From IPMS to You . . .

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Anesthesia News

A Message From IPMS's Training Specialist

New Medicare Adjustment Code

Effective January 1, 2009 Medicare is implementing a new adjustment code #213: "Non-compliance with the Physician Self-Referral Prohibition Legislation or Payer Policy." This means that a physician cannot refer a patient for "designated health services (DHS)" if that referral will financially benefit that physician or that physician's immediate family. Per Medicare, this financial benefit would include "both ownership/investment interests and compensation arrangements (ex., contractual arrangements)".

DHS that would be included are listed in the MLN Matters Number: MM6131, released on August 15, 2008, which can be found on the Medicare website.

This is a new code and there was no previous code for this situation. This adjustment code follows section 1877 of the Social Security Act also referred to as the "Stark Law".

—Michele Krpata, CPC
Training Specialist

Knowing the ABC's of PQRIs

Pay-for-performance (P4P) programs are being implemented by many payors, including the Centers for Medicare and Medicaid Services (CMS). This quality initiative has made physicians collect and report data—which in the long run will improve the quality of care that patients receive. Several organizations have developed performance measures that are currently being reviewed for implementation.

The American Medical Association's Physicians Consortium for Performance Improvement (PCPI) and the National Committee for Quality Assurance (NCQA) are two of the major organizations that are responsible for developing performance measures. To help alleviate the problem of multiple, similar measures, the PCPI and NCQA have recently agreed to come together in the development of performance measures.

The National Quality Forum (NQF) is a not-for-profit membership organization created to develop and implement a national strategy for healthcare quality measurement and reporting. The NQF is made up from various parts of the healthcare system, including national, state, regional and local groups representing consumers, employers, healthcare professionals, provider organizations, health plans and organizations involved in quality improvement in healthcare. Once the PCPI and NCQA have developed and voted on the measures, they are sent to the NQF where they are reviewed.

Once approved by the NQF, the Ambulatory Care Quality Alliance (AQA) must approve measures before they are scheduled for implementation by payors. The AQA is a collaborative venture of physicians, consumers, purchasers and health insurance plans. Their hope is to improve health care quality and patient safety through a collaborative process in which all organizations agree upon a performance measurement at the physician or group level in the least burdensome way while reporting meaningful information to improve patient care. The physician members of the AQA are pushing for a universal implementation of AQA-approved measures to prevent overlapping of reporting measures.

The Surgical Quality Alliance (SQA) is a consortium of 20 surgical specialties that meets prior to AQA meetings to discuss issues. The SQA helps to ensure that all surgical specialties present a united front at the AQA and ensure that the issues and characteristics of surgical care measurement, data collection and reporting are addressed.

Although this process may seem complex, it is a greater comfort than the alternative, which would allow for measures to be developed by nonprovider groups.

—Tina Scavetta
Anesthesia Account Manager

Coding Corner

Sharon Donelli, CPC
Administrative Officer

ICD-9 Update The "New" Headache

Pain physicians treating patients with chronic headaches will have several new diagnosis codes from which to choose effective October 1, 2008. The two dozen new codes are much more specific, expanding the list for cluster headaches and introducing additional categories of headaches for tension, drug-induced, post-traumatic, as well as headache syndromes.

The generic old standby headache code—784.0—should now just be used for facial pain and any "not otherwise specified" head pain.

When choosing one of the new specific head pain codes, be sure your documentation matches the condition or subcategory that you have selected. Find them in the series of codes beginning with 339.XX.

Credentialing Delays

Having trouble with your Medicare enrollment applications? The delay may be preventable! This topic was recently discussed in an Open Door Forum on enrollment at the Centers for Medicare & Medicaid Services (CMS). Providers were told that if they are submitting a complete application the first time or responding fully to requests there should be little or no need to follow up and obtain status requests.

Some tips to help make sure your doctor's enrollment applications go through on the first try:

- Use the correct, most up-to-date form. If you have the 2001 or earlier version, your application will be sent back right away. The correct form can be obtained at www.cms.hhs.gov/medicareprovidersupenroll.
- Be sure that the carriers have your correct mailing address. A big part of delays are attributed to carriers sending provider communications to the wrong addresses. Instead of sending them to your "correspondence address" they may be sending the letter to your "pay-to address" which will hold up getting the needed information to the correct area.
- Make sure that the physician reads the application over and checks that all the information is accurate and complete before you send it in.
- Be prepared. If a physician has not submitted an enrollment application since 2001, you'll have to submit a whole new form for the doctor—even if you're just changing some information. For changes of information, you only have to fill out Section 1B of the form.
- Your legal business name must match the name listed with the Social Security Administration and the National Provider Identifier (NPI) database. If you're applying as an organization, it also must match the name in the Internal Revenue Service database. Don't abbreviate it or change anything.
- If the provider is re-assigning Medicare benefits to someone else, list that person's Medicare ID number in section 1A, if applicable.

