

ORTHOPEDIC OUTLOOK

A Message From IPMS



*David L. Korn
Chief Administrative Officer*

In this edition of Orthopedic Outlook, we would like to introduce Mr. David L. Korn, Chief Administrative Officer of IPMS. Mr. Korn has been very successful in the healthcare industry during his career. He has proven to be an innovative leader with an impressive record of accomplishment, and more importantly, he has demonstrated a deep interest in IPMS and its future.

With more than 25 years of experience in the healthcare industry, his diverse experience includes executive management, business development, project management and client consulting in the healthcare and information technology industries.

Mr. Korn's healthcare background focuses on service delivery and strategic business development. He be-

(continued on page 3)

RED FLAG RULES ~ARE YOU READY?

The Federal Trade Commission (FTC) has announced that the enforcement of the Red Flag Rule will go into effect November 1, 2009 for health care providers. So what exactly is a "Red Flag"? The rules define a "Red Flag" as any "pattern, practice or specific activity that indicates the possible existence of identity theft". The intention of the Red Flag Rule is to provide consumers, our patients, with protection from identity theft. At IPMS, we are ready for the Red Flag Regulations. We have a high obligation to our clients to provide our services in accordance with the Red Flag Rule requirements and have developed policies and procedures designed to detect, prevent and mitigate identity theft. We have internally performed a risk analysis; developed an Identity Theft Prevention Program; and have fully trained our staff on this ruling as well as existing HIPAA-related policies and procedures—which already puts us ahead of the curve.



According to the FTC, a physician falls under the definition of "creditor", one who maintains "covered accounts". These are accounts that are set up to permit multiple payments or transactions, such as insurance payments allowing unpaid balances to be billed to the patient.

In order for your practice to comply with the "Red Flag" Rule, there are four measures that must be taken to provide the necessary administration of the program. The healthcare entity must establish policies and procedures to:

- Identify relevant Red Flags and incorporate them into the program.
- Detect Red Flags that are part of the program.
- Respond appropriately to any Red Flags that are detected.
- Ensure the program is updated periodically to address changes.

There are extra steps physician offices should take to decrease the possibility of identity theft. They should not only take the patient's insurance card for review, but also compare the name on the card and the patient's photo identification. If the office is making copies of these forms of identification (i.e., insurance card, driver's license), the office must be sure that this information is kept secure. According to the World Privacy Forum, staff should take patient complaints and inquiries seriously. Should a complaint or question arise from a patient on the receipt of a bill for another patient, a service they state they never received, a physician they never saw, or an insurance explanation of benefits they feel is incorrect, the "Red Flag" policies should be followed to investigate the possibility of identity theft.

Every physician practice and every billing entity must be ready for the Red Flag enforcement on November 1, 2009. Further information regarding Red Flag Rules can be found on the Federal Trade Commission's website at <http://www.ftc.gov/opa/2009/07/redflag.shtm>.

*—Tina Scavetta
Account Manager*

CODING CORNER



Sharon Donelli, CPC, CPC-H
Administrative Officer

Consultation Pay to go Away?

The codes will still exist in the CPT books, but you may not be able to use them for Medicare patients. The July 13, 2009 Federal Register contained a CMS (Centers for Medicare and Medicaid Services) announcement about a proposal to eliminate consultation codes effective January 1, 2010. The plan would include eliminating CMS reimbursement for all inpatient (99251-99255) and outpatient/office consultation codes (99241-99245). CMS proposes to bundle back the net savings from consultations into initial hospital care and nursing facility care visits.

In that this is a CMS initiative, it would apply only to Medicare patient consultation visits. The concern among providers is that private payers may also begin to adopt this practice. CMS may see this as an answer to the ongoing confusion and debate over what constitutes a true con-

(continued on page 3)

RAC AUDITS ~ ARE YOU PREPARED?

There is a growing trend within the insurance payer industry. Payers are hiring third party vendors to perform post payment audits and claim reviews where such areas as medical necessity, E&M selection levels, documentation and general appropriateness of billing are scrutinized. Where inadequacies are noted, a sum of money representing the calculated overpayments is asked back as a refund. Depending on the scope of the issue, the pull back amount can be quite significant—several thousands of dollars.

Recovery Audit Contractors (RAC) is a CMS initiative for auditing past claims. A two-year demonstration study in three states returned \$693 million to the Medicare trust fund. This demonstration proved that RAC was a strong tool for detecting improper past payments, therefore, Section 302 of the Tax Relief and Health Care Act of 2006 made the RAC program permanent. It will be expanded to all 50 states no later than 2010. It's in Connecticut now!

What triggers an audit? Here are some areas that Medicare RAC auditors focus on:

- Inconsistent coding among partners within a group.
- Upcoding evaluation and management services.
- Improper use of modifiers.
- Inadequate documentation.
- Submitting "unspecified" diagnoses consistently.
- Patient and/or provider complaints.

Cases that are prosecuted most often involved suspected fraud for such activities as:

- Billing for goods and services not rendered.
- Upcoding or billing for more time than the duration of the actual service.
- Charging Medicare patients more than non-Medicare patients for the same services.
- Billing for medically unnecessary tests.
- Misrepresenting the quality of care provided.
- Double billing.

