



Medi-Data Service, Ltd

Quarterly Newsletter
July 2009 - Third Quarter

Illinois General Assembly Approves 50-Percent Budget Cut

Changes to Expect

By: Alison A. Spooner

Illinois Department of Healthcare and Family Services reported in its June 17, 2009 Informational Notice, that the General Assembly recently approved a “50-percent budget” for the twelve month period that went into effect July 1, 2009. The fiscal year 2010 budget underfunds a long list of vital services and programs which include the medical assistance programs administered by the Department. One can expect to see reductions in the following programs:

- The Illinois Cares Rx program, paying for the pharmacy bills of nearly 200,000 seniors and people with disabilities.
- The Allkids expansion program, and the Allkids Rebate program, paying for providing care to over 73,700 children not otherwise provided medical coverage under Medicaid or CHIPRA.
- The Renal, Hemophilia, and Sexual Assault Survivors programs, covering specialized care for nearly 1,500 people.
- The General Assistance medical program, paying for healthcare for nearly 8,600 adults in Chicago.

Even with these cuts, the budget as passed will mean an increase in the time length the state has to pay certain providers - in some cases adding more than 200 days to the amount of time the state takes to make payments for services rendered. The budget does allow the Department’s medical assistance providers to be paid in 30 days or less.

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Preventing Identity Theft With Red Flag Rules

Get Your Prevention Program in Place Today

By: **Alison A. Spooner**

Make sure that you have your Identity Theft Prevention Program in order and you have successfully trained your staff on identifying potential Red Flags. Listed below are helpful points you will need to know about Red Flag Rules.

What Are Red Flag Rules - The Red Flag Rules require providers to create and administer a written Identity Theft Prevention Program. Providers are required to have this program in place by **August 1st, 2009**. Failure to do so could result in a penalty of up to \$2,500.00 per violation of the rule.

How Do Providers Comply - To be in compliance with Red Flag Rules, providers must enact policies and procedures that will identify, prevent and mitigate identity theft.

Refer to the following links for more information on the Red Flag Rules:

<http://www.ama-assn.org/ama/no-index/physician-resources/red-flags-rule.shtml>

<http://www.ftc.gov/bcp/edu/pubs/business/alerts/alt050.shtm>

By identifying red flags in advance, you'll be better equipped to spot suspicious activity when it arises and know how to take preventative steps to avoid a red flag from escalating into a costly episode of identity theft.

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Medicare Recovery Audit Contractors:

What You Need To Know

By: **Alison A. Spooner**

The Medicare Modernization Act of 2003 established the Medicare Recovery Contractor (RAC) program as a 3 year demonstration from 2005-2007. The RAC demonstration was established to identify and collect on perceived overpayments and underpayments to providers. During this demonstration the RACs were able to collect over \$990 million in overpayments from providers in New York, California and Florida. In The Tax Relief and Health Care Act of 2006 (THRCA), the RAC program was made permanent and directs HHS to expand the RAC program to all 50 states by January 1st, 2010.

What can MDS clients expect: MDS clients can expect to see medical record requests produced by RACs, practices will be audited and refunds will be getting issued. Trained staff at Medi-Data Service, Ltd. are prepared to assist clients in which case an audit is being performed. Full cooperation is required from the physician's office in order for Medi-Data Service, Ltd. to provide adequate preparation and support for such audits.

It is important that providers know and understand that RACs have the ability to analyze claims with payment dates that date back as far as October 1, 2007.

The CMS has divided the United States into 4 geographic regions with a single RAC serving each region and performing the recovery audit services for that designated region. CGI Technologies and Solutions, Inc. has been reported being the RAC for Illinois. Illinois claims are scheduled to be available for RAC review beginning in August 2009.

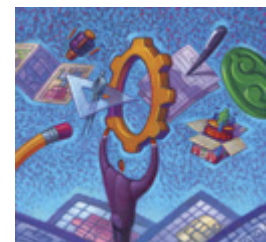
Refer to the following link for more information regarding the Medicare RAC Program:
http://medicareupdate.typepad.com/medicare_update/recovery_audit_contractors/

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Put a Plug in It!

