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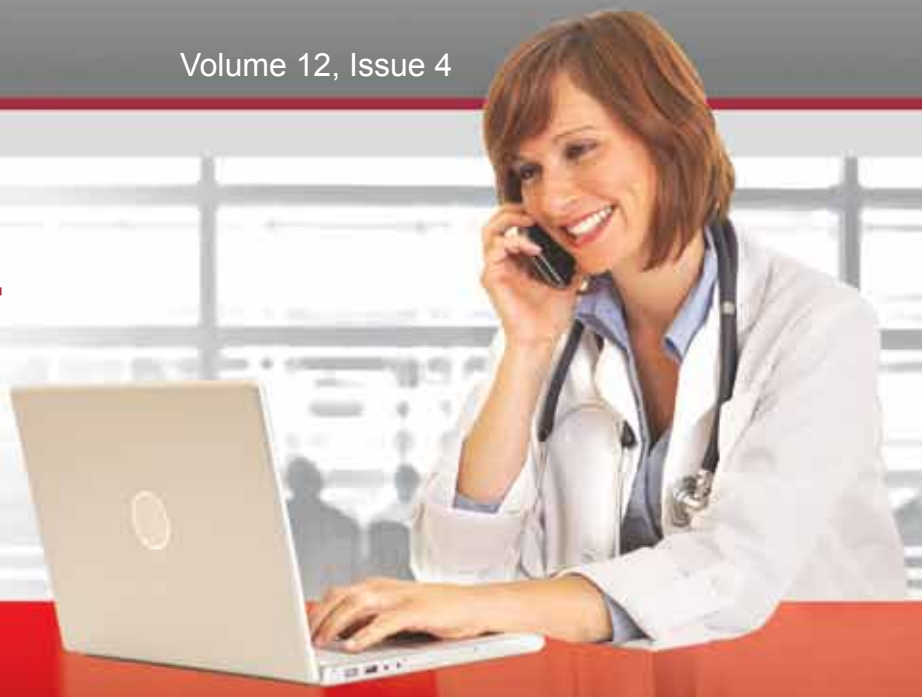
AcSel Medical Solutions LLC

ADVISOR

Medical Billing & Compliance Bimonthly Newsletter



The AcSel Advisor is now available via email. Just email, **info@acselmedical.com** and place the word **"Advisor"** in the subject field to receive your copy!

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PQRS PAYMENT ADJUSTMENT

Year 2014 is moving fast...you only have a short time left to satisfactorily report PQRS quality measures this year to avoid a 2% payment adjustment in 2016. Your reporting MUST be done now. The 2016 PQRS payment ad-justment will be based on 2014 program year data.

There are 37 PQRS Individual Measures for the 2014 program year. 45 measures were retired in 2014. Specifications for any given individual qual-ity measure may be different for the quality measure used for 2013.

For 2014 PQRS Measures Groups can only be reported via qualified registry. Three new measures groups were added for 2014. These groups are Total Knee Replacement, General Surgery, and Optimizing Patient Exposure to Ionizing Radiation.

All Eligible Professionals should make sure they are using the most current version of the 2014 PQRS measure specifications.

Complete information is available on the CMS PQRS website at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS

BLANKET ABNs

Hopefully your practice is not one that uses a "Blanket ABN" for all your patients. CMS does not allow blanket use of ABNs-giving an ABN to every Medicare patient. The ABN is to be used for the purpose of informing your patient(s) BEFORE THE SERVICE IS RENDERED that you believe you are furnishing items or services you believe Medicare will not pay for on the basis of medical necessity. The only exception to a blanket ABN is when the Medicare patient is having a frequency-limited service.

When having a Medicare patient sign an ABN, you form should be completed and each service explained to the patient.

Commercial payers do not always require you to use an ABN to allow the provider to collect from the patient any denied services. However, you should check each of your contracts to be sure of their rules and how they apply.

ICD-10-CM NEWS CORNER

LATEST NEWS...CMS has released a statement that sets the deadline for ICD-10 implementation at October 1, 2015.

AcSel Medical Solutions is here to provide education to you, your staff and your providers. We are available to do five (5) charts per provider at $20.00 per chart which includes a report of our findings — is the documentation compliant, non-compliant or not coded to the highest level of specificity.

Education to your staff and providers is considered a consultation charge. Please call AcSel Medical Solutions for details and rates.

Existing AcSel clients will receive a 10% discount.

Don't let **ICD-10** take a bite out of your cash flow. Let AcSel's team of experts help lead you through the change.

We can help you with documentation reviews, **ICD-10** education, implementation of the new coding guidelines, and any other revenue cycle management services your practice may need.

