

The Main Sheet

Excellence in Emergency Medicine Coding and Billing since 1981

INSIDE THIS ISSUE:

<i>Critical Care Documentation</i>	1
<i>CMS PQRI 1.5% program</i>	2
<i>Choosing a Billing Company-Part I</i>	3
<i>Medicare Rates</i>	4
<i>Marina Medical</i>	4

Upcoming 2007 Meetings to be Attended by Marina:

- April 15-18 Washington ACEP (Vancouver, BC);
- April 24-26 ACEP Spring Conference (San Diego);
- May 31-June 1 CAL/ACEP (Newport Beach)
- June 8-10 Georgia ACEP (Hilton Head, SC)
- June 15-17 North Carolina ACEP (Myrtle Beach, SC)
- October 8-11 ACEP Scientific Assembly (Seattle)



Greer Contreras

CRITICAL CARE-KNOW IT (AND DOCUMENT IT) WHEN YOU SEE IT!

Greer Contreras

Critical care is a service many emergency physicians have a tendency to under report, likely due to undervaluing the care being provided. While EDs with normal acuity and admit rates can often have 4-6% Critical Care patients, many EDs under-report and only have 1-2% Critical Care.

The definition of critical care is broader than that of just your "crash and burn-handwringer" type patients. CPT defines Critical Care such that ". . . *there is a high probability of sudden clinically significant, or life threatening deterioration*" and ". . . *which requires the highest level of physician preparedness to intervene urgently.*" There is not a requirement for unstable vital signs, thus the patient may remain stable yet still have the immediate potential for life threatening deterioration. It is your intervention(s) that are preventing further deterioration.

Think of patients requiring aggressive therapies and prolonged observation. For example, acute asthma exacerbations with multiple nebulizer treatments, active chest pain and/or various arrhythmias requiring IV medications. All of these presentations have the potential for life threatening deterioration if you do not intervene on an urgent basis.

Critical Care is a time-based code, meaning you must meet a minimum of *thirty minutes* of non-continuous time, remembering to subtract any billable procedures you have performed. When documenting your critical care be careful to include your total time; this is your aggregate time, which encompasses actions as well as bedside time. Reviewing test results, discussing the case with other physicians and/or staff, speaking to the

patient's family, and making management decisions are all part of your total Critical Care time.

A good Critical Care note includes comments about the patient's progress throughout the encounter, responses to the interventions provided, and timed exam assessments - all of which will help support the patient's clinical condition as well as reflect the time spent providing patient care. Remember:

- Document total aggregate time,
- Subtract billable procedures from CC time, and
- Include comments about the patients progress and responses.

Keep Critical Care in mind when treating your patients. Recognize these are patients you see and treat frequently, after all - it is an Emergency Department!

Greer Contreras is Senior Director of Coding for Marina Medical Billing Service, Inc.

CMS' 1.5% "PHYSICIAN QUALITY REPORTING INITIATIVE"

MAGGIE CAMILLERI (DIRECTOR OF OPERATIONS, MARINA)

Tax Note

Remember—1099s from Medicare may not match total Medicare payments posted by a billing company for the calendar year because payments were electronically deposited by Medicare before the posting information reached the billing office!



The CMS Physician Quality Reporting Initiative goes into effect July 1, 2007. It establishes a financial incentive for eligible emergency physicians and others who participate in a voluntary quality-reporting program.

Eligible professionals who systematically report a defined set of quality measures on claims for dates of service 7/1/07-12/31/07 may earn a bonus payment of 1.5% of total allowed charges for covered Medicare physician fee schedule services. The bonus is subject to a cap and applies to traditional fee for service claims only. While 1.5% may not at first seem like a lot, for a typical group with a 20% Medicare population and a 5-10% pre-tax operating margin, it equates to a 3-6% increase profit.

The bonus payments will be made in a lump sum in mid-2008. The cap calculation is: individual's instances of reporting X 300% X National average per measure payment amount. A validation plan is under development and confidential feedback and reports will be available to the individual physician in

2008. "Eligible professionals" are defined, in part, as Doctors of Medicine and Osteopathy as well as Physician Assistants and Nurse Practitioners. Participating and non-participating providers are eligible to submit claims and no registration is required.

There are a total of 74 quality measures; 7 or more may apply to Emergency Medicine (**see p. 4**). You may view the detailed complete list of physician quality measures at <http://www.cms.hhs.gov/PQRI/Downloads/PQRI MeasuresList.pdf>. Detailed measure specifications and instructions will be posted well in advance of the July 1, 2007 start date. Final specifications for the 2007 PQRI measures will be published on CMS' web site not later than July 1.

Each quality measure has been assigned a CPT Category II code or a temporary G code. The provider of service must document the quality measures. Previously, when there were fewer quality measures planned (66, when it was published as "PVRP" quality measures),

a template was contemplated; that template concept may possibly be applied now as well. The documented measures will then be captured by the procedure coder and reported on the claims as a \$0.00 charge; Marina's coders will capture the documented measures for Marina's clients. Quality codes, which supply the measure numerator, will be reported on the same claim as the payment or CPT codes which supply the measure denominator.

