

The MAIN SHEET



MARINA MEDICAL™
BILLING SERVICE INC



Winter 2009

Converting Emergency Care Into Compensation

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Upcoming Events:

January 22-26
ACEP Reimbursement & Advanced Coding Conference

January 25-28
Oregon ACEP Annual Northwest Winter Conference

February 11-12
Virginia ACEP Hot Topics

March 2-4
AAEM Annual Scientific Assembly

Position Available: Data Entry Clerk, M.D.

Geoffrey E. Renk, M.D., Ph.D., FACEP,
Medical Director, Marina Medical



9 - 12 hours per day in highly stressful environment. Copious background noise with frequent interruptions. Must be able to navigate

complex software quickly and meet highly variable documentation guidelines on the fly. Ability to import and interpret laboratory and radiology data, as well as information from old medical records from diverse, non integrated software systems a must. Computerized order entry also required. And oh, yes, must be able to save lives.

Does this sound like your job description? Then you must already be using an Electronic Medical Record (EMR) system in your Emergency Department (ED). If you are not, you can be sure you will be soon. Implementation of EMR's is clearly a national priority. From sharing of medical information to patient safety via physician ordering and electronic prescribing, you cannot read or hear about healthcare reform without mention of the increasing use of information technology as a means to improving healthcare. It is highly likely that your institution is or will soon be considering purchasing or creating an EMR for the hospital as a whole and for your ED in particular.

If designing an EMR for the ED was an Olympic diving event, the degree of difficulty would be like an arm stand

reverse double somersault with a 4 1/2 twist. The environment is probably the least conducive to interacting with a computer screen than you could make up. EMS radio calls and arrivals, multiple patients in various stages of workup and treatment, constant questions from staff and patient's families, phone calls from



attending docs, radiologists, and consultants, all make it hard to focus on the radio buttons or menus that need to be clicked. Add to that the huge diversity in the types of patients presenting and the myriad approaches to diagnosis and treatment of that wide range of chief complaints, and the design of a logical, simple and rapid computer interface becomes daunting. One has to look very carefully at how any EMR product will actually function in the ED, rather than on the trade show exhibit floor.

One of the major challenges of an EMR is producing the type of narrative that effectively communicates, with other medical professionals, what happened during a medical encounter. This is really the primary purpose of the medical record - to tell the medical story. Making sure the EMR delivers on this aim should

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be the highest priority in designing or choosing a system. Interestingly, at a recent seminar I attended on transitioning to an EMR, there was a slide listing the forces driving the implementation of an EMR. The word "Communication" was last on the list after reimbursement, coding, pay for performance, risk management, and data management.

Obviously, all these concerns are important but in my view this list is reversed. The EMR is or should be a tool to help you take better care of your patients and assist you to effectively and efficiently record the encounter. Yes, it should help you accurately document in a way that meets appropriate guidelines for effective coding but most importantly it must create a document in the end that is useful to another practitioner.

Recently I was talking to a Cardiologist seeing one of my patients in the ED about the EMR records we send him, and he said, "I never even look at them." He found that he had to sift through so much extraneous text to find important facts that it was easier to start over and find out himself.

Don't let this happen in your department. Being proactive and taking a leadership

role in the search for an EMR is key for successful implementation. It will come, and you'd better help them choose or you may find yourself with a system that is not ideal and which affects your practice profoundly. The important thing to understand is how complex the products are and how many aspects of the practice will be affected by an EMR. There is no perfect solution. Every product will have its strengths and weaknesses and you need to be able to live with those weaknesses on a daily basis.

Done well, this can be an opportunity to advance your practice, improve the flow in your department and widen the range and detail of information available to you as you care for a patient. EMR's that integrate well with tracking boards, old medical records, laboratory results, EKG databases, etc. can help take you to the next level. Get involved at the ground level in your institution and make sure your EMR is one that can help you elevate your practice.

Next time we will talk about some of the details to look for in Information Technology solutions for the ED, and how this can affect your efficiency and reimbursement.

Split/Shared Visits - Nuts and/or Bolts?

