



# Financial Matters

## Special Points of Interest for Vision Providers:

- As of July 1, 2006—Medi-Cal will discontinue acceptance of non-HIPAA standard electronic formats for vision claim transactions. **REGARDLESS** of Date of Service.
- Electronic claims must be billed using the HIPAA-compliant ASC X12N 837 Professional version 4010A1 format or Internet Professional Claims Submission System (IPCS).

## From the Desk of the CEO

The healthcare system is in flux..... and the sun rises in the east and a bear, well, you know. For the physician in individual practice there seems to be ghostly ghoulies at every turn. Navigating around these phantoms

**Is this what your billing feels like? Need Help?**



requires a skill and knowledge set never taught in school. Indeed, for many of you, the school would not even have known that there were these things to teach about. Optometrists, allied health professionals, medical transportation companies and others

navigate these same waters with even more numerous apparitions appearing before them.

This issue of Financial Matters helps you to navigate a couple of the obstacles in these rapidly flowing waters. First, we'll focus on audits and best practices to avoid them. Second, we'll look at an alert regarding credentialing, offered up by none other than the Center for Medicare and Medicaid Services, aka CMS.

"Audit" is never a pleasant word but renders itself even more dastardly when performed by an insurance company or, even worse, a government agency. Madelon Burger, in a reprint from an HBMA publication, explores what might trigger such audits and how you can avoid them.

Credentialing is usually a lengthy and difficult process, particularly when it involves a government payor. However, it is more treacherous when there are unscrupulous types

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## Target Practice

### HOW TO AVOID AN INSURANCE AUDIT

The Office of Inspector General (OIG) has recouped millions of dollars in highly publicized settlements targeting teaching hospitals, suppliers, laboratories, physicians, and other healthcare providers. In August 2000, CMS instituted the Comprehensive Error Rate Testing (CERT) program. Local carriers review "outlier" patterns and CPT codes that are billed over or under national or local averages, such as over coding a particular CPT code or upcoding E/M levels.

Insurance and managed-care companies have jumped on the auditing bandwagon, finding it to be a lucrative income source. Their sophisticated software systems generate historical reports and identify outliers, comparing specialties by locality and utilization. They generally request a small number of chart notes, and through extrapolation, typically over a number of years,



determine that \$X was over billed, upcoded, and/or not medically necessary. They then demand large repayments. Flagrant coding abuses can result in termination from the carrier or insurance plan, reporting to other insurances, and ultimately, loss of licensure.

Medicare policies are explicit and easily available to providers. The 1995 and 1997 Medicare Guidelines defined E/M requirements. The Correct Coding Initiative (CCI) edits are published and CMS and the carrier Web sites identify policies. However, insurance companies make their own rules; they don't always

recognize modifiers or abide by the CCI edits. Some have their own non-published policies. They generally do refer to CPT definitions and criteria in their contracts with providers.

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## Provider Enrollment Fraud



**“CMS believes that with your help we can target those unscrupulous individuals”**

### Question:

We’ve received a call from Medicare to update lost information. Something didn’t seem right about it. Should I be concerned about giving information to a Medicare caller?

### Answer:

Yes. The following is a fraud alert sent out by Florida’s Medicare carrier. As you all may know, Florida has the dubious honor of leading the country in abuse and fraud. Perhaps if this tactic is squashed here it won’t spread to the rest of the country, but please inform your staffs to be extra careful. —*Bing Herald CHBME (HBMA)*

This is to inform you that Medicare is aware of an organized group who is representing themselves as either a Medicare fraud investigator or a Medicare employee from the enrollment, claim or audit units.

These callers tell the physician, or office personnel, that the Medicare computer system has had a malfunction and they need to update lost information. The callers may also say they need to update the physician E28099s provider record. They then request via telephone or fax the following information:

- E280A2: Copy of physician E28099s drivers license
- E280A2: Copy of physician E28099s social security number (SSN)
- E280A2: Unique physician identification number (UPIN)
- E280A2: Verification of education
- E280A2: Verification of practice location
- E280A2: Copy of physician E28099s medical license
- E280A2: Copy of patient E28099s charts for a specific period of time.

Once the entity receives this information, they falsify enrollment data using the physician E28099s name and request a change to their practice locations, telephone numbers, and pay-to-addresses.

