From IPMS to You . . .

Anesthesia News

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A Message From IPMS

Tina Scavetta
Anesthesia Account Manager

As everyone knows, May 23rd was the deadline for "NPI only". The provider's NPI number must now be used in lieu of legacy provider identifiers in the HIPAA standards transactions for all claim submissions to Medicare, Medicaid and managed care payors.

Medicare allowed legacy-only numbers in the secondary fields until May 23rd to assist billing providers that were unable to obtain NPIs for secondary providers. Provider offices that were unprepared for the deadline can expect cash flow issues. IPMS stayed ahead of the deadlines. As a result, we have successfully made the switch and are monitoring all claims to ensure that our providers do not experience an interruption in their reimbursement flow. You can be assured that IPMS will make this transition a seamless one to your wallet.

Controversial New Drug on the Horizon for GI Procedures

The American Society of Anesthesiologists (ASA) is leading the fight along with many other concerned anesthesia groups with their recent testimony against the use of a new anesthetic agent, which is due out on the market soon. This drug may inspire more gastroenterologists and other physicians to administer deep sedation themselves. The Food and Drug Administration (FDA) Advisory Committee on Anesthetic and Life Support Drugs (ALSDAC) has voted 6 to 3 in favor of approval of fospropofol disodium injection (proposed tradename Aquavan) for use as an intravenous sedative-hypnotic agent in adult patients undergoing diagnostic or therapeutic procedures.

Japan's Eisai Company, Ltd., the fospropofol manufacturer, has advertised this drug claiming that it can be administered by non-anesthesiologists, unlike propofol itself. You may recall that Aetna alluded to fospropofol when it withdrew its plan to stop paying anesthesiologists for providing sedation for patients undergoing GI endoscopies earlier this year, hinting that the new drug would make it easier for gastroenterologists to sedate their patients on their own. Also in favor of the new drug is the American Gastroenterologic Association (AGA) Institute's president, who wrote a letter to the FDA's Anesthetic and Life Support Drug Advisory Committee urging approval of new sedation options for colonoscopy and their use by "properly trained gastroenterologists."

> ***". . . the fospropofol manufacturer, has advertised this drug claiming that it can be administered by non-anesthesiologists, unlike propofol itself."***

On April 23, 2008 ASA filed formal comments with the FDA Committee on behalf of it's 42,000+ physician members, who believe that patient safety is paramount. This fight is reminiscent of the 2005 argument when the gastroenterologists sought removal of the "black box warning" on propofol, which continues to read that the drug ***"should be administered only by persons trained in the administration of general anesthesia and not involved in the conduct of the surgical/diagnostic procedure. Patients should be continuously monitored, and facilities for maintenance of a patent airway, artificial ventilation, and oxygen enrichment and circulatory resuscitation must be immediately available."*** ASA strongly believes that fospropofol should be packaged with the same warning and provided numerous reasons both in the letter from their president, Jeffrey L. Apfelbaum, M.D., as well as in oral testimony before the FDA panel by Dr. Thomas Henthorn, Professor and Chair of the Department of Anesthesiology at the University of Colorado.

The FDA's decision on the approval of Aquavan and on any warning labels that may be required on the drug packaging are expected on July 26, 2008. You can read ASA's formal comments on this matter at http://www.asahq.org/Washington/ASAfospropofolcomments4-23-08.pdf. IPMS will continue to keep you updated on this controversial topic as more develops.

If you have any questions or concerns please feel to contact us at 860-282-0833.

—Tina Scavetta

Coding Corner

Sharon Donelli, CPC
Administrative Officer

ICD-9 Coming Attractions

If all are approved by CMS (Centers for Medicare and Medicaid Services), 2009 ICD-9 will be presenting over 400 diagnosis code changes—a significant increase in changes over recent years. A good number of these changes will be in the nervous system chapter of ICD-9 with 64 new codes, 13 revised and 1 deleted. There are 52 new codes associated with headache pain, which pain practices will no doubt find useful in submitting more specific descriptors for their chronic pain patient billing.

Upon final approval, all will be published in 2009 ICD-9, which has an effective date of October 1, 2008. Meanwhile, the proposed code changes can be viewed at http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/07_summarytables.asp.

Don't Lose Revenue on Your GRNA Claims

Is a GRNA the same as a CRNA? Not in all respects! A Graduate Registered Nurse Anesthetist (GRNA) has indeed received their certification, but for billing purposes is not considered a Certified Registered Nurse Anesthetist (CRNA) until fully credentialed.

The fact that GRNAs often perform anesthesia services prior to their credentialing application being complete at the insurance company calls for precise coordination by the billing office.

The following is a typical scenario: The GRNA files the appropriate paperwork to receive their APRN and DEA licensure. Meanwhile, he or she also secures employment. In a few weeks the APRN license arrives with an effective date. Armed with the APRN license and DEA registration, the Credentialing Department may now submit the credentialing paperwork with the payers. The time that elapses between the APRN license effective date until the credentialing application is processed and approved by the payer is an interim period fraught with "conditions".

