THE LEADING EDGE

Radiology

Billing Technology Results

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WELCOME

David H. Langsam, President & CEO

Welcome to the second issue of the AHS Newsletter, now called "The Leading Edge." As you recall, we asked for name suggestions for the AHS newsletter in the first issue and offered a $150 prize to the person who suggested the winning name. That person turned out to be Dennis Stine in our Chambersburg Office. Congratulations to Dennis: you can read more about Dennis on page 2.

Given the time of year, much of this issue of The Leading Edge focuses on changes coming in the new year. There are always coding and other changes, as described in the insights section. With all of the attention on healthcare reform, we've provided an article highlighting some of the impacts. Plus an article about the "RAC" audits which are gaining increasing attention and notoriety. Every practice needs to be aware of these audits and how to respond if a request is received.

You will also read about an intrepid team from our Portland office who made a bicycle trek across the state of Maine on behalf of the American Lung Association.

It has been an eventful year at AHS with the addition of two new offices and many new clients and employees. But our main focus remains on meeting each client practice's needs. We strive to do that every day by focusing on consistent and strong collections, useful information available to you anytime, compliance, and client-first service. Thank you for making 2010 so successful!

Please let us know what topics you would like to see included in future issues of this newsletter: email Bill Gilbert (bgilbert@ahsrcm.com) with your suggestions.

As the year draws to a close, I want to offer my personal thanks for your business this year and wish you and your family a great holiday season and a healthy, happy new year! It's been an exciting year for all of us at AHS and for our clients. We hope next year is even more profitable for your practice and more rewarding for you personally.

David Langsam, President and CEO

AHS PROFILE: STATEN ISLAND

Located on Edgewater Street in Staten Island, with an awe-inspiring view of New York Harbor and the lower Manhattan skyline, is AHS New York; the foundation and original processing center of the rapidly-expanding AHS. Often referred to as Staten Island (and sometimes as "the rock"), the office was established in 1999 to serve AHS' first client and has grown to serve many hospitals and physicians during the past eleven years.

The New York office serves hospital-based practices with hundreds of physicians ranging from internal medicine to radiology, with cardiac surgery as one highlight.

This multi-specialty focus is driven by clients such as Staten Island University Hospital and SUNY Downstate, large teaching institutions that have most specialties on staff. As a result, the New York office is proficient with a large list of specialties, including emergency medicine, hospitalist, Ob/Gyn, pediatrics, oncology, physical therapy, gastroenterology, cardiology and many more.

The New York office started in 1999 on Virtual Manager and today serves as a reference for new AHS offices as they adapt their office to the AHS technology. AHS experience with complex hospital systems and interfaces has been developed and honed with New York clients and staff members.

The New York office has more than 50 associates serving its clients; client management services are provided by Tracey Devito.

Of historical note: the entire AHS company started in Staten Island. The corporate team including founders Jeanne Gilreath and Manny DaSilva were in Staten Island until about four years ago when the Warren office was established.

For more information about the New York office and the services offered, please contact Ray Cassidy, Senior Vice President Operations.

WHEN IS IT NECESSARY TO CHANGE A MEDICAL RECORD AND WHY SHOULD THE PROVIDER AND PATIENT CARE?

In the last issue, we described a number of reasons why a medical record needs to be accurate and the various types of corrections that can be made. An additional reason that the patient's medical record must be accurate is the consumer reporting agency, Medical Information Bureau Group, Inc. (MIB). MIB is a "trade association" for approximately 470 insurance companies (health, life, disability income, and long-term care) in North America. It collects the following information which remains on file for seven years from the time the information is collected.

- Credit information
- Medical conditions
- Medical tests and results
- Habits such as smoking, overeating, gambling, drugs
- Hazardous avocations and hobbies
- Motor vehicle reports (poor driving history and accidents)

If any of its member insurance companies have requested your file in the previous 12 months that will be listed with your records. All of this data is collected and used by member companies to evaluate their risk of insuring consumers.

As a consumer you are entitled to access your personal information once each year at no cost, by calling 866.692.6901.

Before you call MIB there are a few things to know: MIB will not have a consumer file (consumer report information) if you have not applied for individually underwritten life, health, or disability income insurance during the preceding seven year period.