The Centers for Medicare & Medicaid Services (CMS) has not suffered any computer system malfunction and are not calling providers requesting the above information be provided. If you should receive such a call, please try to verify the telephone number of the caller, and immediately notify your Medicare carrier that you suspect fraud.

CMS is committed to protect all Medicare providers/ suppliers and to ensure that only those qualified make changes to enrollment data. CMS believes that with your help we can target those

unscrupulous individuals that are looking to take advantage of you and the Medicare trust fund.

To report these calls please contact the toll-free number for First Coast Service Options, Inc. Medicare Part B Customer

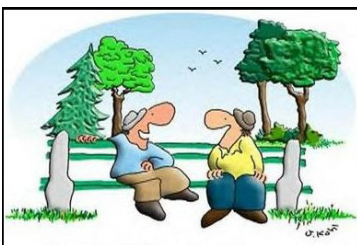
Service Center at 1-866-454-9007. F4808299

Source: CMS JSM-05154, December 27, 2004

## Funny Comments

### found in Medical Records...

1. “By the time he was admitted, his rapid heart had stopped, and he was feeling better.”
2. “The patient has been depressed ever since she began seeing me in 1983.”
3. “Patient was released to outpatient department without dressing.”
4. “The patient will need disposition, and therefore we will get Dr. Blank to dispose of him.”
5. “The patient expired on the floor uneventfully.”
6. “The patient’s past medical history has been remarkably insignificant with only a 40-pound weight gain in the past 3 days.”
7. “The skin was moist and dry.”
8. “The patient had waffles for breakfast and anorexia for lunch.”
9. “The patient was in his usual good health until his airplane ran out of gas and crashed.”
10. “She is numb from her toes down.”
11. “Coming from Detroit, this man has no children.”
12. “She slipped on the ice and apparently her legs went in separate directions early in December.”
13. “Patient was alert and unresponsive.”



**“My doctor told me to avoid any unnecessary stress, so I didn’t open his bill.”**

## How do I handle angry or dissatisfied patients & customers?

Here's a list of suggested actions when dealing with a dissatisfied or angry customer.

**Take ownership.** The customer wants someone to take personal responsibility for resolving their problem. If you have the authority and responsibility, then take personal ownership. If not, then quickly identify and secure someone (manager) who can.

**Listen.** The angry or dissatisfied customer wants to tell someone about their problem and to vent their frustration. Allow them to do that. Apply the skills of active listening.

**Apologize.** This will open the door to problem resolution.

**Empathize.** Let the customer know that you understand why they are upset. Then work to separate the problem from the emotion.

**Identify the problem.** What, specifically, has caused the customer to be angry or dissatisfied?

**Identify points of agreement.** Then, you can work toward a common and mutually satisfactory solution.

*(Continued on page 4)*

### Target Practice *(Continued from page 1)*

If your practice has been long-standing established and has not been targeted by an insurance company, don't assume you are home free. Insurance companies are tracking down solo practices as well as groups, regardless of how long they have been treating patients.

How can you protect your business from getting audited? Every provider must view medical necessity as the springboard to provision of services and procedures. Here are some suggestions:

- Develop a Compliance Plan as recommended by the OIG. The Draft Compliance Program Guidance for Individual and Small Group Physician Practices can be found at [www.hhs.gov/oig](http://www.hhs.gov/oig).
- Update your CPT and ICD-9 books annually (ICD-9 changes go into effect 10/1, not 1/1).
- Use modifiers appropriately. Don't think that you will remain under the radar screen by billing all low-level codes; this can also trigger an audit (outliers include codes below the average). Additionally, providers may be cheating themselves out of revenue for work that warrants higher-level codes.
- Be pro-active. Review coding patterns and note aberrant coding patterns.
- Be aware of specialty coding seminars and ensure that they document your attendance.
- Conduct an internal prospective audit as recommended by the OIG, to review five to ten charts per physician a year. If the results show

incorrect coding patterns, you should attend specialty seminars and more frequent reviews should be conducted.

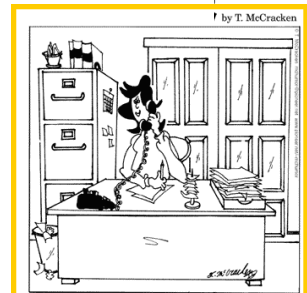
Keep in mind that if your practice has a sub-specialized practice, or patients with a higher level of acuity, you may be able to justify higher level CPT visit codes or procedures more frequently than your peers. However, all coding must be well documented and medically necessary.

