

ORTHOPEDIC OUTLOOK

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*

NEW LAW RE-DEFINING DEPENDENTS

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

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CODING CORNER



Sharon Donelli, CPC
Administrative Officer

Arth Corocoid

You won't find a code in 2008 CPT for either an arthroscopic or open coracoplasty. Quoting CPT guidelines, "... if no specific code exists, then report the service using the appropriate unlisted procedure or service code". The correct unlisted code to utilize for an arthroscopic procedure is 29999.

When billing an unlisted code to a payer, you need to compare the unlisted service to another code to help them decide reimbursement. Typically, you can compare arthroscopic coracoplasty to 29826 which describes the arthroscopic decompression of the subacromial space with partial acromioplasty, with or without coracoacromial release.

Follow up on the payer to be sure reimbursement is appropriate for the particular unlisted procedure. Also check out your 2009 CPT when it's released for any additions to the arthroscopic section.

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

NEW LAW RE-DEFINING DEPENDENTS

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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.

—Cynthia Ambrose
IPMS Human Resources Manager

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.

DO YOU HEAR WHAT I HEAR?

Sitting in an exam room waiting to see my physician I could hear the conversation in the next room. It was only a discussion about dinner plans between the patient and the person accompanying her to the visit, but it could have been a discussion of her medical condition with her doctor.

How private are discussions of patient information in your office? Are you sure a patient visiting your office is not overhearing discussions regarding other patients?

How can you check an area for privacy? Sit in that area of the office. What can you hear? Can you hear conversations regarding patient information being discussed across the room, through a closed door or through a wall?

Areas you may want to check:

- Patient waiting area - Can discussions at the reception desk be heard from the waiting area?
- Exam rooms - When the door is closed or partially open can you hear a conversation being held outside the door or in the next room?
- Physician's office - Does the physician speak with or about patients in his/her office? Are other patients within the area of this office? Can conversations within this office be heard in the hall outside the office?

What simple things can be done to mask private conversations around the office?

- Play music in waiting area and exam rooms.
- Place a television in the waiting area.
- Place white sound machines around the office.

—Michele Krpata, CPC

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

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



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 . . .

“IPMS has brought organization to our office, allowing our staff to focus less on billing and more on patient care. They have great reporting. Having their CEO in the driver’s seat with managed care contracting has been a significant benefit to our practice . . . I have recommended IPMS without reservation and will continue to do so.”

Daniel Veltri, M.D.
Sports Medicine and Orthopedic Surgery
Manchester, Connecticut



IPMS Integrated Physicians
Management Services

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

Orthopedic Outlook Staff

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

Bea George, Editorial Assistant