In order to be eligible for the bonus payment, reporting thresholds must be met. If there are no more than 3 measures that apply, each must be reported for at least 80% of the cases in which a measure is reportable. If 4 or more apply, at least 3 measures must be reported for at least 80% of the reportable cases.

This initiative is an opportunity to achieve a modest increase in compensation for treating Medicare patients, but it's likely to also be a program which, if successful, serves as a harbinger for the expansion of the concept.

CHOOSING A BILLING COMPANY (PART I)

With millions of dollars in A/R to manage as well as ongoing coding, billing and cash collections, ***choosing a billing company is among the most important business decisions an ED group or outsourcing hospital will make.***

There are two core competencies a good medical billing company must have: Those which relate to the operation of the business itself, and those which have to do with the medical specialty. Key drivers of business competency include:

- a demonstrated passion for excellence,
- depth and quality of senior management,
- company ownership,
- number of years in business,
- an organization that can efficiently execute the key skills of finance, human resources, information technology, accounting, reporting, document management and storage, patient responses, and
- strong day-to-day operational management.

Two vitally important requirements are that the billing company have fully audited financial statements

annually by a major CPA firm as your assurance that independent financial checks are being made and that your finances are being properly handled. Verify this by asking to see the auditors' annual letter which typically starts with "We have . . ." It's essential that a billing company have an in-place disaster recovery plan (such as IBM's Disaster Recovery Program with offsite hardware, software and data back up) as would be needed in case of fire, flood or earthquake—otherwise the finances of your entire medical practice are at risk. If a billing company doesn't meet these two protective criteria you should move on to another billing company which does. By far the best way to assess these areas is to visit the billing company at its offices, observe what they're doing and how, talk with a number of key people, and assess the quality of the business. Good billing companies will welcome prospective clients to visit. Visiting the billing company will be time very well-spent.

With respect to criteria directly related to emergency medicine, things to examine include:

Coding—are their coders specially trained to work with the 7,000+ CPT codes

involved with emergency medicine, and is the coders' training kept up to date? Coders who don't specialize in emergency medicine are highly likely to miss substantial charges, and to incorrectly code due to the extraordinary variety of presenting symptoms in the ED.

Specialization—emergency medicine billing is complex with a non-recurring patient base, and as with coding, requires specialization to do it really well;

Compliance—does the billing company have any history of being cited for compliance or HIPAA violations?

Client referrals—ask for 5-10 client referrals and contact those physicians to get their independent assessment of the billing company's work, staff, systems and reports; Client longevity—look at the billing company's client list and ask how many years each has been a client—numerous long-term clients is a positive indication of sustained quality and results.

Choosing a medical billing company is an extremely important decision for an emergency medicine group. In Part II we'll discuss additional selection criteria.

"Good companies think about the competition. Great companies think about their clients!"

Henry Paulson
CEO
Goldman Sachs



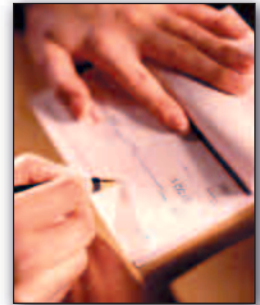
CMS July 1 Quality Measures for EDs (cont'd from p. 2)

Of the 74 measures listed for the Physicians Quality Reporting Initiative ("PQRI", p. 2), 7 or more may apply to emergency medicine:

- # 28 Aspirin for AMI on arrival;
- # 29 Beta Blockers;

- # 54 EKG re chest Pain;
- # 55 EKG for Syncope;
- # 56-58 Signs and assessment for dispersed bacterial pneumonia.

The CMS web site URL for a complete explanation is cited on p. 2.



Marina Medical Billing – More Than a Quarter-Century of Service to Emergency Medicine

Since 1981 Marina Medical has been known for its *intense commitment to the principle that emergency physicians deserve to be paid fairly and promptly* for the care provided their patients. Marina collects more per patient visit than other billing companies by consistently executing the fundamentals, and by focusing greater attention on contracts and the claims follow up process. Marina serves clients across the country and each client receives close personal attention through Marina's

proprietary Client Manager system.

Coding at Marina is a nationally-recognized **"Center of Excellence"**. Every coder is specifically trained in a comprehensive 6-9 month program for emergency medicine. Marina's coding audits are consistently rated 'excellent'.

Marina has a 26 year track record of excellence and reliability, a pristine compliance history, and is the strongest company in the industry with stable

management committed to the business for the long term.

As specialists in emergency medicine, Marina's entire organization is structured to deliver consistently superior results to its clients, from chart flow to coding to billing and collecting. Marina emphasizes long stable client relationships, still serves its very first clients from '81, and has an exceptional track record of client retention.



Marsha Besley
President and Founder
562.809.3501
MBesley@MarinaBilling.com

Marina Medical

BILLING SERVICE INC.

EXCELLENCE IN EMERGENCY MEDICINE CODING AND BILLING SINCE 1981

18000 Studebaker Road, Fourth Floor
Cerritos, California 90703
800 287 8166, 562 402 2755 fax

www.MarinaBilling.com

For additional information, please contact
Marsha Besley, President, at (562) 809-3501; MBesley@MarinaBilling.com
Michael Connellan, CEO, at (562) 809-3500; Michael.Connellan@yahoo.com