Tips for Capturing Money that Slips through the Cracks
By Melody W. Mulaik, MSHS, PCS, FCS, RCC

It's no revelation for me to state that in today's economy you can't afford to let any revenue slip away. Whether the economy is good, bad, or otherwise, as business owners we can never afford to spend too much and collect too little. So let's focus on a few key processes that you should review to ensure that you aren't losing money through cracks that you can easily plug.



Advance Beneficiary Notices (ABNs)

An Advance Beneficiary Notice of Noncoverage (ABN) is a written notice that the provider gives to the patient when the provider believes that Medicare will deny payment for a service because it is not medically necessary. The ABN gives the patient the opportunity to choose whether to receive the service or not. If the patient chooses to receive the service and Medicare does not pay, the patient is responsible for payment.

If you bill for any specialties where Medicare patients may not meet medical necessity guidelines, it is important that the facility utilize ABNs appropriately *and provide that information to you* so that you may bill the patient for the services.

If the provider does not give the patient an ABN, the provider cannot bill the patient for any services that are denied by Medicare due to medical necessity. Proper use of ABNs is very important in many specialties, such as radiology. Many imaging facilities and radiologists experience high rates of medical necessity denials related to imaging exams that were performed for non-covered diagnoses.

For example, in radiology, ABNs are most often used in the following situations:

- **An exam is ordered for a condition that is not covered under the Medicare Local Coverage Determination (LCD).** Unless a covered condition is discovered during the exam, this exam will be denied as not medically necessary. For example, an MRI of the brain is ordered due to headache (784.0), which may not be a covered code under your LCD. Unless the exam reveals a covered condition that caused the patient's headache, the exam will not be paid.
- **An exam is subject to frequency limitations.** For example, screening mammograms are covered by Medicare on an annual basis. If the patient's last screening mammogram was less than a year ago, the current mammogram will be denied.

ABNs can also be issued for services that are excluded from Medicare coverage by law. Examples of these statutorily excluded services include routine physical exams, most screening tests (other than covered tests like screening mammograms), cosmetic services, routine dental and vision services, etc.

Providers are not required to issue ABNs for statutorily excluded services. Every beneficiary has already been notified at the time of Medicare enrollment that these services will not be covered. However, providers are permitted to issue an ABN for a statutorily excluded service to remind the patient that Medicare will not pay. By using the ABN, the provider can make sure the patient understands that the service will need to be paid out of pocket or by a secondary payor.

An ABN cannot be issued after the exam has already been performed, or when the patient has already been prepped and is about to begin the exam. The ABN must be provided far enough in advance that the patient has time to consider the options. The imaging facility can issue an ABN that covers both the technical component and the professional component of the imaging exam. For example, a hospital can issue an ABN that also covers the radiologist, even though the radiologist's professional services are not billed by the hospital. In this situation the radiologist's contact information should be included on the ABN.

ABNs are particularly challenging for billing companies because there must be a process in place to inform the billing staff that an ABN has been obtained for a particular service. This notification will allow the billing staff to submit the claim to Medicare with a correct modifier and subsequently bill the patient. Without proper notification and modifier application, the patient cannot be held financially responsible. When this occurs your client has provided a free service, and in most cases you will not be reimbursed for your time either.

Detailed instructions for the use of ABNs are available on the Beneficiary Notice Initiative page of the CMS website www.cms.gov/bni. All of this information should be carefully reviewed to ensure compliance with Medicare requirements.

Electronic Medical Records (EMRs)

Many organizations have moved to Electronic Medical Records to streamline and store their patient information. If your physician has an EMR, or works at a facility that is utilizing this technology, it is vital that your staff have access to the patient information.

I would argue that one of the main reasons that claims being processed by third party billing companies do not get paid is lack of proof of medical necessity. Incomplete information provided to and by physicians impacts diagnosis code assignment, and this frequently results in denials and rejections by payors. If the coding staff could retrieve patient information in a timely manner on the front end before the claim is filed, potentially there could be a decrease in medical necessity denials.

Use of modifiers

Without getting into specifics about any one particular modifier, I raise this issue just as a reminder that modifiers can be as important as procedure codes. Because of their importance, they should be assigned with care. Modifiers that affect reimbursement, such as modifier 59, should never be routinely or automatically appended.

