

EMRge users may qualify for stimulus money

Surely by now you have heard the terms, "HITECH Act", "ARRA", and "Meaningful Use". Just in case you don't feel like reading and understanding all 700 pages outlining what this means to you, here is what these terms mean to an Origin Healthcare Solutions customer.

Do I qualify for stimulus money if I am using EMRge?

Short answer - most likely. The HITECH act is reimbursing "Eligible Professionals" up to \$44,000 (more if you are in a health provider shortage area) through extra Medicare payments made in yearly installments. Eligible professionals are defined as "a doctor of medicine or osteopathy legally authorized to practice medicine or surgery". This includes physicians, dentists, podiatrists, optometrists, and chiropractors.

How much can I expect to receive?

This depends on three things: first it depends on how much business you do with Medicare - the stimulus money is a direct extension of Medicare. The more payments you receive from Medicare, the higher your reimbursement will be. The second thing it depends on is that you can provide proof that you are a "meaningful user" of a "certified EMR". The meaningful use requirements become more stringent every year the program is offered. Displaying meaningful use is the responsibility of the physician; it mostly includes providing patient access to records, electronically transferring information to payers and other providers, and computerized physician order entry (electronic labs and prescriptions). The last thing it depends on is when you become a "meaningful user". The HITECH plan is designed to reward early adopters, so the only way to get the maximum amount offered is to be able to prove meaningful use within the first two years of the program. Proving meaningful use is not something you will be able to do the week after you implement a certified EMR - it will require a significant amount (6 months in most cases) of data to be able to complete the reports required.

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SUMMARY of the OIG WORK PLAN 2010

By Helen Hadley
VantagePoint HealthCare Advisors



The Office of the Inspector General/Department of Health and Human Services published the 2010 Work Plan that describes activities that will be initiated or continued by the department in this fiscal year (the plan was effective October 2009).

The OIG's mission is to detect and prevent waste, fraud, and abuse and to hold accountable those who do not meet program requirements or who violate federal laws.

To report instances of waste, fraud, or abuse related to HHS's programs, you may call the OIG Hotline at 1-800-HHS-TIPS or email HHSTips@oig.hhs.gov.

The summary below is only the highlights that impact on private practice.

MEDICARE PART A and PART B

HOSPITALS

Provider-Based Status for Inpatient and Outpatient Facilities

- Will review cost reports of hospitals claiming provider-based status for inpatient and outpatient facilities.
- Will determine the appropriateness of the provider-based designation and the potential impact on the Medicare program and the beneficiaries of hospitals improperly claiming provider-based status for inpatient and outpatient facilities.

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meaningful use cont.

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Does Origin's software meet the guidelines of "Meaningful Use"?

Eligible Professionals (sometimes abbreviated to EP's) must display meaningful use of a "Certified EMR/EHR" to qualify for stimulus money. The guidelines a "Certified EMR" were published at the same time as the guidelines for physicians. Software companies must go through a testing process in order to be labeled "certified". The testing bodies for this certification have not yet been appointed or announced (although it is believed that CCHIT will be one of these certifying bodies). After reading the

initial guidelines published in the Interim Final Rule, however, we are happy to say that Origin's EMRge software already meets 95% of the published guidelines. After minor software adjustments (provided free of charge to our EMRge clients), Origin will be one of the first companies to test and become a "Certified EMR".

Hopefully this answers most of your questions about this confusing subject. Look for changes to our website coming soon for more information at www.originhs.com.

keep in touch

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training

Need more training on our software? Not to worry—we offer standard or custom training classes at convenient times either on or off-site. To sign-up for any of the following classes or create your own custom training, please contact Jeff Bouchard at 860.925.6327 or via e-mail at jbouchard@originhs.com.

EMRge Managers/High Level Users *

FREE to current clients

Training covers the definition and parameters menus inside of EMRge. Topics include adding/editing allergies, pharmacies, provider drug favorites, message and task types, and user securities along with various reports and useful features your practice should be utilizing such as flow sheets, lab favorites, and custom forms. Class runs 9:00 am - 3:00 pm with lunch provided for the attendees.

Class meets at 1095 Day Hill Road, Windsor, CT

March 26

Managers Class/High-level Users Training*

FREE to current clients

This class is geared towards the Practice Administrator/Office Manager to accomplish tasks in setup, parameters and definitions.

Classes run 9:00 am – 3:00 pm.

