and as required by law
(Menu) Perform at least one test of EHR system capacity to submit electronic syndromic surveillance data to public agencies and follow up submission if the test is successful (unless none of EP's relevant agencies has capability to receive it)	Moved from menu to core
Does not exist	30% of visits have at least one electronic EP note*
Does not exist	Online secure patient messaging is in use*
Does not exist	Patient preferences for communication medium record for 20% or patients*
Does not exist	List of care team members (including primary care provider) available for 10% or patients in EHR*
Does not exist	Record a longitudinal care plan for 20% of patients with high-priority health conditions*
* New measures that appear in the stage 2 RFI draft and have not yet been specified as being either core or menu measures	

July Quarterly HCPCS 2011 Update Released

CR7345 CODE ADDITIONS AND DELETIONS

CR7345 instructs Medicare systems to add:

- Current Procedural Terminology (CPT) codes 74176, 74177 and 74178 to Major Category I.A. (Exclusion of Services Beyond the Scope of an SNF (Computerized Axial Tomography (CT) Scans)) effective January 1, 2011;
- HCPCS codes Q2035, Q2036, Q2037, Q2038 and Q2039 to Major Category IV.B. (U((Additional Excluded Preventive and Screening Services (Vaccines (Pneumococcal, Flu or Hepatitis B)) effective January 1, 2011;
- HCPCS code G0105 to Major Category IV.E. (U((Additional Excluded Preventive and Screening Services (Colorectal Screening Services)) effective January 1, 2011;
- CPT codes 93451, 93452, 93453, 93454, 93455, 93456, 93457, 93458, 93459, 93460, 93461, 93462, 93463, 93464, 93563, 93564, 93565, 93566, 93567 and 93568 to Major Category I.B. (Exclusion of Services Beyond the Scope of an SNF (Cardiac Catheterization)) effective January 1, 2011; and
- CPT code 96466 to Major Category III.B (Additional Exclusion of Services Rendered by Certified Providers (Chemotherapy Administration)) effective January 1, 2011.

CR7345 instructs Medicare systems to terminate:

- CPT code 90658 from Major Category IV.B. (U((Additional Excluded Preventive and Screening Services (Vaccines (Pneumococcal, Flu or Hepatitis B))) effective December 31, 2010; and
- CPT codes 93501, 93508, 93510, 93511, 93514, 93524, 93526, 93527, 93528, 93529, 93539, 93540, 93541, 93542, 93543, 93544 and 93545 from Major Category I.B. (Exclusion of Services Beyond the Scope of an SNF (Cardiac Catheterization)) effective December 31, 2010.

Modifier Madness

JULY 1ST MARKS THE BEGINNING OF AUTO-DENY FOR GZ MODIFIER CLAIMS

If you need another good reason to make sure your patient signs an ABN (in cases where you feel a claim doesn't meet your carrier's medical necessity requirement), here it is. CMS gives contractors discretion to auto-deny claims with GZ: Item or service expected to be denied as not reasonable and necessary. No ABN on-file (transmittal 2148, issued Feb. 4, 2011). In laymen terms, this modifier means there is no signed ABN on-file, and the provider cannot bill the unpaid service(s) to the patient if Medicare denies it.

In regards to the new transmittal, experts advise if you have reason to believe a code will be denied and no ABN is signed, Medicare policy states to add GZ. Now, based on guidance from HHS Office of General Counsel, CMS is establishing an automated edit to deny part A and B claim line(s) that contain GZ.

This indicates, you may quickly find, a number of codes that were historically paid – even with GZ- are being denied.

Experts further advise, when using GZ, be sure you have good reason to believe it will not get paid because you will have to write-off the charge.

Reminder:
MACs increasingly define "not medically necessary" as "not complying with the LCD".

Expert Tips:
List payable ICD-9 codes including frequency limits and documentation guidelines in the criteria for medical necessity. Re-evaluate your ABN process so in the event of medical necessity denials, there is some recourse to bill the patient.

CMS Boast of Improvements to PECOS System

ENHANCED WEBSITE MAKES PROCESSING PROVIDER CHANGES EASIER THAN EVER

There have been recent improvements to Internet-based Provider Enrollment Chain Ownership System(PECOS) to make the process of enrollment changes and applications more efficient than the longstanding method of filling out and mailing paper forms
Reminder: when you make changes to enrollment info via online PECOS, you are still required to mail in a 2-page certification statement. Send it along with paper copies of supporting documents that apply, (CMS-588) to authorize e-funds transfer.

List of improvements include:

Paperwork time
The time frame you have to send in signed certification statements doubled, from 7 days to 15 days after making a change or enrolling a provider via online PECOS.

Paperwork reminder
After changes are made on the PECOS website, a pop-up reminder will prompt you to print and mail the appropriate documents.

Progress Indicator
New PECOS features a "tracking bar" that appears on the website that changes to show how much of the process you've completed and how much remains

Status checker
New PECOS also includes an "application status module" that will show where your Medicare enrollment application is in your carrier's process. There are currently 5 possible status types: 'received by MAC', 'reviewed by MAC', 'returned to sender for additional information', 'approved' and 'rejected'. There are hopes for more detailed indicators in the future, but it's a start.