- You must check "YES" or "NO" for the question in Section 3 about adverse legal actions. If the answer is "YES", you have to list all adverse legal actions that you've faced—and provide any supporting documentation.
- If your physician has multiple NPIs or associated Medicare ID numbers, list all possible combinations in Section 4.
- Choose your contact person carefully and list that person in Section 13. This will be the only person the Medicare contractor will try to reach, so it should be someone who is easy to get in contact with. It should be someone with direct access to your physicians, so he/she can obtain the answers to any questions quickly. If the contact person is hard to reach, your application may be delayed. If you don't list anyone, the contractor will call your physician directly.
- Include all documentation, including professional licenses, business licenses, the notification you received of the physician's NPI number and your electronic funds transfer agreement with Medicare—the CMS form 588.
- Don't use a copied or stamped signature. Get your physician to sign the form personally.

If all of these steps are followed, chances are your application will go through without a hitch!

—Tina Scavetta

PA Hospital-Based Billing

When an anesthesia group employs a Physician's Assistant (PA) they often have them perform such services as the placement of preoperative lines, pain management follow-up visits or other types of hospital consultations or visits. It's very important that the documentation of these billable services reflects whether the service was provided solely by the PA or in conjunction with another physician provider.

Many payers require direct PA billing when the service is indeed solely performed by the PA. The payers that accept direct PA billing are:

- Blue Cross
- Community Health Network
- Northeast Health Direct
- Connecticare
- Healthnet
- Medicare
- Railroad Medicare
- Tricare
- Private Healthcare Systems (includes: Northeast Healthcare Alliance (NEHCA), HMC PPO and Multiplan)

Direct PA billing yields 85% of the allowable fee from the payer.

There are other payers that do not accept direct PA billing. Included in that list are:

- Aetna
- Cigna
- Medicaid
- UHC/Oxford

You would have to contact those payers for direction on how to bill PA charges to them, but often the answer is to send it in under the supervisory physician's name. In these cases, the payer will reimburse 100% of the allowable fee for the particular charge.

—Sharon Donelli, CPC

New Law Re-Defining Dependents

Cynthia Ambrose
Human Resources Manager

Last year, Connecticut passed a law that changed the definition of dependent under group and individual health policies. This law will extend coverage to children until the age of 26. The former definition under most plans was "a child under age of 19 or a child under 23 who is a full time student". The new definition will change to "a child under 26 who resides in the State of Connecticut" subject to certain conditions in the law.

This law takes effect for group health plans on January 1, 2009. Changes for individual policies take effect for new policies issued on or after January 1, 2009 and for existing policies on the first date of policy renewal after January 1, 2009. This definition does not require an economic relationship, i.e., no requirement that the child rely on the employee-parent for support in order to be a dependent under their health plan.

The right of enrollment ends when the child:

- Marries
- Ceases to be a resident in the state (except for students)
- Becomes covered under a group health plan through the dependent's own employment; or,
- Attains the age of 26

If you are covered under a group plan, you will be able to add dependents that are under age 26 effective January 1, 2009.

Why Days in AR Matter

Liz Dickman
Chief Financial Officer

While the argument could be made that there is really no difference between 30 and 60 days in AR because the accounts are still paid—the reality is that the older a claim is, the greater the risk that it will not be paid. Most carriers have timely filing limits, meaning the provider will not be paid if a charge is not submitted within a certain number of days from the date of service. A service that is payable, but not submitted timely, is basically being provided for free.

Electronic claims submission and direct payer billing have sped up the payment process significantly over the past five years. With the average payment turnaround time for Medicare and Blue Cross Blue Shield being within 15 days, and the other major payers being within 30 days, a high days in AR is the result of poor performance by the billing service or department. It is often due to a slow charge process, lack of follow up on unpaid accounts, or a combination of the two.

In addition, the excess cash sitting in AR could be used to either invest or pay out bonuses sooner to the owners.

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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