MIB will ask you for personal identification information to assist them in locating a consumer file, if one exists. MIB may validate the identification information that you provided with other consumer reporting agencies.

You will be asked to certify under penalty of perjury that the information you provided about yourself to request disclosure of your MIB consumer file is accurate, complete and you represent that you are the person that is requesting disclosure.

DENNIS STINE NAMES THE AHS NEWSLETTER!

The newsletter naming "contest" described in David Langsam's welcome to the first issue drew nearly 40 creative suggestions representing all of the AHS locations. In late November, all of them were listed on a chart and reviewed by the AHS management team. After some discussion, the group converged on "The Edge", suggested by Dennis Stine from the Chambersburg office. Subsequent discussion modified it to "The Leading Edge," which was not on the original list. Since Dennis was the originator of the winning name, he was awarded the $150 prize.

Dennis has been an employee of AHS for over 3 years. He holds a degree in Computer Network Systems and is a member of the AHS IT Team. He works in the Chambersburg office supporting fellow employees and clients alike. As a personal interest he enjoys video games and is an avid video gamer. His prize was a $150 gift certificate to his favorite video game store.

Congratulations Dennis!

DID YOU KNOW?

OUR PROMISE
TO EACH CLIENT

More Money, Faster
Compliance, Built-in
Practice Financial Data Anytime, Anywhere
Client First Service

ahs

- AHS files claims for its clients with more than 1.5 billion dollars in charges!
- AHS offers practice management services like accounts payable, payroll, HR services and more?
- AHS recently installed an IBM Power 750 mainframe now supporting all Virtual Manager users.
- 5010 is coming!

CLIENT QUOTES/TESTIMONIALS

"I previously worked for a billing company. Therefore, I knew exactly what I wanted when looking for a billing company for our new surgery center. After a nationwide search, I chose AdvantEdge Healthcare Solutions. The startup was well-planned and well-executed. I am very pleased with my decision to partner with AHS."

IN THE NEWS

- In November, AHS was named as one of New Jersey's "50 Fastest Growing Companies."

- Jeanne Gilreath was quoted extensively in the November issue of CAP Today in an article about "Assessing the Security Practices of Third Party Billing Firms."

- An article by Brice Voithofer and Bill Gilbert on"Four Key Steps to Improve ASC Billing and Increase ASC Collections" was published on Becker's ASC Review web site in late November and is expected to be included in an upcoming issue of Becker's ASC Review magazine. The article is an outgrowth of a presentation by Bill and Brice at the Annual ASC Conference in October.

- Effective in January, Jeanne Gilreath is leading the HBMA Commercial Payor Relations Committee: Congratulations!

- Becker's ASC Review just named Brice Voithofer as one of the "People to know in the ASC Industry." Congratulations!

CALENDAR

Jan 3 – New Year's Day Holiday (AHS closed)

Jan 17 – Martin Luther King, Jr.'s Birthday Holiday (AHS closed)

Jan 28-30 – American Society of Anesthesiologists Conference on Practice Management, Houston (AHS Exhibiting)

Feb 21 – President's Day Holiday (AHS closed)

March 20-23 – MGMA Anesthesia Administration Assembly, Baltimore (AHS Exhibiting)

FEATURED EMPLOYEES

Six AHS employees participated in the Trek Across Maine, a cycling event that benefits the American Lung Association. On a beautiful weekend in June, Andrea Edwards, Penelope Andriakos, Doug Reed, Chris Greenwood, Al Carpentier, and Lee Larson got on their bikes in the western Maine town of Bethel and ended two days later in the seacoast town of Belfast, Maine. The Trek covered 180 miles of scenic countryside and included almost 2000 riders, making it one of the largest events of its kind. More importantly, riders raised over $1,600,000 for the ALA. The six riders from AHS raised over $3,500 for research, education and advocacy to promote lung health and prevent lung disease.

The AHS cycling team, dubbed the **Twisted Sprockets**, are looking to add members to the team, so if you're interested, please contact Al Carpentier at acarpentier@ahsrcm.com.