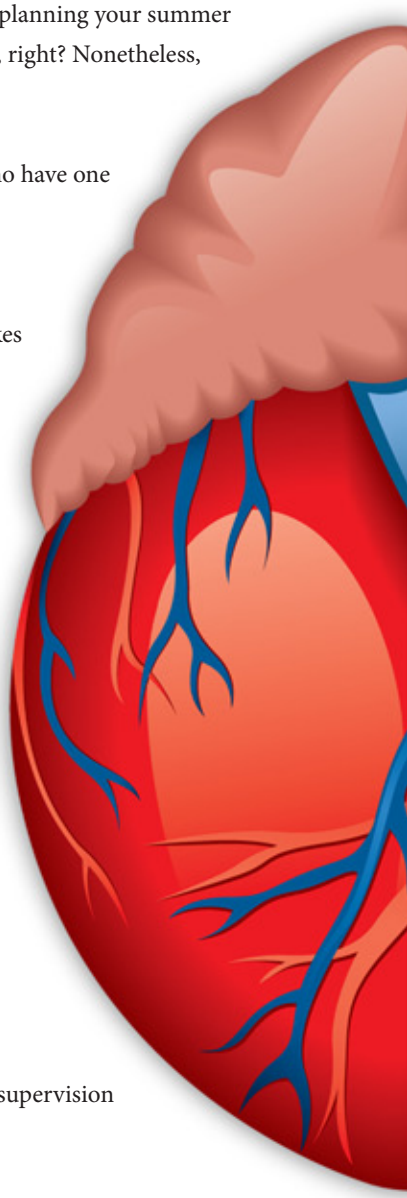
Assorted process improvements
It is now simpler and there are 'easy-to-understand directions' for signing up for online PECOS. You may also note a clearer process for following up on results, whether it's a case of more information needed or explanations on why enrollment applications are denied.

More improvements on the way
CMS plans to address several outstanding problems with on-line PECOS in the next round of enhancements. Ideas include, adding the ability for non-physician practitioners (NPPs) to specify their specialty and add the ability for providers who furnish services in multiple MAC jurisdictions to register with each MAC.

CARDIOVASCULAR
Statistics and Code Changes

A 2011 CLIFFS NOTES TUTORIAL

Although February was National Heart Health Month, now that tax season has come to a close, some of us may truly be feeling our own cardiovascular systems calming down for the first time since the holidays. Now it's time to relax - let "Spring Fever" set in and start planning your summer vacations. Uh oh, there goes my heart again - I probably shouldn't get ahead of myself…who has time for a vacation, right? Nonetheless, this is a quick guide to cardiovascular health as a whole, in addition to 2011 coding updates and changes.



According to the American Heart Association (AHA), there's an estimated 81,100,000 people in the United States who have one or more forms of cardiovascular disease (CVD).

This includes over 73 million with high blood pressure, over 17 million with Coronoary heart disease, 8.5 million to Myocardial infarction (acute heart attack) and over 10 million with Angina pectoris (chest pain or discomfort), strokes claim 6,400,000 and Heart Failure brings in 5,800,000. AHA President Daniel Jones, notes that heart disease is still the nation's number one killer, with stroke holding the number three spot. The AHA projects as many as 240,000 lives will be saved this year, but according to the most recent census figures, cardiovascular disease still claimed over 806,156 Americans in 2007.

The analysis of data by the National Center of Health Statistics doesn't entirely explain why death rates continue to fall. Studies suggest people are eating better, smoking less and getting better medical care than in generations before us. However, Jones also states, "Unless we can find a new strategy to stem diabetes and obesity, we can anticipate a new wave of cardiovascular disease deaths". Each year, the AHA advocates raise money through Walks and Fundraising, to save lives from America's No. 1 and No. 3 killers. For us on the business side of health care, with that kind of support comes changes to indicate the new technologies and procedures.

At the turn of 2011, the CPT brought about some big changes to cardiac catheterization coding. In whole, there were 19 deleted cardiac codes, 20 added cardiac cath codes and only eight cardiac cath codes remained unchanged. Lets take a look at the rules that apply to the new left (LHC) and right heart cath (RHC) codes 93451-93453:

93451: RHC includes measurement(s) of oxygen saturation and cardiac output, when performed

93452: LHC, including intraprocedural injection(s) for left ventriculography, imagain supervision and interpretation, when performed

93453: Combined RHC and LHC including intraprocedural injection(s) for left ventriculography, imaging supervision and interpretation, when performed.

Reminders:

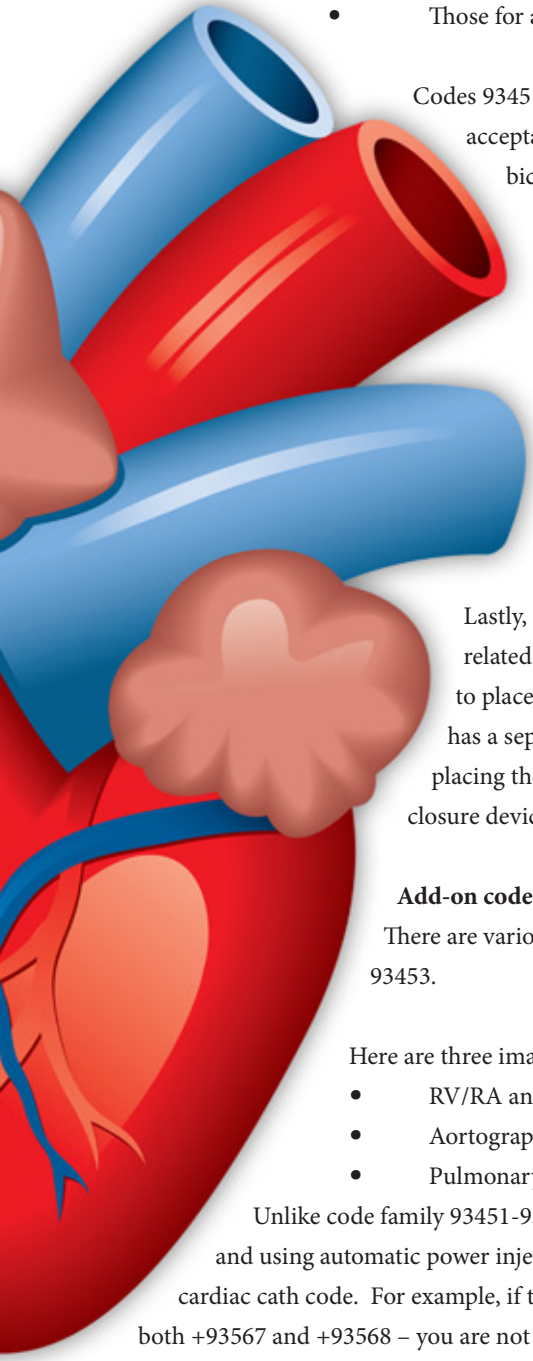
Some of the deleted cardiac cath codes are 93501 (RHC), 93510 (LHC) and 93526 (combined RHC and retrograde LHC), which you may have used in reporting similar services in 2010. The entire list of deleted codes includes 93501, 93508-93529, and 93539-93556.

Be sure to look at the overarching sections guidelines. With so many code changes, the CPT offers "Cardiac Cateterization" section guidelines to help use the new codes the correct way.

Families

CPT 2011 also segregates the cardiac cath codes into two families to keep congenital case codes separate. The two families are:

- For congenital heart disease
- Those for all other conditions



Codes 93451-93453 fall under the latter. However, do not miss that CPT guidelines include them in the codes acceptable for cases involving anomalous coronary arteries, patent foramen ovale, mitra valve prolapse and bicuspid aortic valve. Also note, there is no separate code for congenital LHC.

So what is included? Catheter Introduction to Closure.

According to the CPT section guidelines, a cardiac cath is a diagnostic medical procedure including all of the following:

- Introduction, positioning as well as any required repositioning of catheter(s) within the vascular system
- Recording intracardiac and/or intravascular pressure(s)
- Final evaluation and report of the procedure

When verifying the codes in the CPT manual, you will notice the symbol indicating the codes include conscious sedation when performed by the same physician.

Lastly, regarding 94351-93453, you shouldn't code rejections separately or the imaging supervision and report related to the road mapping as the code range includes the 'road mapping' angiography the cardiologist uses to place the caths. However, you may report contrast injections and the supervision and report for imaging that has a separate procedure code, but keep in mind CPT guidelines declare that you should not separately report placing the closure device at the access site, nor should you report any contrast injection required for placing the closure device.

Add-on codes

There are various new add-on codes that you may report in addition to multiple cardiac cath codes, including 93451-93453.

Here are three imaging/injection procedure codes:

- RV/RA angiography: =93566
- Aortography: +93567
- Pulmonary angiography: +93568

Unlike code family 93451-93453, these add-on codes do not include cath introduction; but they do include repositioning the cath and using automatic power injections. CPT also permits the reporting of any combination of +93566, +93567, and +93568 with your cardiac cath code. For example, if the cardiologist performs and documents both aortography and pulmonary angiography, you may report both +93567 and +93568 – you are not limited to just one add-on. However, if the cardiologist carries out angiography of noncoronary vessels "as a distinct service", take a look at the Radiology and Vascular Injection Procedures sections to find the proper codes.

On to more add-on codes; if the cardiologist administers a pharmacologic agent or has the patient exercise to evaluate hemodynamic response, you may use the following apart from the cardiac cath codes:

- Agent: +93463
- Exercise: +93464

Each code is only to be used once per procedure. Remember, CPT guidelines state that the above add-on codes are proper when the cardiologist uses the pharmacologic agent or exercise with the specific reason of repeating hemodynamic measurements to assess hemodynamic response.

Single Vessel Exception

Get familiar with the following femoral/popliteal service codes, if you haven't already, and remember that all of the codes include angioplasty in the same vessel when that service is performed:

- Angioplasy: 37224
- Atherectomy (and angioplasty): 37335
- Stent (and angioplasty): 37226
- Stent and atherectomy (and angioplasty): 37227

The general rule for 37224-37227 is that you should use one code that represents the most intensive service performed in a single lower extremity vessel. All lesser services are covered in that one code.

Example:

Your surgeon performs a stent placement and angioplasty. You should report 37226. This code covers stent placement and angioplasty. You would not report 37224 (angioplasty) in addition to 37226 in this case.