The need for detailed documentation and understanding of the Documentation Guidelines cannot be emphasized enough. Review the Medicare Documentation Guidelines ([www.cms.gov/medlearn/emdoc.asp](http://www.cms.gov/medlearn/emdoc.asp)) and determine which are more favorable for your practice, 1995 or 1997. Keep in mind every auditor's credo: If it isn't documented, it didn't happen. Also, if it's illegible, it won't be considered.

If a managed care company audits a provider, it is strongly advisable that the provider retain an experienced healthcare attorney before returning any money. The attorney or firm may retain a coding expert who can review the provider's notes and analyze the insurance company's findings. Furthermore, legal firms can usually negotiate with insurance companies. Also, proof of ongoing education and development of a compliance plan by the provider will often be taken into consideration.

By taking these measures, your practice will become more compliant, resulting in cleaner claims with faster turnaround, and, in the event of an audit, the documentation to substantiate the coding.

*Madelon I. Berger, MPH, MA, CCS-P, CPC, CHBME (HBMA)*



**"Let me put you on ignore.... I mean hold."**

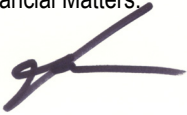
**"If it isn't documented, it didn't happen. Also, if it's illegible, it won't be considered."**

From the Desk of...  
(Continued from page 1)

taking advantage of providers and their staffs. CMS has issued an alert regarding one such scam and we reprinted it on page 2 so that you are aware of it.

As part of our ongoing effort to educate our clients, we will continue to present timely articles on important developments affecting your practices or business. If you feel there is an issue that you'd like more information about, or feel it's one that your colleagues should learn more about, please email me directly at [ArthurRoosa@SyMedCorporation.com](mailto:ArthurRoosa@SyMedCorporation.com).

I invite you to relax and enjoy this edition of Financial Matters.



Arthur Roosa, President & CEO  
SyMed Corporation

How do I handle...  
(Continued from page 3)

**Determine what solution(s) the customer wants.**

**Provide solution options** that satisfy the customer's needs and the policies of your organization.

**If you can't satisfy the customer** tell them so, why, and what you can do.

**Ask if you can provide additional service and if the customer is satisfied.**

**Exceed expectations.** Provide additional products or services above and beyond the problem resolution the customer expects. This simple act, resolving the problem at the 110% level, is among the most potent ways to earn long-term customer satisfaction and loyalty.

Source: Small Business Development Center  
<http://www.wsdbc.org>

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SyMed Corporation  
P.O. Box 238  
Napa, CA 94559-0238  
Phone: 707-255-3300  
Fax: 707-255-3527

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## Advice on Selecting a Billing Service

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Are you considering making a transition from an in-house billing department to a billing service? Or are you thinking of replacing your current billing service? Either way, the process requires many hours of work—including research, phone and face-to-face interviews. While there are management considerations such as the conversion process, down-time during the transition and follow-up on aged accounts receivable, this article focuses on the interview process.

For those of you considering changing companies, the process begins with reviewing your current contract. Pay particular attention to clauses addressing:

- Inadequate notice;
- Ownership of data and its format;
- Automatic contract extensions;
- Written notice requirements;
- Termination options;
- Continuation beyond termination date; and
- Potential penalties.

These contractual areas also are key for practices wanting to change billing services with the same company.

One of the best ways to start searching for a billing service is by asking for recommendations from other practice managers. Initially,

decide if you want an in-state company or if you are open to an out-of-state firm. Then obtain the names of at least three companies.

Do your research systematically. Ask questions about the company's background, billing processes, payment posting and follow-up procedures, data entry, reports, costs, computer and software, collections and references.

The billing service checklist can help you in the interview process. You can use it in face-to-face meetings or over the telephone. Let the billing company know that you will require approximately 45 minutes for the interview. Generally, the company will schedule you with a senior person. Familiarize yourself with the checklist because you will find that one answer will often flow to another question.

After you have gathered information, narrow your choice to two billing companies. If you do not have two good companies to choose between, continue your search until you do.

If you would like to receive a copy of the entire article including the **BILLING SERVICE CHECKLIST** (3 pages)

Please call Jan at 707-255-3300 or  
email [JanWienecke@SyMedCorporation.com](mailto:JanWienecke@SyMedCorporation.com)  
and request your copy today