Health Care Reform

The "Affordable Care Act" (ACA) and related legislation and regulations implement a wide array of changes during the next few years. The last issue of the newsletter provided a timeline for key provisions. In this issue, we describe a few of the changes.

High Impact Changes for 2011
Health insurance companies will be prevented from rescinding policies and can no longer have a lifetime limit on benefits. Exclusions for children pre-existing conditions are no longer allowed. And children with pre-existing conditions can now be carried on their parents' policy to age 26.

Medicare will now cover, with no cost sharing, an annual wellness visit. Medicare will have no patient fee (copay or otherwise) for a long list of preventive services. Some examples include cholesterol tests for all men and at-risk women, depression screening, obesity screening, weight-loss counseling, and colorectal cancer screening.

In 2011 Medicare part D patients affected by the so-called "donut hole" (prescription drug costs between $2830 and $6440) will get a 50 percent discount on brand-name prescriptions and a 7 percent discount on generics. After 2011, the discounts get larger until patient costs are 25 percent for all drugs in 2020.

Demonstration Projects and Pilots
Over one hundred demonstration projects, pilot programs, and grants are chartered by the ACA. Demonstration projects run for a limited period of time whereas pilot projects can be "scaled up" without congressional action if determined to be successful.

Pilots include a national pilot program on payment bundling; one on healthy aging; an evaluation of community-based prevention and wellness programs for Medicare beneficiaries; and Pilot testing pay-for-performance programs for certain Medicare providers. Certain other initiatives, such as ACO's, are often referred to as pilots though they are technically chartered in a different way.

There are more than 50 demonstration projects including malpractice, bundled Medicaid payments, bundled Medicare payments, quality improvement, reporting and research on outcomes, long-term care, management of chronic conditions, and primary care expansion.

This decentralized approach to innovation is designed to put responsibility into the hands of doctors, nurses, patients, employers, and other community and state leaders who are most affected by the problems that health reform is working to solve.

Many projects incent multi-stakeholder partnerships between government and local health care leaders so each can learn from the other about what is feasible given budgetary, personnel, and other constraints. The aim is to generate solutions that can be replicated by other states and medical providers across the country. [1]

Innovation Center
In addition to the pilots and demonstrations, the ACA established the Center for Medicare and Medicaid Innovation (CMI). The stated purpose of the CMI is to test innovative payment and service delivery models to bring about a reduction in Medicare and Medicaid program expenditures while preserving or enhancing quality of care.

Aimed at improving care coordination, the first initiatives of the Innovation Center are:

- An eight-state multi-payer medical home demonstration
- A new medical home demonstration involving Federally Qualified Health Centers (FQHCs)
- A new state plan option allowing states enhanced Medicaid funds for placing certain beneficiaries in health homes
- An opportunity to improve care for beneficiaries eligible for both Medicare and Medicaid, also known as "dual eligibles"

Accountable Care Organizations (ACO's)
One of the items in healthcare reform getting a huge amount of industry attention is the accountable care organization (ACO). The ACA establishes a Shared Savings Program under both Parts A (hospital) and B (physician) of Medicare to improve the quality and efficiency of the healthcare delivery system, to be effective no later than January 1, 2012. At the most basic level, an ACO is a mechanism for healthcare providers to participate in the Shared Savings Program. Technically, ACOs may be created by group practice arrangements, by networks of individual practices, by partnerships or joint venture arrangements between hospitals and physicians, by hospitals employing physicians, or by other groups of providers specified by CMS.

An ACO will be assigned a group of Medicare patients and must participate in the Shared Savings Program. The ACO will be eligible for additional Medicare payments when performance guidelines are met and cost-savings targets are achieved. The additional payment will be a percentage of the projected savings to Medicare.

Recently, CMS Administrator Don Berwick, MD, described his view of ACO objectives:

- Reduce dependence on hospitals.
- Using a proactive approach, ACOs will advance ways to help people stay healthy.
- Use a rich trove of healthcare data; i.e. data-driven approaches such as patient registries.
- Take an innovative approach: "We want to help integrated care thrive in America."
- Maintain and execute plans:"I don't view the ACO as primarily a financing mechanism."