Call us today:

1-800-336-3038

or email us at

info@acselmedical.com

Let us add you to our mailing list for

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BILATERAL PROCEDURES

UNITS, MODFIIER 50, 1 OR 2 LINES?

How many times have you or your staff asked yourselves when billing a bilateral procedure.

- Do I submit as a single line with modifier 50, with 1 unit
- Do I submit as 2 lines with RT and LT modifiers, with 1 unit each
- Do I submit as 1 line with no modifier and 2 units

As I am sure you are aware, this can vary from carrier to carrier. They each seem to have their own criteria. However, MEDICARE says unless the CPT descriptor in-cludes bilateral, you should submit all your bilateral procedure to them as:

A single unit of service and the modifier - 50

At the recommendation of the OIG, CMS has confirmed a pattern of inappropriate billings of the services in order to bypass the MUEs. Therefore, CMS is converting most MUEs into per day edits.

Effective July 1, 2014 update, published per day edits are identified on the CMS NCCI website:

https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/MUE.html

Virginia Providers Terminated With Medcost

At Did you know that your direct network agreements with Medcost were going to be terminated by them effective June 30, 2014. Because of the competitive network offered by VHN to Medcost clients, Medcost made the decision only for Virginia providers.

Any questions you may have regarding this termination notice, you can contact Cindy Hughes at 336-774-4375 or chughes@medcost.com

MYTHS ABOUT MODIFIER - 24

Every provider wants to get paid for the services they render...especially those doing a global period of a major procedure. There are several myths that have raised their heads and we want to clear the fog.

1 Modifier 24 applies to any service done in the post-op period…WRONG

- Modifier 24 is only used on E/M codes
- You can only bill an E/M service during the global period if it is UNRELATED to the procedure

2 A Scheduled Office Visit Rules Out Modifier 24…WRONG

- Just because the patient may be scheduled for a visit type of "follow-up" doesn't mean that it is not related to the procedure
- Do not rely on the visit type for the booking of the appointment deter you from why the patient is actually being seen

3 You Can Never Use Modifier 24 For Complication-Related Services…WRONG

- First thing to remember when your patient incurs a complication during the post-op period is the patient's insurance
- Medicare does not allow complications of surgery (ex. Hematoma, seroma, infection) unless there is a need to return to the operating room and then a different modifier is used
- Some private/commercial carriers will pay for complications during the global period.
- Bottom-line of when to bill a complication is to know the guidelines of the carrier

4 There Must Be A Different Diagnosis…WRONG

- While it is not mandatory that a different diagnosis is used, it is easier to justify your E/M is the diagnosis clearly states it is not related to the surgery or is a complication unrelated
- Your E/M level should clearly be documented with the components of the CPT code and should not be related to the surgery such as discussing the results, changing the bandages or checking the wound.

5 You Should Never Use Modifier 24 and Modifier 25 Together…WRONG

- Be very careful when these two modifiers are required on the same claim, but it can be done.
- E/M must be a separately identifiable evaluation and management service by the same physician o nthe same day of the procedure or other service.

TIP: Always put the modifier 24 first on your CPT code before any other modifier

MYTHS ABOUT MEDICARE AUDITS

Don't be fooled in thinking that just because the sespension of appeals has anything to do with an audit. The audit appeal process was suspended due to a back log. Audits are still an ongoing process by Medicare.

Do you think that Medical Necessity doesn't matter for your patients that only stay for two midnights in observation? Medicare is not going to approve a stay, regardless of how long or "short", if the medical necessity is not there. CMS created the "two-midnight" rule to clarify which patients are sick enough to be admitted to the hospital by requiring doctors to certify they have good reason to expect patients to need two nights in the hospital.

Can you *Code* it...???

It is important to know the main body systems and understanding the components, the major com-bining form (medical terms) and their major function whether you are selecting a CPT or a diagnosis code. Let's continue with:: Musculoskeletal System...which best describes all the major combining forms of this body system?

A. Ortho, arthro, chondro, myo, fascio, tendo, tendino

B. Osteo, arthro, chondro, myo, fascio, tendo, tendino

C. Chondro, ortho, chondro, tendo

D. All of the above

LAST ISSUE'S ANSWERS: Answer 'D'...all of the above. Their major function is support, shape, protect, store minerals, locomotion, hold body erect, movement of body fluids, and generate body heat.

Find us on the web: **www.acsel.org**

AcSeL Medical Solutions LLC

Since 1977, **AcSel Medical Solutions** has provided world class billing services throughout the U.S. to practices such as yours. Our seasoned staff of expert billing professionals is able to assist your practice in all aspects of the business of medicine, in all sub-specialties. Acsel is committed to competent, compliant processes that maximize our clients' cash flow.

For more information, or to meet with one our consultants, call 800-336-3038

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