Class meets at 1095 Day Hill Road, Windsor, CT.

February 25—Software/Systems Only Clients

April 22—Software/Systems Only Clients

Practice Reporter and Closing Reports*

FREE to current clients

Basic overview of Practice Reporter and all of its capabilities. Review Daily Closing, Month-End Reports and Ad-Hoc Reporting and Mail Merge. Classes run 10:00 am – 2:00 pm. Class meets at 1095 Day Hill Road, Windsor, CT

February 11—Full Billing Service Clients

March 25—Software/Systems Clients

April 8—Full Billing Service Clients

Custom Training

Custom training programs are available by contacting Jeff Bouchard. Additional fees will apply.

Topics covered include:

Basic training for new employees
Custom Form Building in EMRge
Refresher training for current users
And much, much more!

Can't make it to one of our classes in-person? Not a problem—we can accommodate clients from far away via Internet-based training sessions.

*Class times and dates subject to change. A fee may apply for certain classes. Please remember to sign-up in advance to attend any training session.

practicalsolutions

By Victor Miller, Vital Signs

New Year's Resolutions: STOP then GO to Succeed

STOP!!

I advise all of my clients to STOP and take stock of what took place in the practice in 2009 – the good, the bad, and the regrettable. .

STOPPING is both personally and professionally a healthy thing to do. Building in some quiet time at the end of each year proves beneficial to all the team members and helps bind them together for the heavy lifting of the New Year.

Unfortunately most practices do not take time to STOP and reflect on the year that was. By reflecting, I mean, set aside a full day for the partners, providers, administrator and your CPA to discuss 2009 and the state of the practice going into 2010 (you may want to include your attorney and consultant).

In my experience those practices who do take time to reflect and plan tend to deal with developments during the year better than a practice that has no plan and just never stops. Without a plan there is no destination...so you never arrive. The ship of state (the practice) simply drifts from one month to another. Therefore STOP and plot your course. Experience is a great teacher – let the data from 2009 be your guide.

If you think STOPPING is a good idea but you are not certain how to structure the STOP, here are a few ideas for conducting the meeting:

First agree on a meeting leader (administrator / consultant), date and place – for the first timers you would benefit from hiring a practice management consultant – they have no bias, they structure the meeting, keep it on track and issue a summary report.

Next, create an agenda and circulate it among the proposed attendees for comments.

Finally, have the meeting, take notes and publish a recap of discussions, decisions and timelines to all the “need to know” individuals.

Important: All decisions should have a date specific and someone appointed / empowered to keep all informed and to get there assignment done.

Compare 2009 vs. 2008 data in the following areas – You will want to discuss reasons for variations, both

good and bad. Where called for, agree on remedial measures and resolve to continue to accelerate the good data.

Below is a STOP agenda sample:

Better or Worse 2009 vs. 2008?

- Accounts Receivable – 30,60,90,120+
- Turn Over to Collection – Ratio of Agency Collections to turnover
- Adjustments – Amount & Top 10 Adjustment Reasons
- Charges – by each provider + ancillary services
- Deposited Revenue – graph by month
- Expense Analysis – List Major Suppliers and Amount Spent
- Staff Turnover
- Profit / Loss

Planning 2010

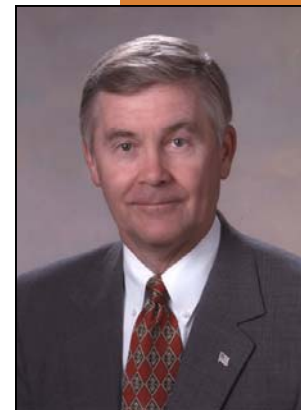
Goal Setting for 2010

- Expense Reduction Targets– Meet with Major Suppliers – Better Pricing
- Renegotiate Office Lease?
- Set Accounts Receivable Reduction Targets – (be realistic)
- Target for Reducing Adjustments
- Challenge Collection Agency to Increase Percentage of Collections
- Reduce Turnover – How?

What's New – By What Date?