Territory rule

The 2011 peripheral revascularization codes (37220-+37235) apply to different "territories". To stay away from denials, keep in mind, each and every territory has its own specific set of guidelines – be sure to read them! For instance, 37224-37227 fall under the femoral/popliteal vascular territory. Here's the rule: Per the CPT, "the entire femoral/popliteal territory in one lower extremity is taken as a single vessel for CPT reporting." Therefore, a single code would be reported even if the surgeon performed different interventions for various lesions in the popliteal artery and in the common, deep, and superficial femoral arteries in the same leg during the same session. In these cases, code for the most difficult service.

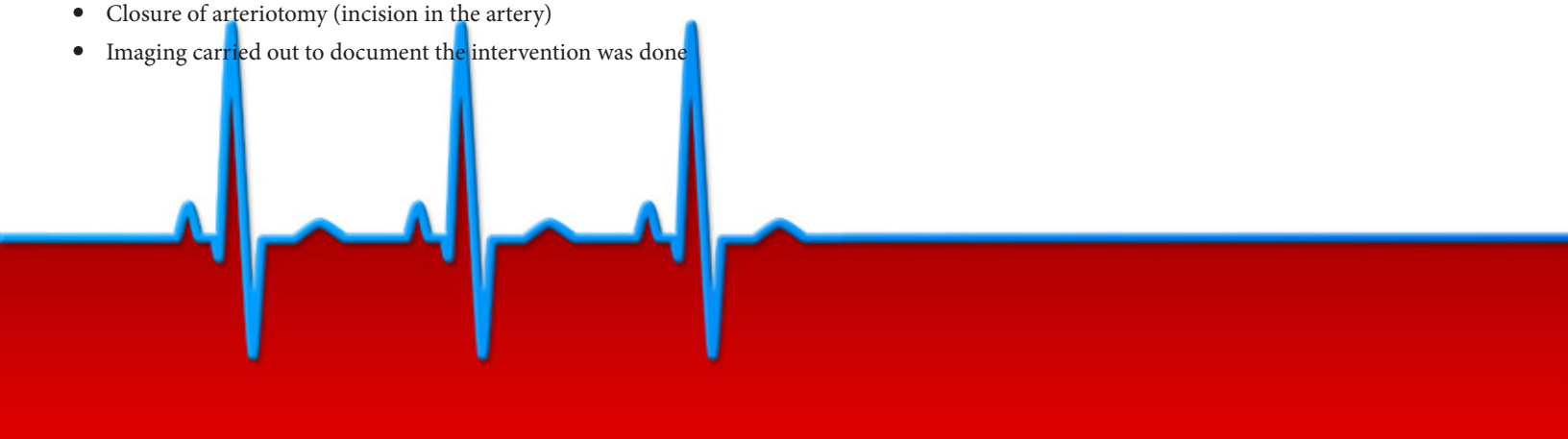
Reminder:

Codes are unilateral. Per the CPT, if the physician treats the identical territory in both legs at the same session, you should append modifier 59 to show both legs are involved. However, be sure to confirm your particular payers' modification preferences. Some may want you to use modifier 50, modifiers RT and LT or a combination to report procedures for both legs.

The difference from traditional component coding

In year past, each individual service was represented by a different code. For 2011, (with the help of the RUC (RVS Update Committee)) per CPT guidelines, in addition to the intervention carried out, the codes include:

- Accessing the vessel
- Catheterizing the vessel selectively
- Crossing the lesion
- Radiological supervision and interpretation for the intervention carried out
- Any embolic protection utilized
- Closure of arteriotomy (incision in the artery)
- Imaging carried out to document the intervention was done



For example, in 2010, you would have reported a superficial femoral artery angiography via antegrade puncture using codes 35474, 36245 and 75962. In 2011, those codes are now deleted and you will report only 37224 for that same service, to cover all services.

SEVEN STEPS TO HEART HEALTH

Everyone can benefit by improving his or her own cardiovascular health. The American Heart Association has revised its guidelines for achieving optimal heart health. Here are seven things you can do to reach that goal:

1. Get Moving for Heart Health. Regular physical activity lowers blood pressure, increases HDL ("good") cholesterol levels, keeps blood sugar in check, and helps you control your weight.

2. Eat a Heart-Healthy Diet. A heart-healthy diet includes:
   - At least 4½ cups of fresh fruit and vegetables per day
   - At least two 3.5-oz servings of fish per week. Ideally, you should choose fish that contain omega-3 fats, like salmon, mackerel, lake trout, sardines, and herring
   - At least three 1-oz servings of whole-grain products that are high in fiber (1.1 g or more of fiber per 10 g of carbohydrate)
   - Less than 36 oz of sugar-sweetened beverages per week (that's less than three 12-oz cans of soda)
   - No more than two servings of processed meats per week
   - No more than 1,500 mg of sodium per day if middle-aged or older.

3. Control Cholesterol for Heart Health. A total blood cholesterol level of 200 mg/dL or higher puts you at risk for a heart attack or cardiovascular disease.

4. Manage Your Blood Pressure for Heart Health. High blood pressure is the single most significant risk factor for heart disease. It's not curable, but it is controllable. Ideally, your blood pressure should be below 120/80 mm Hg.