Conversely, there are many situations that warrant the assignment of a modifier and to not do so potentially forfeits due revenue. It is important to remain current on the latest CPT® guidelines regarding modifiers; and it is equally important to become familiar with federal and commercial payors' guidelines. Claims that include modifiers should be monitored until you have determined a pattern of how their use affects payment.

Reviewing Rejections/Denials

No matter how much attention you pay to front-end coding and billing operations, you will receive payor denials and/or rejections. Your handling of these situations can impact your revenue stream tremendously. Sometimes I think certain payors deny claims just to see how badly you really want to be paid!

Every organization must have a plan in place to address payor denials. Inaction is equivalent to surrender, which translates into no reimbursement. Look at your follow-up policies and procedures and do a quick operational review to ensure that your staff is following them. What is on paper does not always match what is occurring. A little bit of time in this area can go a long way to ensuring that money is properly collected.

There are many other areas that we could discuss to ensure that you are not missing revenue for yourself or your clients. I encourage you to always be willing to look beneath the surface, challenge the status quo for your operations, and be open to new approaches to old problems. You can stop the flow of money slipping through those cracks.

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Spring Office Cleaning

Time to Clear Out the Dead Wood

By David F. Jakielo, CHBME

First the Bad News: The economy is tanking and unemployment is rising.

Now the Good News (for some): Unemployment is on the rise and that is good for our industry and your company. There is an abundance of extremely talented people looking for new jobs and or careers.

Given the pool of new talent that is available, now is a good time to upgrade your staff and improve your company for the long term. Have you been putting up with “warm bodies” because you needed employees? Just a few years ago it was difficult to attract and retain qualified employees; many companies, in a panic for workers, lowered their hiring standards and may have hired marginal candidates just to fill open positions. Those employees have become the dead wood on your payroll.

In the past, when asking managers about their staff, more than once I have heard them say, “Well a marginal employee is better than no employee,” or “I know she has a bad attitude but at least she shows up everyday.” Wrong.

Compromising your standards by hiring and maintaining the wrong person on your team can lead to:

- Lower productivity throughout your entire operation because others are affected by an underperformer
- Your best employees leaving the company because they feel underappreciated for a job well done, knowing you tolerate sub standard staff members
- Negative employees becoming a major disruption and pulling everyone else down with their poor attitudes.

These economic hard times offer an excellent opportunity to clear out the dead wood and upgrade your team. You needn't fear discussing the need for a change in behavior or attitude with a problem employee because his or her replacement is standing in line for the job.

At times I've heard managers say, “Well I can't get rid of George he's been with me for years.” But if George is disruptive to your organization you owe him nothing. You have provided him with income and opportunities and he has repaid you with lousy performance or a bad attitude.

Now I'm not telling you to walk in on Monday and fire George; but if you've had candid conversations with him about his poor performance or attitude and he's shown no improvement, then it's time to free him up for other opportunities. Think about it: if you remove him from your company, you'll win twice. First the attitude of every employee will improve because Grumbling George is gone. It's like removing a splinter from under your fingernail. Secondly, he may end up working for your competitors—and his disruptive behavior will be *their* problem.

Recruiting Tips

Now for the fun part—recruiting. Remember the first quality you are looking for in candidates is a positive attitude, which is more important than a mountain of experience. In the billing industry, experience is highly overrated because no two companies handle billing the same way. You can teach someone how to do accounts receivable follow-up, but you can't teach people to have a positive attitude.

Here are some other hiring tips to keep in mind:

- Test applicants for the skills sets you require, such as coding, keyboarding, answering the phone, etc. Don't take a person word when particular skills are integral to the position.
- Administer an assessment profile to determine the candidate's attitude, work ethic, integrity etc. This will help to ensure he or she will be a cultural fit for your organization.
- Make sure you interview everyone *three* times and have *three different people* conduct the interviews. This is important because by the third interview, the candidate will assume he or she has the job and you'll meet the real person behind the façade.

Today finding candidates is easy. Check with personnel departments of companies in your area that have been downsizing. Almost every company that has laid off employees has some type of outplacement service and can point you in the right direction to locate the qualified candidates.

So take a look at the dead wood in your office. If you have a person whom you would not rehire today, knowing what you now know about them, it is time for a little Spring office cleaning.

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