Many hospitals, health plans, and some physician groups have started to work on a host of ACO "pilots" across the country. But this has been in advance of the specific rules and requirements, the first version of which are expected to be published in January. The recent trend of hospitals to acquire additional physician practices has been driven, at least in part, by the ACO model. Some industry observers think that the rush toward ACO's is premature until the ground rules and funding mechanisms are more clearly understood. For example, recent discussions have suggested that ACO's could be exposed to cost penalties as well as incentives.

[1] Funding Opportunities in the Affordable Care Act (P.L. 111-148), Pilot Programs, Demonstration Projects, and Grants; Center for Health Law and Economics, UMass Medical School

AHS BenefitsEdge

Open enrollment is over, but don't forget you can access AHS BenefitsEdge all year to verify or update personal information or benefits elections (if you have a qualifying event such as marriage or birth of a child). You can also access other HR information such as the Employee Guide, payroll and holiday schedules, and company expense report forms. Go to www.crystalconnect.com/ahs, use the standard company login (Login ID: ahsemployee, Password: benefits), and click on the "HR Information" tab from the top navigation bar. Benefit plan summaries and forms are in the "Benefits" tab in this same section.

Click on the "Click Here to Update or Enroll" button on the left side of your screen to access your personal information including your current benefit statement. **If you ever have questions about your benefits or need help with a claim, you may contact our Benefit Service Center at 877.350.9828 or ahsbenefits@fcrystal.com.**

PECOS Referral/Ordering Update

At this time, CMS has not turned on the automated edits that would deny claims for services that were ordered or referred by a physician or other eligible professional simply for lack of an approved file in PECOS. While there have been rumors that the edits will be turned on in January, in fact CMS has not announced any date (January 3 or otherwise) for when the ordering/referring edits will be activated. AHS continues to monitor this issue and will provide an update to clients when there is an official timetable.

Physicians or other eligible professionals not currently enrolled in PECOS, or not sure of enrollment status for their referring physicians, can contact their AHS account manager for ways to verify enrollment or to submit an application.

HIPAA 5010 transactions and ICD-10

5010 represents a new set of transactions between health care providers (including their billing companies) and payers. They will officially go into effect the beginning of 2012 but testing is beginning in January, with CMS already having announced that it is ready to test. AHS is set to begin testing in the first quarter of 2011.

ICD-10 is an entirely new set of 68,000 diagnosis codes that will replace the 13,000 ICD-9 codes in 2013. The magnitude of this change means that preparation work is already well underway, including significant updates to the AHS Virtual Manager technology.

An upcoming issue of this newsletter will provide more detail on both of these major industry changes.

Medicare Deductibles for 2011

For 2011, the Medicare deductible will be $162, up from $155 in 2010. Basic Part B (physician) premiums are increased to $115.40 per month but this rate affects a minority of Medicare beneficiaries. Higher income beneficiaries pay significantly higher rates and other beneficiaries receiving social security for at least three years pay $96.40.

FTC Red Flags Rule

In early December, the House and Senate passed a bill exempting physician practices and ASC's (but not hospitals) from the FTC's "Red Flags Rule" that was due to go into effect January 1. That rule requires businesses to implement written identity theft programs to aid in fraud prevention.

RACS ARE HERE...
and coming to a practice very near you

Recovery Audit Contractors: a term unknown until recently is now taking center stage. RAC's began innocently enough in 2003. New legislation directed the Department of Health and Human Services (HHS) to conduct a 3-year "demonstration project", to see if the Recovery Audit Contractors would be cost effective identifying Medicare overpayments and underpayments and effective at recovering overpayments.

Fast forward to 2006 when Congress made the RAC program permanent in the Tax Relief and Health Care Act of 2006.

In July 2008, CMS released the results of the demonstration project. The "demonstration" identified more than $1.03 billion in improper Medicare payments at a cost of $187 million. It returned $694 million to the Medicare Trust Funds. Ninety-six percent of the money recovered was due to overpayments; only 4% to underpayments. Obviously, the demonstration was declared a success. So much so that health care reform legislation allocates substantially more resources to RAC's and similar audits. This despite much early criticism about the entire process, since the RAC's basically get paid a portion of the monies they identify as overpayments.