- Add Procedures
- Expansion – Office / Satellite
- Equipment Needed – business / clinical
- Providers
- Staff – Additional / Reduction ?
- Money available for staff salary increases...bonus?
- Electronic Medical Records / Web Site
- Partner Retirement? Plan in place?
- Merger?
- How to react to anticipated changes in the marketplace – Hospital / Competition / Medicare / Third Party / New Procedures

Important - Agree to quarterly updates throughout 2010



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Delay in Phase 2 of Change Requests (CRs) 6417 and 6421

The Centers for Medicare & Medicaid Services (CMS) will delay, until April 5, 2010, the implementation of Phase 2 of Change Request (CR) 6417 (Expansion of the Current Scope of Editing for Ordering/Referring Providers for Claims Processed by Medicare Carriers and Part B Medicare Administrative Contractors (MACs)) and CR 6421 (Expansion of the Current Scope of Editing for Ordering/Referring Providers for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Supplier Claims Processed by Durable Medical Equipment Medicare Administrative Contractors (DME MACs)). CRs 6417 and 6421 are applicable to Part B claims only.

The delay in implementing Phase 2 of these CRs will give physicians and non-physician practitioners who order items or services for Medicare beneficiaries or who refer Medicare beneficiaries to other Medicare providers or suppliers sufficient time to enroll in Medicare or take the action necessary to establish a **current enrollment** record in Medicare prior to Phase 2 implementation.

Many physicians and non-physician practitioners who are already enrolled and eligible to order items or services or refer Medicare beneficiaries to other Medicare providers or suppliers for services do not have current enrollment records in Medicare. A current enrollment record is:

- one that is in the Medicare Provider Enrollment, Chain and Ownership System (PECOS)
- contains the physician/non-physician practitioner's National Provider Identifier (NPI)

Under Phase 2 of the above referenced CRs, a physician or non-physician practitioner who orders or refers and who does not have a current enrollment record that contains the NPI will cause the claim submitted by the Part B provider/supplier who furnished the ordered or referred item or service to be rejected.

CMS continues to urge physicians and non-physician practitioners who are enrolled in Medicare but who have not updated their Medicare enrollment record since November 2003 to update their enrollment record now. If these physicians and non-physician practitioners have no changes to their enrollment data,

they need to submit an initial enrollment application which will establish a current enrollment record in PECOS.

How to know if your enrollment is current:

For physicians and non-physician practitioners who order or refer:

If you are not enrolled in the Medicare program, or if you enrolled more than 6 years ago and have not submitted any updates or changes to your enrollment information in more than 6 years, you do not have an enrollment record in PECOS. In order to continue to order or refer items or services for Medicare beneficiaries, you will have to submit an initial enrollment application. You may do so either by

- (1) using Internet-based PECOS (which transmits your enrollment application to the Medicare carrier or A/B MAC via the Internet-be sure to mail the signed and dated Certification Statement to the carrier or A/B MAC immediately after submitting the application), or
- (2) filling out the appropriate paper Medicare provider enrollment application(s) (CMS-855I and CMS-855R, if appropriate) and mailing the application, along with any required additional supplemental documentation, to the local Medicare carrier or A/B MAC, who will enter your information into PECOS and process your enrollment application.

Information on how to enroll in Medicare is found on the Medicare provider/supplier enrollment web site at www.cms.hhs.gov/MedicareProviderSupEnroll.

If you are already enrolled in Medicare, make sure you have a current enrollment record. You can find out if you have an enrollment record in PECOS by calling your designated carrier or A/B MAC or by going on-line, using Internet-based PECOS, to view your enrollment record. CMS will be posting information to the Medicare provider/supplier enrollment web site that will guide you through this process.

Information about internet-based PECOS and a link to internet-based PECOS can be found on the Medicare provider/supplier enrollment web site. Before using Internet-based PECOS, we recommend that you read the information that is posted there and that is available in the downloadable documents section.

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CMS Revision to Consultation Services Payment Policy

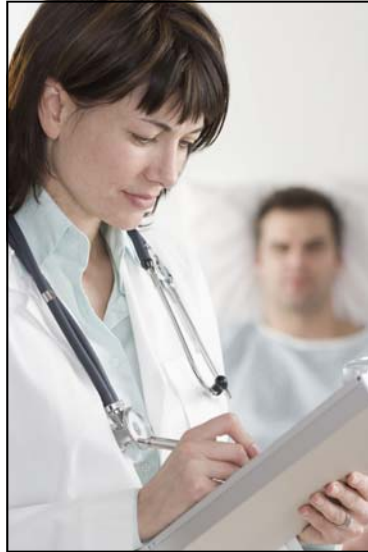
As you know, CMS has decided to no longer pay for consultation codes from 99241-99255. CMS gave the following guidance as to how to bill for consultative services.

