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Physician's VIEW POINT

MARCH 2011

2011 OIG WORK PLAN

New Time Limits for Medicare Fee-for-Service Claims

Healthcare Industry Checklist

Get More Cash Flow, For the Same Work!

MARCH 2011

*Physician's View Point – Brought to you by
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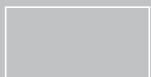
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PRIMARY CONTACT

Now head of our firm's ACS Department and Healthcare Group, Robert Lane has been in practice for over 30 years. He is certified as a Personal Financial Specialist (PFS) by the American Institute of Public Accountants (AICPA) and holds a state of Texas CPA license. In addition, he holds both Texas and federal securities licenses.

For more information about LGT or to speak to a Healthcare Specialist please contact Robert Lane, Partner at 214-461-1450.



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INSIDE FEATURES

2011 OIG Work Plan

New Time Limits for
Medicare Fee-for-Service Claims

Healthcare Industry Checklist

Get more Cash Flow, For the Same Work!

Worldwide Clients World Class Service



2011 OIG WORK PLAN

PLACE OF SERVICE ERRORS

Review of physician coding of place of service on claims for services performed in Ambulatory Surgical Centers (ASC) and hospital outpatient departments.

AMBULATORY SURGICAL CENTER PAYMENT SYSTEM

Review appropriateness of the methodology for setting ASC payment rates under the revised ASC payment system.

CODING OF EVALUATION AND MANAGEMENT (E/M) SERVICES

Review to identify trends in the coding of E/M services. E/M codes represent the type, setting and complexity of services provided and the patient status, new or established.

PAYMENTS FOR E/M SERVICES

Review the extent of potentially inappropriate payments for E/M services and the consistency of E/M medical review determinations. Providers must select the code for the service based upon the content of the service, and documentation should support the level of service reported.

E/M SERVICES DURING GLOBAL SURGERY PERIODS

Review 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

Review payments for Part B imaging services. Selected imaging services will be focused on the practice expense components, including the equipment utilization rate.



BILLING OF PORTABLE X-RAY SUPPLIERS

Review providers of portable X-ray services with unusual claims patterns and identify claims that are questionable.

SERVICES PERFORMED BY CLINICAL SOCIAL WORKERS

Review services furnished by Clinical Social Workers (CSWs) to inpatients of Medicare participating hospitals or Skilled Nursing Facilities (SNFs) to determine whether the services were separately billed to Medicare Part B.

OUTPATIENT PHYSICAL THERAPY SERVICES PROVIDED BY INDEPENDENT THERAPISTS

Review outpatient physical therapy services provided by independent therapists to determine whether they are in compliance with Medicare reimbursement regulations.

QUESTIONABLE BILLING FOR MEDICARE OUTPATIENT THERAPY SERVICES

Review paid claims data for Medicare outpatient therapy services from 2009 and identify questionable billing patterns.

APPROPRIATENESS OF MEDICARE PAYMENTS FOR POLYSOMNOGRAPHY

Review appropriateness of Medicare payments for sleep studies.

MEDICARE PAYMENTS FOR SLEEP TESTING

Review appropriateness of Medicare payments for sleep test procedures provided at sleep disorder clinics.

EXCESSIVE PAYMENTS FOR DIAGNOSTIC TESTS

Review Medicare payments for high-cost diagnostic tests to determine whether they are medically necessary.

LABORATORY TEST UNBUNDLING BY CLINICAL LABORATORIES

Review the extent to which clinical laboratories have inappropriately unbundled laboratory profile or panel tests to maximize Medicare payments.

MEDICARE PART B PAYMENTS FOR GLYCATED HEMOGLOBIN A1C TESTS

Review Medicare procedures for screening the frequency of clinical laboratory claims for glycosylated hemoglobin A1C tests.

TRENDS IN LABORATORY UTILIZATION

Review trends in laboratory utilization under the Medicare program.

LAB TEST PAYMENTS: COMPARISON OF MEDICARE WITH OTHER PUBLIC PAYERS

Review the extent to which Medicare payment rates for laboratory tests vary from other public payers.



GEOGRAPHIC AREAS WITH A HIGH DENSITY OF INDEPENDENT DIAGNOSTIC TESTING FACILITIES (IDTFs)

Review services and billing patterns in geographic areas with high concentrations of IDTFs.

Independent Diagnostic Testing Facilities' Compliance With Medicare Standards

Review selected IDTFs enrolled in Medicare to determine the extent to which they comply with Medicare standards.