In the initial demonstration, most of the recoveries were related to services provided in hospitals and providers weren't too concerned. But now that the RAC's have spent several years working on hospital overpayments and underpayments, and with an expanded remit, the focus is turning towards physicians.

Most experts feel that a practice of any size will be party to a RAC audit, sooner or later. That being the case, what should a practice do? The short answer: BE INFORMED. Let's start with the types of claims/payments the RAC's are looking for:

- Incorrect place of service. Claims received indicating that patient services were rendered in an office setting when the services were actually provided in an outpatient hospital setting.
- Claims submitted for services after the patient's death.
- Duplicate billing for an office visit on the same day the patient is admitted to a hospital and billing for admission services. Both are E&M services.
- Provider billed for patient services after patient entered hospice care.
- Billing incorrect number of "units" for chemotherapy or physical therapy sessions or all at once instead of as they are performed
- New patient versus established patient E&M visits.
- Billing for E&M visits during the "global period" after surgery.

Many healthcare industry experts believe that the RACs will initially focus on specialties typically associated with hospitals, e.g. radiologists and surgeons, etc.

RAC's select specific providers to review using proprietary software to analyze claims for possible improper payments. Once a RAC becomes interested in a data trend and decides to investigate, the RAC will post the issue to its website. Frequently the RAC sends medical record requests to a provider for an issue not yet identified on their website, as a way of validating whether it is worth pursuing. Of course, CMS is at the core of the investigatory work as it is CMS that provides RAC's with a data file containing a provider's claim history. Methods used for this activity are "automated review" and "complex review."

The automated review is done without human intervention when there is certainty that the service is not covered or is incorrectly coded, and there is a Medicare LCD or NCD coding guideline. There is also the "clinically unbelievable" situation not supported by Medicare coding guidelines or articles, where the RAC could request permission from CMS to do an automated review.

A complex review involves human review of the medical record and makes a claim determination that requirements for automated review are not met, or there is a high probability (but not a certainty) that the service is not covered, or there is no Medicare LCD, NCD in support of the RAC's suspicions of incorrect claim submission.

If a practice receives a RAC audit, it has 45 calendar days to respond to the medical records request. It is possible to receive an extension if the request for extension is made within the 45 day window. **Failure to comply within 45 calendar days may lead to an automatic overpayment status by the RAC.**

RAC's are required to report results of automated reviews to providers only if an overpayment determination is made. In the case of a complex review, the RAC is required to report findings to the provider regardless of the determination made by the RAC.

We all know that there are no hard and fast rules in this type of environment. But AHS experience with payor audits similar to the RAC audits strongly suggests that practices with AHS coding, billing and compliance procedures in place have little to fear from the audit findings. At the same time, of course, any audit is time-consuming and a distraction to the practice.

From this experience, here are areas that a practice can review to assure that the RAC's won't find anything significant in their review:

- Provide accurate documentation that supports medical necessity when completing patient charts;
- Make sure your staff understands billing guidelines associated with charts and other patient records;
- Visit your RAC's website often to see what new issues are posted and for other pertinent information.

RAC Contact information:

Region A: Diversified Collection Services
www.dcsrac.com
States Covered: CT, DE, DC, ME, MD, MA, NH, NJ, NY, PA, RI, VT
Telephone: 1.866.201.0580

Region B: CGI
http://racb.cgi.com
States Covered: IL, IN, KY, MI, MN, OH, WI
Telephone: 1.877.316.7222

Region C: Connolly, Inc.
www.connollyhealthcare.com/RAC
States Covered: AL, AR, CO, FL, GA, LA, MS, NC, NM, OK, SC, TN, VA, WV
Telephone: 1.866.360.2507

Region D: HealthDataInsights
http://racinfo.healthdatainsights.com
States Covered: AK, AZ, CA, HI, IA, ID, KS, MO, MT, ND, NE, NV, OR, SD, UT, WA, WY, GU, AS, MP
Telephone: 1.866.376.2319

If you receive a RAC audit notice, please contact your AHS account manager immediately. He or she will immediately involve the AHS compliance officer and other experts to assist in the preparing the proper response.