5. Maintain a Healthy BMI for Heart Health. Body mass index (BMI) assesses your body weight relative to your height and indicates your level of body fat. An ideal BMI is lower than 25.

6. Stop Smoking for Heart Health. Smoking by itself increases the risk of coronary heart disease. When it acts with the other factors, it greatly increases your risk from those factors, too.

7. Reduce Blood Glucose for Heart Health. Adults with diabetes are two to four times more likely to have heart disease or a stroke than adults without diabetes. If your fasting blood glucose level falls in the category of "prediabetes" -- a level between 100 mg/dL and 125 mg/dL -- weight loss can help get your blood glucose down

Physician Quality Reporting System

TIPS TO AVOID COMMON ERRORS

CMS representatives recently shed light on these issues and shared the following information about the five most common PQRS pitfalls.

1. Off Target:
Are you missing your eligible population? When choosing your measures to report, carefully review all ICD-9-CM diagnoses and CPT service codes that will qualify claims for inclusion in physician quality reporting measurement calculations.
Remember, some measures have specified patient demographics that must be met before you can report them (i.e., age or gender parameters).

For those measures that call for you to capture clinical values for coding, ensure that the people in your practice who code your claims have access to them. Otherwise, they won't know the claims are eligible for PQRS.

2. Reporting wrong information:
This means you have used wrong specifications, quality data codes, or individual NPI numbers. Be sure that you use correct measure specifications for the present year and reporting method. In instances where measures need more than one quality data code (QDC, which refers to a CPT or G code), ensure that you have reported all of the codes on the claim and any applicable modifiers are added.
Also, see to it that you include the individual rendering NPI number(s) on the claim. These QDC should be submitted on the line item of the claim as a zero charge. If your billing software does not permit a zero charge line item, try entering one cent as your charge since the field cannot be left blank.

3. Outside of the reporting frequency:
Each PQRS measure has its own reporting frequency (time frame requirement) for each eligible patient seen during the reporting period, per eligible professional (NPI). Some measures require you to report once per patient, per NPI, each reporting period (also called 'patient-level') while others may need to be reported once per procedure performed, once per visit, or once per acute episode.

You can find the "measure tag", which indicates reporting frequency, in the instructions section of each measure specification – bear in mind, even if you know the frequency requirements, you will not be able to find them if the practitioner's documentation is not thorough. Ensure all members of the team know and capture this information in the clinical record to facilitate reporting.

CMS Waives Coinsurance and Deductible for Preventative Services in RHCs

Transmittal 2186 was released by the Centers for Medicare and Medicaid Services (CMS) on March 28, 2011. It regards a change in the way claims will be processed for preventative services provided in Rural Health Clinics (RHCs). It was implemented April 4, and is effective from January 1, 2011.

In order to properly code for this change, an additional line with the correct site of service revenue code in the 052X series should be submitted with the appropriate HCPCS code and associated charges. For example a visit of $150 with $50 of that attributed to qualified preventative services should be coded as such:

Line	Revenue Code	HCPCS code	Date of Service	Charges
1	052X		01/01/2011	100.00
2	052X	preventive service code	01/01/2011	50.00

This does not apply to the initial preventive physical examination (IPPE), individual Diabetes Self Management (DSMT), and individual Medical Nutrition Therapy (MNT).

Navigating a Sea of Information

A HEALTHY DOSE OF HHS.GOV

The Department of Health and Human Services (HHS) is the Pacific Ocean of healthcare regulation. Not only is it massive, it connects to almost every other government website concerning medicine. Since HHS is the agency that encompasses smaller organizations like the Centers for Disease Control (CDC), the Food and Drug Administration (FDA) and even the Centers for Medicare and Medicaid Services (CMS), this month's installment of navigation will outline the main shipping lanes between the proverbial major ports.

Start your cruise at www.hhs.gov. From this homepage, you can travel anywhere in the HHS world. The first resource you will need to know about is the Regulations tab at the top of the page. Here you can find Health Information Privacy regulations, as well as new HHS installments in the Federal Register. To the left side of the site, you can see how to lodge a HIPAA complaint, and also view FAQs. Under the HIPAA FAQ section, you can peruse the different categories to look up just about any question on HIPAA compliance, including regulations pertaining to new Health Information Technology. On the right side of the Regulations page, you can find postings of all proposed and final rules, and even link to the full Federal Register articles.

Another useful tab is the Grants/Funding section. Everyone wants to get paid, and this section can show you if you qualify for any Federal Grants. The "check your eligibility" link will send you to benefits.gov. Here you can enter your practice's information to determine if you qualify for any Federal money, like Health Information Technology adoption funding for example. Back on the Grants/Funding page, you can also find forecasted funding grants, and check when they will take effect. This way, you can prepare for grants and become eligible before they even are released.

The News tab is pretty self-explanatory. Here you will find everything new in HHS. This section can be extremely general, but it's not a bad idea to check it periodically for a new regulation or policy that you might have otherwise missed.