MEDICARE PROVIDERS' COMPLIANCE WITH ASSIGNMENT RULES

Review the extent to which providers comply with assignment rules and determine whether and to what extent beneficiaries are inappropriately billed in excess of amounts allowed by Medicare requirements.

MEDICARE PAYMENTS FOR CLAIMS DEEMED NOT REASONABLE AND NECESSARY

Review payments for claims in 2009 that providers note as not reasonable and necessary on claims submissions.

MEDICARE BILLING WITH MODIFIER GY

Review appropriateness of providers' use of modifier GY on claims for services that are not covered by Medicare.

PAYMENTS FOR SERVICES ORDERED OR REFERRED BY EXCLUDED PROVIDERS

Review the nature and extent of Medicare payments for services ordered or referred by excluded providers.

PAYMENTS FOR ESRD BENEFICIARIES ENTITLED TO MEDICARE UNDER SPECIAL PROVISIONS

Review claims for End Stage Renal Disease (ESRD) beneficiaries entitled to Medicare coverage only because of special circumstances.

Error-Prone Providers: Part A and Part B
Review claims submitted by error-prone providers.



COMPREHENSIVE ERROR RATE TESTING (CERT) PROGRAM: FY 2010 ERROR RATE OVERSIGHT

The head of a federal agency with any program or activity that may be susceptible to significant improper payments is required to report to Congress the agency's estimate of improper payments.

MEDICARE SERVICES BILLED WITH DATES OF SERVICE AFTER BENEFICIARY'S DATE OF DEATH

Review Medicare claims with dates of service after beneficiary's date of death to assess CMS's controls to preclude or identify and recover improper payments.

- Physician billing for hospice beneficiaries.
- Trends in hospice utilization.
- Incentive payments made for e-prescribing to eligible professionals.
- Place-of-service errors.
- ASC payment system.
- E/M services during global period.
- Payment for imaging services.
- Services performed by CSWs.
- Outpatient physical therapy services provided by independent therapists.
- Appropriateness of Medicare payments for polysomnography.
- Laboratory test unbundling by clinical laboratories.
- Medicare billing with the GY modifier.
- Geographic areas with a high density of IDTFs.
- Enrollment standards for IDTFs.
- Physician reassignment of benefits.
- Medicare providers' compliance with assignment rules.
- Payments for services ordered or referred by excluded providers.
- Ambulance services used to transport ESRD beneficiaries.
- Medicare payments for transforaminal epidural injections.
- CERT program error rate (2008 transportation claims error rate).
- CERT program (2008 Part A and B error rates).
- Medicare services billed with dates of service after the beneficiary's date of death.

New Time Limits for Medicare Fee-for-Service Claims

The Centers for Medicare & Medicaid Services (CMS) has updated chapter 1 of the Medicare Claims Processing Manual and changed the time limits for filing Medicare claims. Essentially, the maximum period for submission of all Medicare Fee-for-Service (FFS) claims has been reduced to one calendar year (12 months) after the date of service.

ACCORDING TO CHANGE REQUEST (CR) 7270, SERVICES FURNISHED:

- Prior to January 1, 2010, must be submitted no later than December 31, 2010
- On or after January 1, 2010, the time limit for filing all Medicare FFS Part A and Part B claims is 12 months, or one calendar year from the date services were furnished.

CR 7270 does allow for exceptions to this time limit if certain conditions are met. If you have any questions or concerns do not hesitate to **contact Robert Lane, the partner in charge of LGT's Healthcare Group, at (214) 461-1450.**



Healthcare Industry Checklist

The Healthcare industry is currently facing many new modification including new coding, regulatory and HR requirements. The following checklist can help your practice document your progress implementing these required changes.

CODING CHANGES

- Go over each change with all staff members affected by coding/bundling changes.
- Document insurer dates for accepting new coding changes if different from the standard updates.
- Determine whether downloading new codes and descriptions from your vendor will benefit you more than manually entering the changes. Be sure to keep verbiage that everyone recognizes and can select accurately.
- Enter new codes with descriptions that everyone recognizes and will be able to find via searches.
- Deactivate discontinued codes in your practice management system, allowing for claims for services that occurred before the changes to be resubmitted (for instance, putting a "Z" in front of a discounted code will drop it to the bottom of a search list but may compromise

its selection if a charge has to be re-billed).