What should you keep in mind regarding insurance audits, in particular Medicare RAC audits? The best defense is good documentation habits. Be sure that all services provided are well documented. Ensure that your billing staff is well versed in E&M rules, bundling, modifier usage and other relevant guidelines for your specialty and are routinely providing you with relevant feedback. Perform periodic audits on your own practice that will reveal potential target areas. Finally, arrange for certified coding professionals to review any medical records associated with your insurance audit or pull back request. Never pay the recovery amount automatically without this important defensive step.

—Sharon Donelli, CPC, CPC-H

FEDERAL INCENTIVES

The 2009 economic stimulus package, which includes money for physicians who add EHRs (electronic health records) to their practice, is already creating a buzz in the medical community.

The proposed stimulus package includes \$44,000 in incentive payments to physicians adopting and using EHRs. Even though physicians won't see the payments right away, this powerful incentive is stirring up interest in the medical community. The payment will come via Medicare and Medicaid beginning in 2011.

Searching for the right EHR for your practice is not an easy task. First, you should decide exactly what you want your EHR to do. You have to be certain what features will best serve your needs. If you want to earn bonuses through the P4P (Pay-For-Performance) program or Medicare's PQRI (Physician Quality Reporting Initiative) you will need to make sure the system you consider can gather patient data and generate reports. Check with your specialty society for suggestions on EHR systems that they have identified as supporting your specialty. Some programs will cater specifically to your specialty's needs.

While the search for the perfect program can be cumbersome, the eventual pay-off and added efficiency to your practice can be worth the headache.

—Tina Scavetta, Account Manager

A MESSAGE FROM IPMS

(continued from page 1)

gan his career as a physical therapist where he learned first-hand the multiple issues and requirements for assuring high quality, effective and people-focused services. Recruited to Mount Sinai Hospital in Hartford, CT he was responsible for the growth and development of the Mount Sinai Hospital Rehabilitation Center. Promoted to Assistant Vice President of Clinical Services, Mr. Korn had executive responsibility for several hospital departments including Cardiology, Obstetrics & Gynecology, Neurology, Pulmonary Medicine and the Mount Sinai Hospital Rehabilitation Center.

Recruited by the Hartford Health Care Corporation to become the President and CEO of Immediate Medical Care Centers (IMCC), David led the financial turn around of IMCC, increased revenues and profitability through significant changes in the operations and marketing functions, and led its initial transition from a group of facilities delivering episodic care to a multi-service primary care organization. He later moved on to help found the Eastern Rehabilitation Network (ERN), a joint venture between Hartford Healthcare Corporation and Advantage Health Corporation (AHCC on NADEQ). As ERN's Vice President of Business Development he helped grow annual revenues from \$2.5mm to \$10mm in an eighteen-month period through practice acquisitions and contract development.

Mr. Korn subsequently founded a health care consulting company, Orion Jones Consulting Group. Orion Jones focused upon business turnarounds and management consulting of for-profit corporations affiliated with large health care systems. Several projects were conducted for health care systems throughout the United States. Consulting efforts focused upon strategic initiatives in medical practice management, occupational healthcare delivery and rehabilitation services.

His entry into the information technology industry began when he and his business partner founded Bletchley Park Advisors. Bletchley Park's mission was to provide business planning, management consulting and access to capital for early stage technology companies. The development of Bletchley Park resulted in the establishment of a business relationship with Court Square Data Group. David and his partner ultimately became employees of Court Square in 2001.

Initially hired as a Strategic Consultant for Court Square Data Group, Mr. Korn was promoted to Vice President of Operations in Groton. Working together with a strong team of professionals he facilitated the growth of Court Square's outsourced and project management service business with Pfizer, Inc. from \$5.5 million to \$14 million per year.

In 2008, he founded David L. Korn, Strategic Consulting, a healthcare consultancy specializing in business and organizational development that assists clients to effectively plan and deliver services and products to the marketplace. Clientele included Yale New Haven Hospital where he was engaged to organize, develop and deliver Business and Operational Plans to guide the implementation and operation of community-based multi-service ambulatory care facilities and centers of excellence.

Mr. Korn holds a Bachelor of Science from Ithaca College and a Master in Public Administration from the University of Hartford. Through the years he has attended several continuing education courses and seminars in executive and financial management and, as an Associate Professor in the University of Hartford's School of Allied Health he has taught undergraduate courses in business administration. Mr. Korn retains his professional licensure in Physical Therapy.

Please join us in welcoming Mr. David Korn to IPMS.

CODING CORNER Consultation Pay to go Away?

(continued from page 2)



sultation versus a transfer or referral of care.

From a coding standpoint, instead of reporting consultation codes, you would now report new or established patient office visits or hospital care; CMS would increase payments for the existing E&M codes. The additional E&M payments, proposed at 6% to 8% most likely will not cover the loss of consultation reimbursement. This would affect specialists in particular.

Per this proposal, CMS plans to create an additional modifier for the admitting physician to append to initial hospital visit codes. This modifier will identify the admitting physician of record for hospital inpatient and nursing facility admissions.

Many physician societies are adamantly opposing this change in policy so the time to panic is not yet. The final rule is to be issued by November 1, 2009.

We Moved!

IPMS recently moved into our new office at 99 East River Drive in East Hartford. Just a stone's throw away from our previous headquarters, our new building is conveniently located at the juncture of I-84 , I-91 and Route 2. We invite you to come visit us in our new home . . .



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