The Business of Spine

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THE SPINAL COLUMN

Fall 2012

INSURANCE DEPENDENCY: GEARING UP FOR NEXT YEAR

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Spine Practices depend on insurance company reimbursement to sustain their practice. Over time this sustainability is directly related to the patient base and insurance reimbursements that the practice develops relative to community, facility and referral relationships. These past years have placed a toll on many spine practices, so maybe it's time to evaluate these relationships to ensure that your practice will be viable well into the future. One way to identify trends in reimbursement, patient populations and referral bases is through an insurance dependency audit.

Insurance dependency is an important aspect that requires the scrutiny of the financial and medical directors along with the physician to track income, patients and referrals. This area involves an analysis of the patient population for both group and individual practitioner's income. It is necessary to examine the impact of an insurance carrier for the group/practitioner as it relates to patient volumes, reimbursement and the stability of the practice over time with the current trends. The insurance dependency analysis also promotes changes in these areas as well to rid the practice of costly, ineffective and insignificant insurance relationships. More importantly, this analysis identifies high dependency volumes, low reimbursement carriers, and presents a clear picture to the analysts.

Areas of concern include:

- **High volume patient base by carrier:** Practices and individual practitioners should be evaluated for insurance dependency on any carrier that is 20-25% or more of their practice. This dependency creates problems as the carrier reduces the rates significantly, therefore producing an immediate reduction in revenues. Additional reimbursement concerns include reductions in cash flow due to changes in policy provision, increased difficulties in authorization and collections processes or the possibility of termination of this carrier with major employers. High volume carriers also absorb appointment times that could be available to other patients.

- **Low volume patient base by carrier:** There is a general understanding that practices will increase patient volumes with a contracted relationship. If you find that the practice has not appreciated this benefit, it may be time to discontinue the relationship or look for ways to increase the patient volumes by reaching out to both your staff and provider relations to ensure that all are aware that you are contractually involved with patient care. This information may have gotten lost amongst either party and correction will help to increase patient volumes. If this is not the case and the patient volumes are not available in your area; reconsider the relationship with that carrier.

- **Fee Schedule Evaluation:** The insurance dependency analysis also looks to evaluate the rates paid by all carriers in a comparison spreadsheet. It will be necessary to identify all product lines for each carrier, as there may be significant differences in reimbursement based on the product type. Generally Medicaid and Medicare programs are the lowest rates with an increase in HMO and PPO products. Preparing a fee schedule comparison spreadsheet in this analysis forces two things, (1) the practice will need to get updated rates and (2) identify those carriers that have unacceptable reimbursement rates. Positioning the practice with full details about carrier reimbursements help to flag those carriers that need to be reconsidered and/or renegotiate with the carriers to an acceptable level.

Additional considerations need to be explored to ensure that the individual physician will not be severely impacted by a decision to withdraw. If the insurance dependency issues are of great concern, there are procedures for consideration to reduce dependency for future consideration of withdrawal. Some options include reducing your overall dependency over time or removing part of the dependency such as the HMO or Medicaid portions of the insurance plans.

- Carriers should be evaluated for fee schedules, labor involved in both the pre- and post-service components of the plan, and percent of patient population.

- Fee schedules need examination for lower than Medicare standards and should be dropped if no adjustment can be made.

- Pre-service labor issues include difficulties in obtaining the referrals necessary, authorizations for additional services and availability of ancillary services within the plan. Post-service labor issues include collection problems such as delays in reimbursement, non-covered charges for physician assistants or nurse practitioners, and unacceptable bundling regulations.

- The patient population analysis involves review of the overall patient base supplied by the carrier, which permits a large reduction in the fee schedule. If the patient base is minimal, then why participate at a reduced fee? A 10% patient base should be considered a minimum for insurance participation.

Continued insurance dependency analysis involves identifying carrier coverage issues, collections and appeals concerns, quantity and quality of the patient base, etc. The analysis ends when you stop looking. The analysis provides patient patterns, reimbursement reliability, and ultimately can lead to greater stability with good forecasting and projections while moving to improve patient base and reimbursement conditions.

