

NEUROSURGICAL NEWS

A Message From IPMS



Tina Scavetta
IPMS 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.

USE MODIFIER 78 APPROPRIATELY

Modifier 78 is the "return to OR within global period" modifier. Specifically it is defined as "Unplanned return to the operating/procedure room by the same physician following initial procedure for a related procedure during the postoperative period".



CCI (Medicare's Correct Coding Initiative Guidelines) states that "when the services described by CPT codes as complications of a primary procedure require a return to the operative room, they may be reported separately; generally, due to global surgery policy, they should be reported with modifier 78 indicating that the service necessary to treat the complication required a return to the operative room during the postoperative period".

A typical case for the neurosurgeon would be: A patient develops an infection a few weeks after having a craniotomy for brain tumor excision. In that the infection occurs deep within the surgical wound, a return to the operating room is planned to surgically debride the area. In this case you would report 11000-78. Be sure that the diagnosis reflects the reason for this encounter, which in this case would be 998.59 (other postoperative infection).

Using a similar example, in this case the infection is only along the suture line. The neurosurgeon inspects and cleans the wound, changes the patient's dressings and administers antibiotics in the office setting. Since the physician treated the complication without a return to the OR, the service is bundled into the initial procedure's global surgical package.

Procedures billed with this modifier include only the service's "intraoperative" portion. No payment is made for pre- and post-operative care and, hence, are generally reimbursed at 65-80 percent of the full fee schedule value depending upon the payer.

—Sharon Donelli, CPC

2007 PQRI FEEDBACK REPORT

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce that 2007 PQRI Final Feedback Reports will be made available in mid-July 2008 on a secure Web site. Although the PQRI feedback reports are not yet available on this Web site, CMS recommends that practices take the time now to set up their online account so they can access their report as soon as it is available.

Click on the [Register Now to Access Your 2007 PQRI Feedback Report](https://applications.cms.hhs.gov/category.html?name=acctmgmt) link at <https://applications.cms.hhs.gov/category.html?name=acctmgmt> for directions and links needed to obtain the 2007 PQRI report.



—Tina Scavetta

CODING CORNER



*Sharon Donelli, CPC
Administrative Officer*

Nursing Facility Services

Medicare's MLN Matters article Number MM5968 reports that effective for services on or after July 1, 2008, you may bill Medicare for medically necessary prolonged services for E/M visits (codes 99356 and 99357) in a SNF or NF with Nursing Facility Services codes (99304 – 99306, 99307 – 99310 and 99318).

You may also use these prolonged services codes (99356 and 99357) with Nursing Facility Services in the code range 99304 – 99306, 99307 – 99310, and 99318 to bill for counseling and/or coordination of care services that are based on time.

Effective January 1, 2006, the American Medical Association (AMA) *Current Procedural Terminology (CPT)* Panel removed the typical/average time units for evaluation and management (E/M) services in the Nursing Facility code family. Until these typical/average times were re-established, this action

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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

DOES GAMMA KNIFE SURGERY CUT YOUR REIMBURSEMENT IN HALF?

No, not if it's coded correctly! Often more than one lesion is treated when performing gamma knife surgery, otherwise known as stereotactic radiosurgery. The AMA now says that surgeons can report 61793 twice if the patient had two lesions, one on the right side and one on the left side of the brain. "Code 61793 is valued for a single metastatic lesion," and multiple lesions require "significantly more physician work" on radiosurgical planning and treatment.

When billing multiple units of 61793, the coder should attach either modifier –59 (Distinct procedural service) or –51 (Multiple procedures), depending on payer requirements, to verify that the surgeon treated two separate lesions.

—Sharon Donelli, CPC

MEDICAID HOT TOPICS ~ KEEPING YOU IN THE LOOP

Medicaid has developed a website to keep providers informed of system issues or ways to resolve common denial issues. Your office will benefit from logging onto www.ctdssmap.com for their weekly Hot Topics listing.

This website can be instrumental to your follow-up on Medicaid claims as they identify system issues as they arise and offer specific instructions on how to get your claims re-processed as necessary for all specialties. It also references other Medicaid Managed Care plans and offers updates to system issues within their programs as well.

—Tina Scavetta

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

UPDATES FROM MELANIE



Melanie Vail
Director, Ops & Marketing

Knowledge is power. "Neurosurgical 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.

A LOOK IN THE MIRROR



It's a well-known fact that we are judged on our appearance, attitude and behaviors in nearly everything we do. It is also known that appearances can be deceiving. Just as people warn their friends and family of bad service at restaurants, or a bad movie at the theater, the same thing can happen to your practice. In most cases, people don't complain to the physicians, but what they will do is warn their friends and family and refuse to return. Without their feedback, you remain unaware of the problem and the patient remains unsatisfied.

An easy fix to this dilemma is to ask your patients for advice and feedback. They actually may be pleased to be solicited for their opinions. Patients want to be heard, both about the negative and the positive. The use of an anonymous written survey, one page, with a series of graded responses, starting with easy questions and getting more serious is one way of obtaining the patients true feelings on dealing with your physicians and staff. Allow some open-ended questions for the patients to express themselves as well. Have the physicians hand the patients the survey at the end of their appointment along with a stamped envelope so that they can fill it out and return it at their leisure.

You may be pleasantly surprised at how many positive and supportive comments you will receive from patients. However, what you really want to focus on are those complaints addressed by more than one patient. Actively listen to what your patients are trying to tell you and try to read between the lines if necessary.

As a follow-up to these surveys, you must correct the weaknesses and problems that have become apparent and take the opportunity to communicate to your patients that you appreciate and value their input. A little effort goes a long way toward making your patients happy and your practice successful.

—Tina Scavetta

Coding Corner Nursing Facility Services (continued from page 2)

precluded the billing of: 1) prolonged services for E/M visits in a skilled nursing facility or nursing facility; and 2) time-based counseling and/or coordination of care for Nursing Facility Services.

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
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