CODING AND MEDICARE CHANGES FOR RADIOLOGY IN 2011

A number of changes will impact Radiology practices in 2011, including coding changes and RVU changes that impact professional component billing. Facility and global coding and reimbursements are further impacted by changes in utilization rates and other factors.

PROFESSIONAL COMPONENT CHANGES

On the coding front, the most important change impacts CT's of the abdomen and pelvis. Until now, these were coded separately. Beginning in January, when conducted at the same time, new combined codes will be used (74176 without contrast, 74177 with contrast, and 74178 both with and without contrast). The RVU's for the combined studies have been reduced versus the sum of the two separate studies (codes for the separate abdomen and pelvic studies are unchanged and RVU's have actually been increased by approximately 5 percent). For the professional component, the reduction in RVU's is approximately 22 to 23 percent. For global billing, the RVU's have been decreased by 40 to 50 percent, but that also reflects the change in utilization factor and multiple procedure rules (see below).

There are also changes in ultrasound coding of extremities to add a code for more limited tests.

Interventional radiology has numerous code changes with the primary effect of combining related activities (e.g. guidance) into one code. Several common procedures now have one all-inclusive code rather than the component codes used in the past. The net effect is to reduce the total RVU's for these common procedures.

As an example, 64479, the injection of an anesthetic and/or steroid, transforaminal epidural, cervical or thoracic, will now include the CT (77012) or Fluoro (77003) guidance. The 2011 fully implemented facility RVU is 4.10. For 2010, the fluoro or CT guidance could be billed separately. The net effect for this procedure under fluoro guidance is a decrease in RVU's from 4.45 in 2010 to 4.10 in 2011. A reduction also applies to the procedure under CT guidance.

The same procedure but done into the lumbar or sacral level (64483) has similar changes. For 2011, the fully implemented facility RVU is 3.41. In 2010 when done under fluoro guidance the RVU was 3.97.

TECHNICAL AND GLOBAL CHANGES

In addition to the coding changes, a number of other adjustments will impact technical and global radiology

Reimbursement from Medicare. Radiology will be impacted by the "multiple payment reduction rule," an increase in the utilization factor, and CMS review of "Potentially Misvalued Services under the Physician Fee Schedule."

The "multiple payment reduction rule" (MPPR) reduces by 50 percent the technical component for the second and subsequent CT, MR, and ultrasound study of non-contiguous body areas on the same day. Currently, Medicare reimbursement is reduced by 25% for multiple studies on non-contiguous body areas. The Affordable Care Act (ACA) mandated that the 25% reduction be increased to 50%. CMS has subsequently expanded this rule to non-contiguous body areas.

The "equipment utilization rate" affects the technical / global rates for CT, CTA, MR, and MRA procedures, including the combined abdomen and pelvic codes described above. The ACA mandates an increase in the utilization rate to 75 percent, from 62.5 percent in 2010 and 50 percent in prior years. The result is a reduction in the technical component reimbursement by a proportionate amount.

An additional factor impacting on some studies is CMS review of "Potentially Misvalued Services under the Physician Fee Schedule." CMS is using five criteria to identify these codes: codes on the multi-specialty points of comparison list; codes with low work RVU's commonly billed in multiple units per single encounter; codes with high volume and low work RVU's; codes with site of service anomalies; and codes that qualify as "23 hour stay" outpatient services. As a result, several radiology codes have lower RVU's for 2011. Examples include CT of thorax, chest, lumbar and spine plus certain ultrasound codes.

IMPACT ON RADIOLOGY PRACTICES

The net effect of these changes for radiology services is estimated to reduce Medicare reimbursement by three billion dollars over a ten year period. The impact on individual radiology practices will vary based on their patient and procedure mix, with imaging centers likely to see a larger percentage decrease than hospital-based practices due to the MPPR and utilization rate changes.

REFERRING PHYSICIANS (STARK LAW CHANGES)

Stark Law provisions are changing for 2011. These impact physicians who refer patients for an imaging study to a site in which they have an ownership interest. In these cases, the referring physician is now obligated to provide a list of five alternative imaging centers in the same geographic area.

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