Back on the Home page, you can find the Secretary's Key initiative links. These are the links that the Secretary wants you to click. Many of them might be irrelevant to you personally, but they at least provide an interesting look into the larger world of medicine. One particularly useful link is the Stop Medicare Fraud Initiative. At stopmedicarefraud.gov, you can find records of every fraud case across the nation. Not only can you report fraud, you can check out the HEAT (Health Care Fraud Prevention and Enforcement Action Team) Newsroom. Here you can search for any fraud actions by date and by location. The most recent medical operation busted for fraud might be right down the street from your own practice.

Returning to the HHS.gov Home page, there is one more important tool available. It is the link to every subdivision of HHS, from the CDC to CMS. At the top right corner of the page, you will see a section labeled HHS Operating & Staff Divisions with a link below it. Through this link you will come to another page, with a link to "a detailed list of HHS's Operating Divisions." From here, you can go virtually everywhere. If you click on the CMS link under Operating Divisions, you will notice the chief administrator for CMS and his contact information. Next to that you will see a link labeled CMS. By clicking here, you wind up right back to last month's feature webpage: www.cms.gov. The other divisions of HHS are set up the same way, with the chief administrator and the subdivision's website.

Prepare to drop anchor, you have made it back into port. While HHS may be massive, it's really just a collection of smaller agencies and websites. Once you know which subdivision to go to, navigating the links becomes much easier. And remember this one helpful hint: when all else fails, search the website. It may be a shot in the dark, but sometimes it can at least point you in the right direction.

Final 2012 CMS Policies Released

UPDATES TO MEDICARE PART C AND D

The Centers for Medicare and Medicaid Services (CMS) have released a list of regulations to take effect for the 2012 contract year. These include several rules for Medicare Parts C and D, and implements provisions of the Affordable Care Act (ACA).

The new rules will limit cost sharing for specific programs, such as chemotherapy and dialysis treatment, under Medicare Advantage (MA) and section 1876 plans. Also, changes in Part D policy to close the coverage gap have been specified, including adjustments to the gap estimation. As a result, the coinsurance rates for certain Part D drugs will be reduced.

All MA organizations and Part D sponsors will now be required to provide interpreters in their call centers for all non-English speakers. The new rules will also give CMS the authority to require MA plans to mail enrollees an explanation of their medical benefits.

Here are the annual updates to Medicare Part D:

- Deductible: From $310 in 2011 and rounded to the nearest multiple of $5.
- Initial Coverage Limit: From $2,840 in 2011 and rounded to the nearest multiple of $10.
- Out-of-Pocket Threshold: From $4,550 in 2011 and rounded to the nearest multiple of $50.
- Minimum Cost-Sharing in the Catastrophic Coverage Portion of the Benefit: From $2.50 per generic or preferred drug that is a multi-source drug, and $6.30 for all other drugs in 2011, and rounded to the nearest multiple of $0.05.
- Maximum Copayments below the Out-of-Pocket Threshold for certain Low Income Full Subsidy Eligible Enrollees: From $2.50 per generic or preferred drug that is a multi-source drug, and $6.30 for all other drugs in 2011, and rounded to the nearest multiple of $0.05.
- Deductible for Low Income (Partial) Subsidy Eligible Enrollees: From $637 in 2011 and rounded to the nearest $1.
- Maximum Copayments above the Out-of-Pocket Threshold for Low Income (Partial) Subsidy Eligible Enrollees: From $2.50 per generic or preferred drug that is a multi-source drug, and $6.30 for all other drugs in 2011, and rounded to the nearest multiple of $0.05.

The entire 153-page notice can be downloaded at:
http://www.cms.gov/MedicareAdvtgSpecRateStats/Downloads/Advance2012.pdf

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CMS Shows Increase in Quality Reporting Participation

EPRESCRIBING AND QUALITY REPORTING INCENTIVE PROGRAMS PAY OUT MORE

The Centers for Medicare and Medicaid Services (CMS) released a report indicating more participation in two key "pay-for-reporting" programs. CMS's 2009 Physician Quality Reporting System and ePrescribing Experience Report showed an increase in the amount of practices and EPs with satisfactory reporting since the programs began in 2007.

Participation in the Physician Quality Reporting System (PQRS) has grown at about 50 percent every year, on average. "On average, 2009 bonus payments for satisfactory reporters in the PQRS were $1,956 per eligible professional and $18,525 per practice," according to the report. Also, the numbers for the ePrescription 2009 payments were over $3,000 per EP and $14,501 per practice.

The reporting programs are designed to better measure indicators of quality care. Currently the PQRS reports 194 measures commonly associated with higher quality of care, such as providing preventative services.

The full report is available at:
http://www.cms.gov/PQRS

Rules Proposed for Accountable Care Organizations

MEDICARE SHARED SAVINGS PROGRAM INTENDS TO IMPROVE QUALITY AND REDUCE COSTS

The Centers for Medicare and Medicaid Services (CMS) announced the proposed rules for determining the quality incentives for Accountable Care Organizations (ACOs). The Medicare Shared Savings Program (MSSP) is a program of payment for ACOs that rewards quality care and lower heath care costs.

ACOs, which were mandated by the Patient Protection and Affordable Care Act (PPACA), are organizations composed of several doctors, hospitals, or other providers working together as a group to provide complete care. Medicare beneficiaries would not sign up for a specific ACO; they would go to their normal providers who would receive MSSP incentives based on the performance of the ACO they are participating in. Providers are required to notify beneficiaries that they are participating in an ACO. Providers would also have to disclose that the patient's information would be shared with other members of the ACO, to better coordinate care. At this point, the beneficiary can either opt in or out of the data sharing agreement.