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Pre-Authorizations: The Practice's New Challenge

Surgical spine procedures have seen rapid increase over the past decade and the cost of spine has increased as well. Changes in insurance protocols have hindered the ability of the practice to obtain pre-authorizations for service, specifically those for fusions and multilevel decompressions. So what is a practice to do to promote the care that the surgeon has indicated when it has been denied as not medically necessary by the carrier?

First and foremost, the surgeon and the practice need to be the advocate for the patient. In doing so, the patient remains to be involved in all steps from the pre-authorization to the final steps of the insurance track. Patients are often kept out of the loop, but since patients are financially responsible for a significant part of their insurance premiums, they should be kept abreast of communications between their carrier and the practice requests. Most patients want to be involved. This often proves to be vital in discussions if there is a disagreement between the carrier and practice as to the availability of surgical and conservative care.

Spine practices will be required to provide the necessary documentation to support the treatment decisions, whether they are conservative, minimally invasive or complex procedures. Communicate with clear documents identifying the definitive request for treatment. Update pre-authorization templates that identify all treatments that have been undertaken. Look to revise treatment requests that identify the proposed care options in plain language so as to have no ambiguity about the next steps.

Insurance carriers' rights include scrutinizing medical records, past medical treatments performed outside of your care and make coverage determinations based on their medical necessity guidelines and policies. If there is a disagreement about the next steps, both the surgeon and the patient have appeal options. Some include independent medical exams, peer conferencing with both patient/surgeon, participating in arbitration hearings, etc to name a few. Each carrier is required to disclose the appeals process. The practice and patient must make sure to follow this precisely, otherwise the appeals process may be hindered or rejected for noncompliance.

Practices and facilities alike are responsible to understand the requirements necessary to obtain approval for any treatment for their patient. The access to general treatment requirements is available on most insurance carrier websites. Staff and surgeons alike should be involved in the education process to understand the policies and procedures that are necessary to obtain the proper authorizations in a timely manner. Ultimately the patient suffers if all involved in the process fail to adhere to the requirements.

The patient and practice can move to ensure compliance with carrier protocols if a structured plan is devised to promote effective authorization programs. Internal policies of the practice/facility need to understand and meet specific carrier guidelines of treatment. Guidelines for spine treatments are available on the websites for most carriers. Disclosure of these guidelines must be made available to patients/insured policy holders. Proactive positioning in acquiring these documents will promote a more complete and successful pre-authorization department and promote patient advocacy as well.

Pre-authorization Requests should include:

- Clear Diagnosis, identified by ICD-9 codes
- Pertinent Medical Finding
- Radiological Findings, including degrees of curvature, excessive motion, suspicious masses, etc
- Issues of Daily Living that diminish quality of life
- Co-morbidities/Secondary Diagnosis that impacts outcomes
- Past Medical Treatments and their outcomes
- Clear request for treatment, utilizing CPT codes to identify procedure
- Other significant information to promote a positive response.

Include a copy of this request in your patient communications; they will appreciate the work involved on their behalf. Scrutinize the carrier response if there is a denial of the whole procedure, or portions of the procedure to ensure that there was no miscommunication or incorrect information submitted to the carrier. Look to the website for confirmation of the carrier rules relative to the procedure and communicate with the patient immediately. Know your appeal rights. The surgeon/physician must be involved immediately to re-mediate the situation. Surgeon/physician involvement demonstrates their commitment to patient care and positive outcomes. Proactive and open communications with the patient throughout the process will strengthen the appeal process as well.

2013 Pre-Sacral Coding Change

For those surgeons and practices that have been struggling with coding and reimbursement issues surrounding the T code for pre-sacral fusion, they will be happy about the release of the new CPT code that represents this code:

22586: Arthrodesis, pre-sacral interbody technique, including disc space preparation, discectomy, with posterior instrumentation, with image guidance, includes bone graft when performed, L5-S1 interspace

0195T has been revised to no longer include instrumentation:

0195T: Arthrodesis, pre-sacral inter-body technique, disc space preparation, discectomy, without instrumentation, with image guidance, includes bone graft when performed, L5-S1 interspace.