For those payers that back-date eligibility to the APRN licensure effective date, it's very important to suspend and capture claims for that particular provider until the insurance company is "ready" to receive them. This ensures ultimate payment on those claims. At IPMS, our computer system has the capability to pend and track these claims. Later, upon notification that credentialing is complete, the claims are released and filed at the insurance company. When this process doesn't happen, it results in either insurance denials for pre-mature filing of claims, or claims that are simply not captured for submission in the first place—hence, a loss of revenue for that entire interim period.

Other payers consider the date of receipt of credentialing applications as the effective date; still other payers don't back-date eligibility at all.

As you can see, coordinating credentialing and billing is a convoluted process that requires individual attention by a dedicated team of professionals for each and every provider application.

—Sharon Donelli, CPC

E&M Menu

When you, as an anesthesiologist, see a patient in the hospital setting for pain management reasons, be sure to choose the appropriate Evaluation and Management (E&M) code for your services.

If you have been consulted by the patient's physician to render your opinion about eligibility for surgery or a particular pain procedure, you should choose from the consultation code series—99251-99255 in the in-patient setting, and 99241-99245 in the out-patient setting. Even though this is the first time you've seen this patient, you cannot use the 9922X series—the admit codes—as those are reserved for the admitting physician.

If you see the same patient on a subsequent day, you should select from the subsequent visit code series—99231-99233. As always, whenever submitting codes from the E&M series, your documentation has to support the level of service provided.

However, if you are following up on a catheter, you would select the daily hospital management of continuous epidural code which is 01996. This code may be reported on the first and subsequent postoperative days as medically necessary.

—Sharon Donelli, CPC

Medicare Alert ~Are You Up to Date?

- **Changes to Information Required When Calling Medicare –** Important changes to the information required when calling Medicare took effect on May 23, 2008 in conjunction with final implementation of the national provider identifier (NPI).
- **Remember to Have Your NPI and PTAN Available –** Beginning May 23, 2008, Medicare guidelines require that contractors ask providers for both their provider transaction access number (PTAN) and NPI number, via both their interactive voice response system (IVR) and customer service representative (CSR) lines. Therefore, it is vitally important you have this information available when calling any of the Medicare service lines.
- **Always Use Your MOST Current NPI When Asked to Provide This Information Via Medicare's Customer Service and/or IVR Service Lines –** First Coast Service Options, Inc. (FCSO) recognizes that some providers may have new NPI numbers as a result of a change you may have made. When calling FCSO service lines, please be prepared to provide your most current NPI number. Having the most current NPI number can help in validating this information at the start of each call.
- **Providers With One NPI and Multiple PTANs –** FCSO is aware that some providers have one NPI and multiple PTANs and multiple NPIs to one PTAN. Beginning May 23, 2008, when calling the IVR line their system will be able to validate multiple NPI/PTAN combinations. However, it is possible you may experience a short delay while your information is being validated. They ask that you be patient and not hang up. The IVR will most likely be able to provide the information you are looking for. Providers are encouraged not to call the CSR line for status, eligibility, and other information currently available via their IVR systems. CSRs are now required to re-direct providers back to the IVR to obtain any information available via the IVR systems.

—Michele Krpata, CPC
Training Specialist

National Increase in Consumer-Directed Health Plans

The number of companies that offer a consumer-directed health plan (CDHP) to their employees is seeing a slow but steady increase according to results of a survey by the National Business Group on Health and the Center for Studying Health System Change and the Commonwealth fund. Nearly half of large employers surveyed nationally say they have offered a CDHP to their employees, and the number of employees enrolled in the programs has nearly doubled over the last two years according to the results of these surveys.

These surveys suggest that CDHPs—typically high-deductible health plans accompanied by either a health reimbursement arrangement (HRA) or health savings account (HSA)—are being offered by a growing number of employers. It is projected that by 2009, 54 percent of companies plan to offer a CDHP.

With more employers offering this type of health plan, the number of employees who enroll rises as well. But does enrolling in a CDHP really save money? Of those companies with at least half of their workforce enrolled in a CDHP, the two-year median medical and pharmacy cost increase was about 3.6 percent. That's about half of the increase for companies with no CDHP offering.

Overall, companies with a CDHP experienced a two-year cost increase of 5.5 percent, versus 7 percent without a CDHP. As the popularity of the consumer-driven approach to health care grows, companies are better able to manage costs and workers will begin to take a more active interest in their own health care.

—Tina Scavetta

Updates From Melanie

Melanie Vail
Director, Ops & Marketing

Knowledge is power. "Anesthesia News" is our way of keeping you informed of industry news, market trends and what's happening at IPMS. We issue quarterly, specialty specific newsletters that explore the ever-changing world of billing and collections with informative articles written by our very own billing and collections experts.

The IPMS newsletters are a must-read for anyone looking to stay ahead of the curve.

Check out our website at www.ipmscorp.com for our past newsletter publications. Stay informed so you can stay ahead.

WHAT OUR HIGHLY VALUED CLIENTS HAVE TO SAY ABOUT IPMS . .

"I have never once called IPMS without getting to speak with the intended person, from our Account Manager to Accounting and the CEO. They are cordial, courteous, professional and always tending to our every need. Their services are impeccable . . . I would recommend them without reservation."

~Gerald Piserchia, M.D.
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