While a provider will usually recommend a patient to another specialist in their ACO, they cannot require the beneficiary to seek care there. The intent is to coordinate care while still giving the Medicare beneficiary complete control over their health care options.

Under the proposed rule, members of ACOs would first have to set an initial benchmark for determining quality of care. Providers would be required to report quality measures to CMS.

The MSSP will be implemented January 1, 2012. CMS has proposed 65 quality measures spanning 5 categories: Patient Experience of Care, Care Coordination, Patient Safety, Preventive Health, and At-Risk Population/Frail Elderly Health. CMS is currently taking comments on the proposed measures.

For a .pdf file of the April 7 Federal Register Notice, visit:
http://www.gpo.gov/fdsys/pkg/FR-2011-04-07/pdf/2011-7880.pdf

What if the PPACA is Declared Unconstitutional?

TAKING A LOOK AT THE PAST TO PREDICT THE FUTURE

Right now, a major concern on everyone's mind is what exactly will happen if the Supreme Court strikes down the Patient Protection and Affordable Care Act (PPACA). Will electronic health record (EHR) incentives still be paid out? Will primary care physicians still receive their extra incentive payments? Most importantly, will funds already paid out under the Act have to be given back, and what if they have already been spent?

These questions have a major impact on how medical practices plan their businesses. Medical managers and physicians need to know these things now, while they are investing all of this money into things like EHRs with the promise of incentives and reimbursements later. Unfortunately, the government doesn't have a satisfactory answer. However, if we look at the history of U.S. legislature, and when similar laws have been struck down, we can at least hedge our bets and have a better idea of the specifics of this possibility.

As far as legislation goes, the PPACA greatly resembles the Franklin D. Roosevelt, New Deal laws passed in the 1930's. From a legal standpoint, it most resembles the Agricultural Adjustment Act (AAA) of 1933, which was later declared unconstitutional in the court. Furthermore, the law went back to Congress and was changed and passed as the AAA of 1938, which the courts later upheld.

The good news is that there were no "take-backsies." Funds paid out and actions taken under the act stood, but actions planned after the courts struck down the law didn't occur. Specifically, the law called for destroying a certain amount of crops to drive up the price of agriculture, and they couldn't exactly turn a pile of ashes into a truckload of corn. However, physicians should be wary, because if the Supreme Court does decide to strike the law down in 2012, then funds that would have been paid in 2013 will not show up.

To get a more accurate barometer of whether the PPACA will stand, the Judge who declared the whole law unconstitutional needs to be considered. Judge Vinson's 78-page opinion stated quite clearly that the Individual Mandate (requiring everyone to buy health insurance or pay a fine) was unconstitutional. Vinson also ruled that the Individual Mandate could not be severed from the rest of the act, so the whole law must therefore be declared null and void.

Vinson cites the 1942 case, Wickard v. Filburn, where the 1938 AAA was upheld. The Supreme Court's ruling in this case greatly increased the Federal government's power under the Commerce Clause, the same clause being used to defend the PPACA. In Wickard, the Supreme Court ruled that even if the economic activity was expressly intrastate (Wilburn wanted to use his excess wheat for consumptions on his farm), its effect on interstate commerce

was palpable. Specifically, by consuming his own wheat Filburn was eliminating a demand that would have been otherwise filled by someone else's wheat, directly affecting the market price of wheat in interstate commerce (however minutely).

A similar argument is being used to defend the PPACA, but with one key difference. Vinson explains that while the precedent set in Wickard v. Filburn allows the government to regulate economic activity, the choice to not buy health insurance is inherently inactivity. Vinson reasons that if the government was allowed to regulate both activity and inactivity, there would be no constitutional limit on the legislature's power. In reality, it would be completely constitutional to pass a law requiring every citizen to buy a pound of bacon per week, or even watch no more than an hour of television per day.

The other main question posed by Vinson is whether the other measures of the PPACA, like the EHR incentive payments, could remain in effect without the individual mandate. It should be noted here, that originally there was a severability clause in the PPACA, which would have explicitly allowed certain parts of the law to be struck down while saving other parts. However, Congress deliberately chose to remove this clause. This does not necessarily imply that the individual mandate is not severable, but Vinson used this as an indication that severing the clause would change the legislature's intent, thus making it not severable and the whole PPACA void.

It is not clear whether the Supreme Court, even if they strike down the individual mandate, will declare the clause severable. The Supreme Court has powers that the lower courts don't have, so it's hard to tell for certain what actions they will take. But it should be noted that there is a very real possibility that the whole law will be struck down, and medical practices need to be prepared.

It is also possible that if the PPACA is struck down, Congress will rework the law and get a later court to uphold it, like in the case of the 1938 AAA. However, this could take years, and the new law might (and probably would) look very different from the original. If your practice is planning on sinking a lot of money into one of these programs while depending on future incentives, the sooner you get started the better. It is unclear when the Supreme Court will see this case. The more time you have between now and then, the more payments you can potentially receive under the PPACA, no matter what the court decides.