Code 0196T still remains in place for the additional L4-L5 interspace. Now, this does not relieve the practice of following through with obtaining the proper authorizations to support the reimbursement requirements for these procedures. Note that some carriers still have categorized pre-sacral fusion as experimental and will not provide coverage for these cases. It is recommended that each case have a very specific authorization, even if performed as an outpatient, and this authorization should include patient name, ID number, place and type of service along with the CPT and ICD-9 code indicated in this written authorization. It will prove to be a useful tool if there is a reimbursement/coverage dispute with the carrier.

Vertebroplasty Coding Reminders

- 22520 Vertebroplasty, thoracic Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injection; Thoracic; Moderate Sedation is bundled

- 22521 Vertebroplasty, lumbar Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injection; Lumbar; Moderate Sedation is bundled

- 22522 Additional level; vertebroplasty; each additional thoracic or lumbar vertebral body, Moderate Sedation is bundled

Imaging codes include:

- 72291 Radiographic supervision and interpretation, percutaneous vertebroplasty, vertebral augmentation or sacral augmentation including cavity creation per vertebral body or sacrum; under fluoroscopy guidance

- 72292 Radiographic supervision and interpretation, percutaneous vertebroplasty, vertebral augmentation or sacral augmentation including cavity creation per vertebral body or sacrum; under CT guidance

Please remember that vertebroplasty procedure codes include the bundling of the moderate sedation often accompanying these cases. Moderate sedation is the anesthesia that does not require breathing support. According to the AMA CPT guidelines for Moderate (Conscious) Sedation "... these services include moderate sedation, it is not appropriate for the same physician or qualified health care professional to report both the service and the sedation codes 99143-99145." There is the possibility to code for associated anesthesia services when performed by other physicians or professionals not performing the diagnostic or therapeutic services.

Be sure to code correctly and avoid unbundling these codes. Bundling edits for this code include the biopsy procedures performed at the same level, and it is not appropriate to use the fracture codes 22325-22328 as these represent open fracture treatments. The practice is still able to code and look to be reimbursed for the fluoroscopy or the CT scan services that are required to perform these percutaneous procedures.

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We aim to raise the bar in the spine industry through increased business and financial awareness for all spine professionals, while promoting national compliance within industry and Federal standards.

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CODING UPDATE INSIDE

About Us

Since its inception in 1998, ***Business Dynamics*** *has emerged as a leading spine coding and medical reimbursement firm serving spine practices, spine product manufacturers and numerous organizations throughout the United States. Based in New York and Texas,* ***Business Dynamics*** *continues to successfully seek new ways to develop and expand knowledge within the spine industry to ensure maximum reimbursement for the spine specialist.*

In order to fill the void in training and education for the spine professional, ***Business Dynamics*** *developed* ***The Business of Spine****, our spine specific education and consulting company. With over 20 years of experience in the field of spine coding and reimbursement,* ***The Business of Spine*** *brings the business mindset into focus by combining many years of spine coding knowledge and experience to assist clients in maximizing reimbursement and increasing office efficiency.*

The Business of Spine *provides a full range of spine-specialized consulting services performed by seasoned experts in Practice Management, Spine Coding & Billing, and Hospital Financial Management. This extensive list offered to spine specialists nationally includes* ***Claims Review and Audit Services, Comprehensive Billing Office Assessment, "The Spinal Cord"****, a hotline service offering real time coding advice, along with onsite educational* ***Lectures and Seminars*** *for Physicians, Facilities, and Manufacturers.*

The Business of Spine's *Accreditation Series for the Spine Reimbursement Specialist is AAPC-approved and provides the spine professionals with resources and tools needed to expand their knowledge of spine coding, collection, and appeals issues, allowing career advancements and providing stronger support to the spine business.*

Our ***Spinal Column Newsletter*** *and* ***Coding and Reimbursement Advisories*** *offer updates for our clients as changes occur in the realm of spine coding and reimbursement in response to state, federal, or insurance commission legislation.*

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