Outpatient (99241-99245):

For what would have been considered an outpatient consultation after 1/1/2010, you will need to bill Medicare with either a New Patient code (99201-99205) or an Established Patient code (99211-99215).

Inpatient (99251-99255):

CMS is instructing physicians to bill out an inpatient consultation as a hospital admission code (99221-99223). The actual admitting provider will also be billing the admission codes, although, CMS is creating a modifier they will be



required to append in order to indicate this.

On December 14th, CMS published Transmittal 1875 entitled Revisions to Consultation Services Payment Policy which states that Modifier “-AI” is to be used by the admitting physician on the initial visit code. Please see excerpt taken directly from the transmittal.

“Modifier “-AI,” defined as “Principal Physician of Record,” shall be used by the admitting or attending physician who oversees the patient’s care, as distinct from other physicians who may be furnishing specialty care. The principal physician of record shall append modifier “-AI” in addition to the initial visit code. All other physicians who perform an initial evaluation on this patient shall bill only the E/M code for the complexity level performed.”

The full transmittal can be found at: <http://www.cms.hhs.gov/transmittals/downloads/R1875CP.pdf>

Delay cont.

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If you are a dentist or a physician with a specialty such as a pediatrics who is eligible to order or refer items or services for Medicare beneficiaries but have not enrolled in Medicare because the services you provide are not covered by Medicare or you treat few Medicare beneficiaries, you need to enroll in Medicare in order to continue to order or refer items or services for Medicare beneficiaries.

CMS actions to mitigate the number of informational messages:

Since many Part B providers and suppliers are receiving a high volume of informational messages in their Remittances, CMS will be preparing a Special Edition Medicare Learning Network (MLN) Matters Article on the implementation of these two new edits. This MLN Matters Article will expand upon the information currently available in MLN Matters Articles MM 6417 and MM 6421.

practical solutions cont.

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To those practices that decide to STOP for the first time, you will experience a great feeling knowing that all of the decisions and the timelines agreed upon provide the practice with specific and measurable goals for 2010. The STOP meeting provides many reasons to believe that your practice can prosper and grow in spite of all the bureaucratic and market roadblocks seemingly established to hamper your success.

Congratulations to you for recognizing that proper planning based on data provides the success key for the practice in 2010. You have taken the first step by STOPPING!

Should you need any help, as always, I invite you to contact me, Vic Miller at 757-876.3208 or email onward@widomaker.com

Best wishes for a fruitful and rewarding 2010!
Now GO!

OIG workplan cont.

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Provider Bad Debts

- Will review Medicare bad debt claims by acute care inpatient hospitals, LTAC's, inpatient rehab facilities, inpatient psych facilities, and SNFs to determine whether they were reimbursable.

Medicare Secondary Payer

- Will evaluate procedures for identifying and resolving credit balance situations, which occur when payments from Medicare and other insurers exceed the providers' charges or the allowed amounts.

Hospital Admissions with Conditions Coded as Present-on-Admission

- Will review Medicare claims to determine the number of inpatient hospital admissions for which certain diagnoses were coded as being present on admission.

Hospital Readmissions

- Will review Medicare claims to determine hospital readmission cases; if a same-day readmission occurs related to prior stay's medical condition.

Payments for Diagnostic X-Rays in Hospital Emergency Departments

- Will review Medicare claims AND medical records for diagnostic x-rays performed in ERs to determine appropriateness of payments. There are concerns about the potential overuse of diagnostic imaging services and interpretations.

Observation Services During Outpatient Visits

- Will review Medicare payments for observation services provided during OP visits in hospitals.

Coding & Documentation Under the MS-DRG System

- Will examine coding patterns under the new system and determine whether specific MS-DRGs are vulnerable to potential upcoding.

OTHER PART A and PART B PROVIDERS PAYMENTS

Medicare Incentive Payments for E-Prescribing

- Will review incentive payments made in 2010 to eligible professionals for their 2009 e-prescribing activities. OIG will assess whether any payments

for e-prescribing were made in error.

Place of Service Errors

- Will review physician coding of place of service on Medicare Part B claims for services performed in ASCs and hospital outpatient departments.
- Will determine whether physicians properly coded the POS for services provided in ASCs and hospital outpatient departments.

E&M Services During Global Surgery Periods

- Will review industry practices related to the number of E&M services provided by physicians and reimbursed as part of the global surgery fee.

