

# ANESTHESIA NEWS

## A Message From IPMS



*Tina Scavetta*

*Anesthesia Account Manager*

Beginning with this newsletter, the Anesthesia News will inform you of the latest news and most up-to-date information on all your billing needs in two seasonal issues—Spring and Fall! We at IPMS hope that you enjoy the Anesthesia News and find it useful in your practice.

We would love to hear your thoughts and invite you to share suggestions for future editions. Email your correspondence to Tina Scavetta at [tina\\_scavetta@ipmscorp.com](mailto:tina_scavetta@ipmscorp.com).

We look forward to hearing from you!



## AN ELECTRONIC STIMULUS WORTH ABOUT \$19 BILLION

Would \$19 billion prompt your investment in electronic medical records (EMR), also known as electronic health records (EHR)? With the American Recovery and Reinvestment Act of 2009 (the "Economic Stimulus Plan"), President Barack Obama is hopeful it will.

The Federal government has elected to make this investment under the premise that once the investment is made, patient care, practice billing efficiency, and profitability will improve. As a result, universal health care—a central platform of the Obama/Biden administration—has the potential to become more affordable.

Under the American Recovery and Reinvestment Act, any physicians or other health professionals are eligible for these incentive payments; as long as they make the investment by 2012 (reduced amounts are available as late as 2014). Under the plan, qualifying healthcare providers will receive a maximum of \$44,000 per physician.

The incentive payments work on a sliding scale—\$18,000 per physician if the initial year is 2011 or 2012, \$15,000 if the initial year is 2013, and \$12,000 if the initial year is 2014. Following the initial year, payments will continue for four more years—\$12,000 in the second year, \$8,000 in the third, \$4,000 in the fourth, and \$2,000 in the fifth and final year. In all events, the final year of payment is 2015.

There are additional limits on the amount a physician can receive. Medicare-participating physicians are limited to 75 percent of the physician's Medicare charges in one year. Physicians with 30 percent or higher Medicaid caseloads can qualify for nearly \$64,000, but Medicaid incentive payments are limited to 85 percent of the physician's Medicaid charges. Slightly different limits apply to certain pediatricians with Medicaid patient caseloads.

An important aspect of this incentive program is that it does not require that the physician or other health provider actually purchase these EMR systems. A lease or other financing arrangement (or other contractual solution) should be acceptable; but in all cases, the physician is expected to use these EMRs in a "meaningful way," or the incentive payments will be lost. The government will need to define a "meaningful way" in order for physicians to comply.

As always, there are a number of other requirements that must be met to qualify for these incentive payments, but the alternative is really no choice. For non-complying physicians, penalties in 2015 will be in the form of a 1 percent reduction in Medicare fees, increasing to a 3 percent reduction in 2017 and later years. Now is the time to begin the process of modernizing your records, and getting your share of this \$19 billion electronic stimulus.

—Donald B. Stevens, CPA  
J. H. Cohn, LLP, Glastonbury, CT



## CODING CORNER



*Sharon Donelli, CPC  
Administrative Officer*

### CABG With Pump

The American Society of Anesthesiologists 2009 Relative Value Guide reports a new code.

#### **00567**

Description: Anesthesia for direct coronary artery bypass grafting; with pump oxygenator  
Base Value: 18 units

Formerly, there was no specific code to report CABG cases performed with a pump and providers had to default to 00562 (anesthesia for procedures on heart, pericardial sac, and great vessels of chest; with pump oxygenator).

The correct code for CABG cases performed without a pump is 00566, which is valued at 25 base units.



## IS IT REALLY A SCREENING?

When providing a diagnosis for sedation colonoscopies, be as specific as possible. Denials are typically due to the diagnosis not meeting a payer's criteria for payment. Automatically defaulting to a "screening" diagnosis may cause reimbursement problems. The reason why is that insurance companies process a true "screening" colonoscopy differently than a diagnostic one. For example, patients are allowed—encouraged—to obtain a screening colonoscopy around age 50. This screening is considered "preventive medicine" and payment of such is allowed and does not count toward the patient "deductible". This translates to no out-of-pocket expense for the patient.

Subsequent colonoscopies prior to the next approved screening that are performed for diagnostic reasons, are also payable. However, since diagnostic colonoscopies are not "preventive" medicine, payment for such may be applied toward the patient's deductible if it has not already been satisfied for the year, possibly resulting in an out-of-pocket expense for the insured patient.

Under the Balanced Budget Act of 1997, the following colorectal endoscopic screening services are covered under Medicare:

- Colorectal screening/flexible sigmoidoscopies every four years for patients age 50 years and older
- Colorectal screening/colonoscopies every two years for patients at high risk for colorectal cancer

Other payers have their own utilization schedules limiting the amount of screenings allowed to a prescribed amount of years.