- Update national coverage determinations (NCDs) and local coverage determinations (LCDs) affecting your procedures.
- Change encounter forms, "cheat sheets" and any other documents using coding to report your services, considering all of the resources available (CPT/HCPCS/ICD-9/NCD/LCD).
- Develop educational materials for staff members who use coding, encompassing the changes, additions and deletions they will be using.

FINANCIAL ANALYSIS

- If you don't have a certified electronic health record system or are still using paper charts, this might be the time to investigate converting to a certified system. Huge financial incentives exist to do so, and meeting the first-year "meaningful use" requirements are much easier than what will be required in years 2,3,4 and 5.
- Consider using a registry to electronically review your data and qualify you for the last year of the Physician Quality Reporting Initiative bonus.

- Generate year-end statistical analysis reports focusing on those things important to track in your practice (top 10 or 20 procedures by charges, payments, units of service, relative value units, etc.).
- Summarize year-end reports to determine reimbursement levels for the top 10 to 20 procedures in your specialty by insurer.
- Use the aforementioned reports to plan future contracting. Many insurers require notification of disenrollment within a given window of time, so if there is an insurer that is reimbursing your top procedure at 50% of what everyone else is doing, you need to comply with the terms of your agreement with that insurer to extricate yourself from the plan.
- Calculate the financial impact of coding changes and CCI edits to your practice for the coming year. Calculate the financial impact of coding changes and CCI edits to your practice in the coming year.

REGULATORY OR HR REQUIREMENTS

- Make sure job descriptions accurately reflect current employee responsibilities.
- Update employee records, documenting mandatory education, licensing, Occupations Safety and Health Administration reporting, etc.
- Update policies to reflect any changes in operations or mandatory regulatory changes.
- Brainstorm how your practice will operationalize “meaningful use” requirements, such as how you will provide electronic copies of medical records to patients or how you will transmit continuity of care information to other healthcare providers. Meet with your information technology support and software vendor to work out the details before meeting these requirements becomes critical.
- Let your staff members know how much you appreciate them.

Get More Cash Flow, For the Same Work!

9 out of 10 Healthcare providers can dramatically increase the amount of money coming into their practices by simply changing the way some standard procedures are coded. Our team of experienced, highly trained professionals can ensure you are paid correctly for the procedures you are already performing!

Call Robert Lane TODAY for your complimentary consultation!
(214) 461-1450



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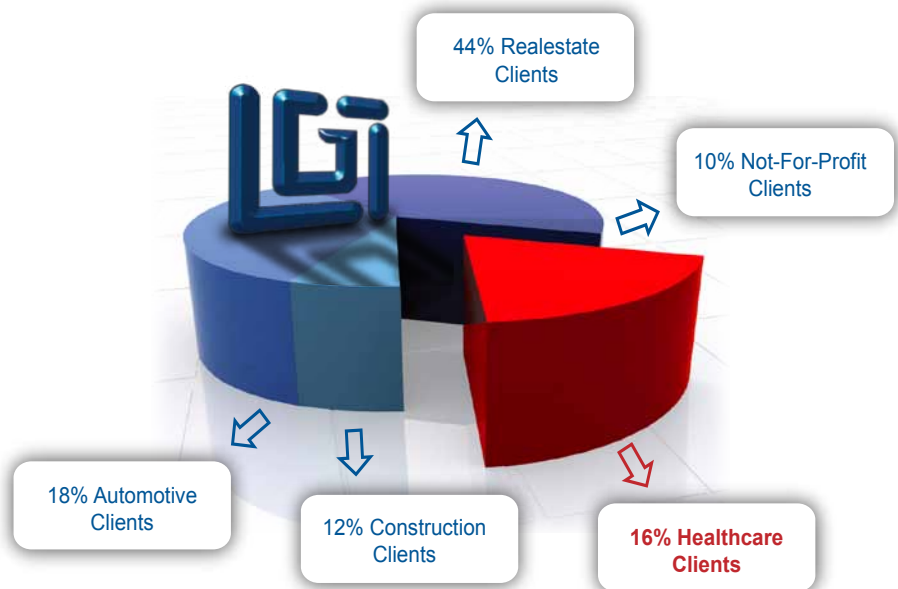
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For more information about LGT or to speak to
a Healthcare Specialist please contact Robert
Lane, Partner at 214-461-1450.



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**Thank you for viewing this month's
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**If you have any questions concerning topics covered in
this issue please contact you LGT Professional today.**

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