Medicare Payments for Part B Imaging Services

- Will focus on the practice expense components, including the equipment utilization rate.
- Will determine whether payment reflects the actual expenses incurred and whether the utilization rate reflects current industry practices.

Services Performed by Clinical Social Workers

- Will reviewed services furnished by CSWs to inpatients of participating hospitals or SNFs.
- Will review PART A and PART B claims with overlapping dates of service.

OP PT Provided by Independent Therapists

- Will review OP PT services provided by independent therapists to determine compliance with Medicare regulations.

Appropriateness of Medicare Payments for Polysomnography

- Will examine appropriateness of payments for sleep studies.
- Will assess provider compliance with federal program requirements.

Medicare Billings with Modifier GY

- Will review appropriateness of use of modifier GY on claims for services that are not covered by Medicare.

Physician Reassignment of Benefits

- Will review extent to which physicians reassign their benefits to other entities.
- Will examine the extent to which physicians are aware of their reassignments.

Medicare Providers' Compliance With Assignment Rules

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2010 Electronic Prescribing Incentive Program – Adoption/Use of Medication Electronic Prescribing Measure Release Notes

CMS has announced the release of the 2010 Electronic Prescribing (eRx) Incentive Program. The list below details changes to this existing measure made since the release of the 2009 eRx Measure Specification.

Instruction Updates

In order to report this measure, a qualified eRx system that meets the above requirements must have been adopted. The measure is to be reported for those patient visits that meet the denominator coding criteria for which an individual eligible professional has electronically prescribed at least one prescription for a patient with Medicare Part B.

The diagnosis associated with the patient encounter that requires the eRx may be used to report the eRx G-code. The individual eligible professional who generates at least one eRx associated with a patient visit on 25 or more unique events during the reporting period will be eligible for incentive payment. (Faxes do not qualify as electronic prescribing).

A denominator CPT code and an electronically generated and transmitted prescription (not faxed) are required to report the measure.

Numerator Updates

A qualified eRx system (as specified above) has been adopted and the following G-code applies to the patient visit.

G8553: At least one electronic prescription created during the encounter was generated and transmitted electronically using a qualified eRx system.

Deleted from Numerator coding: G8443, G8445, G8446

Denominator Updates

Deleted from the Denominator Coding: CPT codes 99348, 99241, 99242, 99243, 99244, 99245

Added to the Denominator Coding: CPT codes 90862, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

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- Will examine extent to which providers comply with assignment rules and determine if and to what extent beneficiaries are inappropriately billed in excess of amounts allowed by Medicare.

Medicare Payments for Transforaminal Epidural Injections

- Will review claims to determine appropriateness of payments for transforaminal epidural injections (used to diagnose or treat back problems and pain). Medicare will cover only services that are considered reasonable and necessary.

Accuracy and Completeness of the NPI

- Will determine whether providers are including NPIs on claims as required.

INVESTIGATIVE AND LEGAL ACTIVITIES RELATE TO CENTERS FOR MEDICARE & MEDICAID SERVICES PROGRAMS AND OPERATIONS

Health Care Fraud

- Will investigate individuals, facilities, or entities

that bill or are alleged to have billed Medicare and/or Medicaid for services not rendered, claims that manipulate payment codes in an effort to inflate reimbursement amounts, and false claims submitted to obtain program funds.

- Will investigate business arrangements that allegedly violate the federal health care anti-kickback statute and the statutory limitation on self-referrals by physicians.

Provider Self-Disclosure

- Will continue to encourage providers to promptly self-disclose improper conduct.

HOW YOU SHOULD PREPARE

Look at where the OIG is focusing and how it might apply to your practice. It would be in your best interest to conduct an internal audit of services to ensure you are in compliance. If you have any concerns at all, contact your advisors to discuss what you should do to minimize risk.

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Join our Email list

In the upcoming year, we will be sending out many notices and client communications along with the electronic version of this newsletter via email. If we do not already have your email, please send it to us at info@originhs.com with your name and office name. There is no limit to the number of people you can have signed up.

Full Billing Service Clients

Please remember to supply us with your **latest fee schedules**. They should be supplied to us on a CD or in an Excel format. If you would like to increase your fees, just send us the percentage for across the board changes. If you would like to update your fees separately, just complete an add/delete form, indicate the fee change and send it to your billing manager.

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