#### **Appropriate Diagnostic Coding for Billing**

- Patient gets a screening colonoscopy at age 50, no symptoms or family history, test results negative.  
Procedure: 45378, Diagnostic Colonoscopy (ASA Code: 00810)  
Dx: #1) V76.51—Screening for Malignant Neoplasm
- Patient gets a screening coloscopy at age 52, no symptoms or family history, polyps are found and removed by snare technique.  
Procedure: 45385 Colonoscopy with removal of polyps by snare technique (ASA code: 00810)  
Dx: #1) V76.51—Screening for Malignant Neoplasm  
Dx: #2) 211.3—colon polyps
- Previous patient returns one year later to check for return of polyps; none found.  
Procedure: 45378 Diagnostic Colonoscopy (ASA code: 00810)  
Dx: #1) V12.72—History of colonic polyps

—Sharon Donelli, CPC

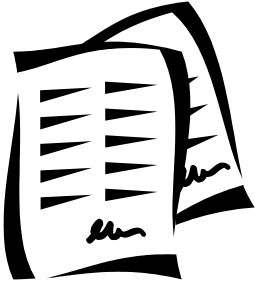
## NO MORE FEES FOR CSMS-IPA

That's right no more fees! Currently, a Connecticut provider who wishes to participate in Health Net is required to go through the Connecticut State Medical Society-IPA (CSMS-IPA). Until recently, a one-time application fee of \$400 was required to become a member of CSMS-IPA and also become a participating provider with Health Net. On February 9, 2009, a decision was made by the Connecticut State Medical Society-IPA Board of Directors to eliminate the one-time \$400 fee as of January 1, 2009.

As a physician organization, CSMS-IPA is the largest and only statewide IPA in Connecticut and one of the largest in the nation. The CSMS-IPA offers a variety of organizational, staff, and consumer-based products that add clinical and financial value to the provider, their practice and their patients.

—Ewa Gaszek  
Credentialing Coordinator

## STIMULUS PACKAGE ~ TEMPORARY COBRA CHANGES FOR 2009



COBRA (the Consolidated Omnibus Reconciliation Act of 1985) provides for a temporary extension of employer-provided group health coverage. The American Recovery and Reinvestment Act of 2009 (ARRA) expands eligibility for COBRA continuation coverage and provides a premium reduction to employees that are involuntarily terminated.

According to the Department of Labor Employee Benefits Security Administration, a General Notice (available at [www.dol.gov/ebsa/](http://www.dol.gov/ebsa/)) must be sent to any employee who experienced a qualifying event from September 1, 2008 through December 31, 2009, regardless of the type of qualifying event. The General Notice includes information on the premium reduction as well as information required in a COBRA election notice. This Notice must be sent by April 18, 2009.

Individuals who were involuntarily terminated from September 1, 2008 through December 31, 2009 and who elect COBRA, may be eligible to pay a reduced premium amount that is 35% of the premium for COBRA coverage for up to 9 months.

The entity to whom premiums are payable under COBRA is entitled to be reimbursed the 65% subsidy paid on behalf of the eligible individual. ARRA identifies that entity as being the employer notwithstanding the fact that the actual premiums may be received by a third party, such as a third party administrator, on the employer's behalf. Reimbursement of the 65% subsidy is given through a credit to payroll taxes.

If an involuntarily terminated individual's adjusted gross income in any year in which the subsidy is received exceeds \$145,000 (for single tax filers) or exceeds \$290,000 (for married filing jointly tax filers), he/she is not eligible to receive the subsidy. If an employee anticipates their modified adjusted gross income will exceed the limits, they may irrevocably waive their rights to the subsidy.

Further information about the temporary COBRA changes can be found at [www.dol.gov/ebsa/](http://www.dol.gov/ebsa/).

—Bea George, Benefits Coordinator

## COMPLIANCE ~ DO YOU HAVE A PLAN?

At IPMS we believe it is imperative that we strive to be 100% compliant with the rules and regulations governing correct billing practices as established by both government and private payers. As recommended by the Office of the Inspector General (OIG), we have implemented a formal compliance program with a designated compliance officer.

Every IPMS employee is required to sign confidentiality and compliance agreements. They're thoroughly trained in HIPAA and compliance issues upon being hired and then on an ongoing basis. If a questionable billing issue arises, it's their job to report it.

At IPMS, we strive to protect your practice against non-compliance. We conduct random internal audits to monitor billing patterns and funnel relevant findings back to your office for implementation and corrective action.

If your practice has specific compliance rules that you would like us to observe in addition to our own internal program, please contact Sharon Donelli at [Sharon\\_Donelli@ipmscorp.com](mailto:Sharon_Donelli@ipmscorp.com).



—Tina Scavetta

## UPDATES FROM MELANIE



Melanie Vail  
Director, Ops & Marketing

### Upcoming Events

IPMS is a proud sponsor of many different physician advocate organizations.

You can find us at the following upcoming events:

- ◆ May 29th, Connecticut Orthopedic Society's Annual Meeting at the Farmington Marriott in Farmington, CT
- ◆ June 19th, CMGMA June Expo at The Aqua Turf Club in Plantsville, CT



# We're moving!

This July IPMS will be relocating our offices to Riverview Square at 99 East River Drive in East Hartford. Just a stone's throw away from our current headquarters, our new building is conveniently located at the juncture of I-84 , I-91 and Route 2. We invite you to come visit us in our new home . . .



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