

DR. KNOW

We won't change the way you do billing...we'll change the way you do business!

An e-newsletter created by **PLEXUS HEALTH SOLUTIONS, INC.**

INSURANCE CONTRACTS *What To Look For*

A lot of medical professionals do not read the agreements or contracts sent to them by insurance carriers.

Below is a list of issues you should look for and see if your practice can "survive" on what is being offered to you.

- *How many enrollees are currently in your area
- *Is the carrier actively marketing the plan in your area
- *What fee schedule are they offering to you on your "bread-and-butter" codes
- *Are codes not listed in the schedule paid
- *Is medical necessity a factor in denying claims
- *Do they accept the industry standard CMS-1500 form
- *Timely filing limits
- *Can you balance bill the patient for any non-covered services
- *Who is responsible for obtaining referral/authorizations
- *Can you live with the termination time line
- *Is there a preferred physician and hospital network?

INTERSTING TIDBITS *New Column*

According to The Wireless Association:

Americans used 1.8 trillion wireless minutes in 2006.

The 2008, first quarter Correct Coding Initiative (CCI) stats:

- *8,081 new edit pairs
- *2,550 deleted edit pairs
- *93 modifier changes on pairs
- *1,531 duplicate entries
- *2,941 swapped edit pairs^

^=Same edit pair only the column 1 and column 2 assignments have been reversed.

There are now 311,114 active edit pairs and 158,210 deleted edit pairs. (CCI is the bundled coding system that CMS uses to process claims.)

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You can view past issues of this newsletter on our website.

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QUICK & EASY REVIEW *2008 ICD-9 Summary*

On December 13, 2007, Plexus faxed to you the entire listing of new and obsolete diagnosis codes.

Please compare this listing with your current encounter form (superbill) and see if any are applicable to your practice.

Please make any necessary changes to this form prior to January 1, 2008 services being performed.

HOSPICE CARE *New POS Code To Use*

If you have a Medicare patient who is a resident in a skilled nursing facility (SNF) and has opted to change from Medicare Part B benefits to Hospice benefits, you must use the correct modifiers and place of service (POS) code.

In a previous edition of *Dr. Know*, we gave you the modifiers to use:

GV = Tx of terminal disease

GW =Tx of non-terminal disease

If you are using CPT-4 codes in the range of 99304 – 99239 you use a POS of 34.

If the hospice services are performed in the patients' home, the POS is 12 with the above modifiers.

POS 34 is not applicable to domiciliary care facilities (99324-99340).

Be sure to keep Plexus informed of where you perform services for these patients.

WITH CONSENT...AUTHORIZED CONSENT???? *How To Tell The Difference*

Under the HIPAA Privacy Rule; consent from the patient may be oral or in writing and is for using protected health information (PHI) for payments, treatment or health care operations purposes.

An authorized use of PHI is obtaining consent from a patient to disclose PHI in ways not permitted in the Privacy Rule.

A valid authorization must have the following elements:

- The PHI to be disclosed
- Name of the person authorized to make the disclosure
- Name of person authorized to receive the PHI
- The purpose of the disclosure

\$8.4 MILLION AWARD *Malpractice Payout*

In the Greenfield v. Physicians Insurance Company case, the verdict removed the cap on non-economic damages (by the WI Supreme Court). \$4.25 million of this \$8.4 million was to be paid by the WI Injured Patients & Families Compensation Fund (WIPFCF). But, the State raided the fund earlier in the year to the tune of \$200 million.

The impact of this raid of fund and its' effect this case is not yet clear. The fund was in a deficit position prior to the raid. See more info at the WI Medical Society website.