

NEUROSURGICAL 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

CONCIERGE MEDICINE

What is that? Concierge medicine is a term used to describe a relationship with a primary care physician where a patient pays an annual fee or retainer. In exchange for this retainer, physicians provide enhanced care. This concept has also been referred to as "boutique medicine", "retainer-based medicine" and our personal favorite—"innovative medical practice design".

Concierge physicians tend to care for fewer patients than in a conventional practice. All claim to be accessible via cell phone or email at any time of the day or night. The annual fees vary widely, from \$60 to \$15,000 per year for an individual, with the lower annual fees being in addition to the usual fees for each service and the higher annual fees including most services.

Those opposed to this practice feel that concierge medicine is not the solution to the healthcare system's woes, but is a symptom of too much emphasis being placed on cost control and too little emphasis on the patient. Insurers are among those opposing.

Proponents of concierge feel that it meets consumer demand, allows physicians to provide the treatment they deem necessary, and improves quality of care by increasing the amount of time that can be spent on preventative medicine. Physicians significantly reduce the number of patients they see in a day which allows them to spend extra time and attention with each patient. Often physicians disillusioned and fed up with managed care rules and exclusions are among those willing to entertain this as a possible solution to their woes.

Some personalized services that a concierge patient may expect are:

- Same day or next day preferred appointments
- Physician availability 24 hours a day, seven days a week
- Private reception area with numerous amenities
- Dedicated support personnel

The Government Accountability Office presently reports 146 such practices and notes that they are mostly concentrated on the East and West coasts.

—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.

—Sharon Donelli, CPC
Administrative Officer

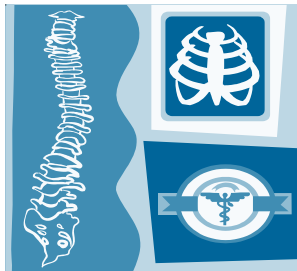
CODING CORNER



Sharon Donelli, CPC
Administrative Officer

Dural Tears Live Elsewhere in ICD-9

An accidental puncture or laceration during a procedure



is coded with 998.2. This included dural tears—up until 2009. The 2009 ICD-9 book which is effective with October 1, 2008 dates of service, revised 998.2 to **EXCLUDE** dural tears and re-directs the user to two new codes:

- 349.31 Accidental puncture or laceration of dural during a procedure
- 349.39 Other dural tear



MENTOR AND MOTIVATE

Mentoring is about motivating and empowering staff, creating a system of semi-structured guidance that encourages staff members to maximize their full potential in the workplace. This sharing of knowledge and experience can have a positive affect throughout the practice.

There are four main types of mentoring that you can tailor to your practice's needs:

1. Mentoring for New Employees

This type of mentoring is useful as a source of information on policies and procedures and for practice orientation.

2. Developmental Mentoring

This mentoring is useful for employees given new roles or increased responsibilities, helping the employee to build confidence, develop strengths and potential.

3. Peer Mentoring

This type of mentoring is for experienced staff that can cover progress and development, but may also involve peer support with project management and accountability to each other for action plans.

4. External Coaching

This type of mentoring is useful where confidentiality is essential. The external mentor will be working purely on behalf of the employee.

A well-developed mentoring system is an efficient way to manage the careers of staff members. It can be used as a vehicle for building an integrated practice team and assist with implementing new initiatives and communicating practice goals.

Mentoring systems can also aid practices in breaking down any barriers that may exist within the team and improve staff satisfaction and motivation by uncovering under-utilized staff skills. Confident staff will feel unthreatened and happy to be mentored as part of their career development.

It is important to remember that mentoring is not about taking remedial action or fixing a problem around a hopeless employee. It is about a skilled colleague sharing knowledge and experience to assist another team member and your practice to grow and progress professionally.



—Tina Scavetta

IPMS Account Manager

CIGNA ACQUIRES GREAT-WEST

CIGNA has acquired Great-West Healthcare. This means Great-West is now part of CIGNA. There are no changes to claims submission, fee schedules, patient benefits or contracts at this time. Providers are to continue to process claims for CIGNA and Great-West as they are currently processed. Providers will be contacted regarding how this will affect them once the merge of the two carriers begins.

Additional information and frequently asked questions regarding this issue can be found on the CIGNA website, www.cignaforhcp.com; click on Important Information in the News You Can Use column (on the right of the screen).



—Michele Krpata, CPC

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.

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UPDATES FROM MELANIE



Melanie Vail
Director, Ops & Marketing

At IPMS, our state of the art billing software has been customized to what IPMS feels is most important—capturing every penny of revenue you're

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.



entitled to. We pride ourselves on our follow through.

We have created special no response reports that we run on a weekly basis to capture any charges that have not been responded to within 30 days of submission. This ensures that nothing falls through the cracks and each and every one of your services are accounted for and followed-up on until we receive payment in the door.

At IPMS no stone is left unturned—IPMS will turn the services you provide into the reimbursement you deserve, both timely and effectively.

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

“We are a large neurosurgical practice that has utilized the billing and collection services of IPMS for the past year and a half. They have done an outstanding job with our accounts receivable, our 121+ has never looked so good . . . I would recommend them without reservation.”

-David Kvam, M.D.
Neurosurgeons of Central Connecticut
Hartford, Connecticut



IPMS Integrated Physicians
Management Services

111 Founders Plaza, Suite 300
East Hartford, CT 06108
Main Phone # (860) 282-0833
Fax # (860) 282-0170

Neurosurgical News Staff

Tina Scavetta, Editor-in-Chief
Email: tina_scavetta@ipmscorp.com
Phone #: 860-282-4118

Bea George, Editorial Assistant
