DR. KNOW

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

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

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COME ON INTO THE 21ST CENTURY – IT'S FUN

Get On-Line

The newest trend in healthcare is being able to email your physician. These dedicated email addresses are first triaged by medical staff, a nurse, PA or NP and responded to by them if the question(s) fall within their realm of authority. If not, it is internally forwarded to the physician on call to be answered as time permits.

Something like this would require internal policies that are communicated with the patients. This would include reasonable response times and the hours it is manned. The patient is not to assume privacy using this method of communication and a phone call is still the best way to get an urgent or emergent response.

Maybe the best way to approach this aspect of your practice is to have a fill in form on your site for patients to use so they do not become too detailed and lengthy.

There is a chance of patient abuse by using it to forward jokes, articles, etc. If they don't use your form, delete it.

THE USE OF SCRIBES

New Niche

As the use of EMR's becomes more widely used the need for **instant** charting is here.

In order for this to happen there is a call for someone to do this task and they are called scribes.

This person, usually non-medical, follows the provider from exam room to hospital room to ER room, etc., with an iPad (or the like) and records from verbal dictation the ailments, findings and discussions during a medical visit. The chart is completed prior to the patient leaving the exam room and electronically signed by the provider.

This person is proficient in the chosen EMR software, is HIPAA trained and is familiar with medical terminology. Electronic prescriptions, blood work, x-rays, etc., are also performed through the software system by the scribe.

Both management and doctors are embracing this staffer. It is felt that this position pays for it self with saved physician time and accurate and immediate charting. Training is usually done by the employer.

POS MISCODED

OIG Audit Finds This

One hundred charts were audited by the OIG for Medicare Part B claims. They found that in only 10 percent of these was the place of service (POS) was coded correctly.

These errors were all billed as being performed in the office when actually they were done in a hospital outpatient setting, ASC or other off site location.

In 2007 this resulted in $13.8 million in overpayments to physicians.

For complete details read the OIG July 2010 report.

ACCURACY IS IMPORTANT

Carriers Cross Checking Data

As you transfer handwritten data from the patient registration form to our software system you will have to double-check various areas. This includes accurately documenting name, including middle initials, dates of birth, suffix (i.e. Jr. or Sr.), etc.

With the use of the new universal claim form (HIPAA 5010) on 1-1-12 Medicare will ***require*** exact matches between personal claim information and their records.

CMS is going to create new codes that will go into effect at the same time and they will accurately detail your denial.

Be sure that the patient legibly fills out your registration form and that you have accurately transferred the data and have an updated copy of all insurance cards.

TIDBITS

Miscellaneous Information

The HIPAA 5010 is being created to accommodate the new longer ICD-10 diagnosis codes.

Begin accumulating email addresses of patients and recording them in our system.

TIDBITS Con't

Be sure to chart and use standing orders, these will help get your claims paid.

-25 modifier does not need a separate diagnosis code.

PROPER USE OF 99211

Not Just for Doctors

You can use the E&M code of 99211 for a non-M.D. medical professional (nurse, medical assistant) if the patient presents with problems that are minimal. Typically, five minutes or less is spent performing the service.

REVIEW OF NURSE'S NOTES

Be Sure to Record Review

In an article in the Part B Insider (Sept 2010, Vol. 11, #31) they warn about physicians not allowing nurses to do their work. The ONLY part of an E&M visit that an RN can document independently is the Review of Systems (ROS). The physician must document in the chart that this system review has been gone over and that it is correct and accurate.

It also notes that only the examining physician can perform the history of present illness. These are CMS guidelines and could be a red flag in an audit if not documented properly. The physician must elaborate in the chart about any nurse findings that he/she documented other than the ROS.

X-RAYS DURING GLOBAL PERIODS

Billable

Normally, every service you perform for a patient after a surgery is global and included in the fee charged to perform the surgery.

Exception: During the global period you can bill and get paid for x-rays on the body part that had surgery.

Please be sure to include these in your billing during the global course of care exams.