Michael Driskill, CPC, Assistant Director of Coding, Marina Medical Billing Service, Inc



When it comes to working with non-physician practitioners such as PA's or NP's, it is important to understand the ins and outs of the documentation

and reimbursement guidelines to insure proper reimbursement. A concept commonly referred to as a "Split/Shared Visit" was created by CMS to make sure physicians are reimbursed "appropriately" when involved to a certain extent in a patient encounter shared with a PA or NP. If a physician and a NP are jointly involved in the patient encounter but do not meet the criteria required to report the visit as a "split/shared visit", CMS payers discount the reimbursement of the Evaluation and Management service.

So, what are the reimbursement rates when a non-physician practitioner performs the E & M service for a CMS patient? In short, it depends.



CMS released the below statement in the form of transmittal 1776; to maintain congruency amongst other policies and avoid over simplifying the entire process:

"When an emergency department E/M is shared between a physician and a NP from the same group practice and the physician provides any face-to-face portion of the E/M encounter with the

patient, the service may be billed under either the physician's or the NP's UPIN/PIN number. However, if there was no face-to-face encounter between the patient and the physician (e.g., even if the physician participated in the service by only reviewing the patient's medical record) then the service may only be billed under the NPP's UPIN/PIN."

In contrast to many CMS policies/guidelines this one is relatively straightforward and easy to navigate. Here is how it breaks down when a PA or NP and the physician are from the same group practice:

The determining factor between the two scenarios recognized by CMS is whether or not there was a face-to-face encounter between the physician and the patient.

- If there is any face-to-face portion of the E & M encounter between the physician and the patient documented in the record, the E & M service may be (and therefore is) billed under the physician's UPIN/PIN and reimbursed at 100% of the physician's Medicare fee schedule.
- If there is no mention in the record of the face-to-face portion of the E & M encounter between the physician and the patient in the record, the E & M service is billed under the NPP's UPIN/PIN and reimbursed at 85% of the physician's Medicare fee schedule.

Keep in mind the shared/split visit concept applies to the E & M service only. Surgical procedures and ancillaries are billed under the UPIN/PIN of the provider that performed the service(s), as supported by the provider's documentation. When multiple providers are involved in a surgical procedure, the procedure is reported with each providers UPIN/PIN number and additional CPT modifiers are appended to the procedure code(s) to reflect these services accurately.

If you have any questions about split/shared visits, please call or email Michael Driskill at 800-287-8166 x 138, or mdriskill@marinabilling.com.

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California Supreme Court Bans ED Balance Billing

The Supreme Court of California – as reported on by the Wall Street Journal - ruled on January 8, 2009 that “patients can no longer be billed by doctors and hospitals for care that isn’t fully paid by their health plans.” This ruling, together with the Department of Managed Health Care’s October 15, 2008 regulation, solidified the State’s position against the practice of “balance billing”. The Court further ruled that disputes over the payment of claims has to be resolved by the physicians and the health plans. The ruling appeared to encompass only HMO patients, who are covered under California’s Knox-Keene statutes.

The ruling, on top of DMHC’s Oct 15 regulation, will have a material adverse impact upon the State’s emergency departments, many of which have marginal economics in the best of times. The court ruling will hurt EDs in two important ways: first, it essentially allows HMOs to pay

whatever they want for care, forcing the physicians into dispute resolution processes for unpaid amounts; and second, it fundamentally shifts the balance of power in managed care contracting because now that HMOs have the ability to set their own payment rates to physicians, they have far less incentive to enter into fair and reasonable contracts with those physicians and are likely to let existing contracts lapse.

“Emergency physicians already see one of every two patients for free, since federal law requires them to treat everyone without even asking if they’re going to be paid. No other profession in America is asked to make this kind of sacrifice for the common good. These doctors are there for all of us 24/7/365. To punish them further by letting for-profit, huge HMOs dictate what doctors are going to be paid is truly disappointing and will in the long run hurt all of us by resulting in a poorer quality of care”, according to Michael Connellan of Marina Medical.

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MARINA MEDICAL™
BILLING SERVICE INC

18000 Studebaker Road, Fourth Floor
Cerritos, CA 90703

(800) 287-8166
Fax (562) 402-2755
www.marinamedicalbilling.com

For Additional Information,
Please Contact:

Marsha Besley, President
(562) 809-3501
mbsesley@marinabilling.com

Michael Connellan, CEO
(562) 809-3500
michael.connellan@yahoo.com

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PAID
Fullerton, CA
permit #664