Senate Confirms US Rep to the WHO

DR. NILS DAULAIRE, ELECTED TO WHO EXECUTIVE BOARD

"I intend to be a force for change and modernization of WHO..."

April 14, 2011, marked a rare day in Senate history: a unanimous vote. Everyone present approved Dr. Nils Daulaire MD, MPH, as the U.S. Representative on the Executive Board of the World Health Organization (WHO).

"Understanding the critical role that WHO plays," Dr. Daulaire said in a statement to the Senate Foreign Relations Committee, "I intend to be a force for change and modernization of WHO – an institution formed more than sixty years ago that in many ways still reflects an earlier world."

Dr. Daulaire is also the Director of the Office of Global Health Affairs for the Department of Health and Human Services (HHS). Before that, he was president and CEO of the Global Health Council, an international non-profit membership organization. He worked with a cornucopia of organizations across international boarders to improve public health in the world's poorest communities.

Dr. Daulaire graduated summa cum laude and Phi Beta Kappa graduate of Harvard College, Harvard Medical School, and the Johns Hopkins School of Hygiene and Public Health. He also speaks seven languages.

CODING CORNER

The most asked questions this month

Q: If you would, please explain the new G codes to me. We have G0438 and G0439 as new Annual Wellness Visits. Are these new to add? Are we to code the initial "Welcome to Medicare" visit this way? What is a subsequent visit? It is my understanding that the "Wellness Physical" is not the same thing. Can you please shed some light on this confusing issue?

A: Regarding new G codes G0438 and G0439 - these codes are to be added and used for services that carry an A or B rating from the US Preventative Services Task Force (USPSTF). The initial welcome to Medicare visit (aka: IPPE) is completely different. Beneficiaries are eligible for Annual Wellness Visit (AWV) 12 months after the IPPE. A subsequent visit is any visit (following the initial) for the same problem.

Q: Can I code the image-guided technology if used with a sinusotomy as mentioned in the manual?

A: To ascertain this information, you will first want to consult the Correct Coding Initiative (CCI) Edits. These edits are updated quarterly by CMS and will indicate whether a service is to be considered bundled within another service. It will also indicate the chances of unbundling the service if you deem one identifiably separate from the other. If you don't have this resource, depending on the code, the CPT may also direct you as to whether the image guidance can be reported separately, or possibly direct you to another code that encompasses all that was done.

Q: Could you please direct me to where I might find the allowable amount for the new Flu Zone high dose code 90662?

A: Medicare published the reimbursement for 90662 at $29.21.

Q: Coding preventative vs. problem-focused visits has been at debate in our practice for some time. When someone comes in every 6 months for stable chronic problems (refills, etc.), we have always viewed this as being a problem focused visit. Some are looking at this now as being a preventative visit stating they are stable therefore it's not a problem. The majority of these patients are geriatric with Medicare. They're not even using the new wellness code established by Medicare. Could you give me some input on this?

A: In order for the encounter to be considered a "defined preventative service" it must carry an A or B on the US Preventative Services Task Force (USPSTF). A pocket guide can be found at www.MBJonline.com for your reference. To indicate these services there are also two modifiers; PT for Medicare patients and new CPT modifier 33 which is considered the commercial carriers version of the same - these are more for indication purposes as they really have no relevance for coding since they do not alter the procedure's definition.

Spring Quarter 2011 Online Programs

Modifiers: How to Communicate Changes & Get Your Doc Paid - 4/20/11 & 6/8/11
Reduced reimbursement is always lurking; understand how to properly use modifiers to communicate what exactly was performed. We will discuss the proper use of the most popular modifiers, the modifiers that are hot for summer and don't forget those modifiers we often overlook.

The Appeals Process: The Rules & The Unwritten Rules - 5/04/11 & 6/22/11
You got to know when to start and, you got to know when to stop. This session covers the important steps to the Appeals process, as well as tips on how to keep the process running smoothly and how to determine if you've run into a wall.

ICD-10: Fundamentals - 5/18/11
This session outlines the guidelines to the ICD-10 as we know it today. We will also discuss how it relates to the currently used ICD-9 and the how to prepare for them now.

HIPAA, HIPAA, HOORAY: Staying Compliant in the Non-Compliant World - 6/8/11
How to pleasantly stay compliant in the everchanging world of compliance.
Being compliant doesn't mean you have to constantly walk on eggshells. Know what to know and get tips on how to tighten up those loose ends. Anyway you slice it, staying compliant saves everyone time and money.

2012 Forecast for Coders & Managers Part 1 - 6/22/11
Call for sunshine with a chance of disgruntled pharmaceutical companies. This session will cover proposed changes and regulation enhancements, thus far, that are up for 2012. We will discuss code set freezes and the looming ICD-10 deadlines. See what's on the horizon for the new year!

**Archived Copies of the class will be available to students who cannot attend or missed the live scheduled class.*

25 YEAR ANNIVERSARY

These are the online, live seminars for Spring Quarter 2011. You can take all of the classes on a regular computer, or participate in the optional iPad program. The iPad program will reduce cost in the long run. The Institute is developing free coding and management resources for the device. The online seminar classes are designed for the working health care professional. Therefore, the school records each live seminar; if you miss a class, you can access it when you have the time! Each course contains an optional CEU quiz which you can access at your convenience.

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