The Business of Spine

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THE SPINAL COLUMN

Spring 2011

THE LIFE CYCLE OF AN INSURANCE CLAIM

By: Barbara Cataletto, MBA, CPC, Chief Executive Officer/Managing Director

Contrary to most beliefs, the life cycle of an insurance claim begins before the patient even enters your waiting room or operating room and continues long after the post-operative visits. Below are steps we recommend be followed in order to process an insurance claim efficiently to maximize your reimbursement.

Preapproval: Establish the viability of the insurance. Secure proper authorization from all carriers involved. Know the limitations/restrictions of the policies. Get authorization in writing, identifying patient by name, ID number and other pertinent information. If the carrier will only authorize verbally, follow up with a confirmatory fax/letter detailing the information. Request any incorrect information be communicated immediately.

Reapprove: Reconfirm all previous information immediately prior to surgery. Establish communications with the carrier, insurance claims representative, case manager, etc to ensure that all required and necessary protocols have been followed and that the case is still open for coverage.

Document/Dictate: The documentation / dictation is the next important step and should be performed immediately after the procedure is completed. Consider this the details of the sales slip. Itemize the procedures in a clear and concise manner. The procedure performed portion is an important introduction of the procedures that require completeness for the initial documentation process. This is a line item detail of services. The additional information in the operative report includes indications and patient medical history. Each procedure should be detailed in its respective paragraph, identifying all of the aspects involved in that specific procedure. The documented procedure should be able to stand on its own with a correlation to the descriptor of the CPT code chosen for submission. Surgeons and co-surgeons, as well as each Assistant, must properly identify themselves on the operative reports. Each surgeon and co-surgeon must provide their own documentation and their respective codes for submission, assistants submit accordingly.

Code: Code selection should represent all the procedures performed in the case. The codes should follow a specific order to correspond to the operative report. It is recommended that the series of codes be formatted to present all decompressive procedures collectively and all arthrodesis procedures in concert with each other. This technique displays the codes uniformity in a summarized manner, keeping all the related codes together.

Recode: Coding once gets the initial process started. Recoding ensures compliance and correct submission process. The need to have the case coded and recoded will be evidenced in reduced corrected claims and appeals. The second coding review will also catch missed coding opportunities that will promote increased income to the practice.

Submit Paper or Electronic: Claim Submission protocols need to be considered for the type of carrier involved. Many carriers permit electronic claims submissions, while others require the paper claim with additional documentation. Medicare requires electronic submission for just about every claim type and practice. It is recommended that the practice consider submitting the surgical claims with the operative reports to ensure that all coding and documentation is provided to support the reimbursement process. This will "thwart" the continued delays often accompanied with electronic submission whereby the carrier delays the reimbursement process while waiting for medical records (supportive documentation; .ie. the operative report). If electronic submission is the only possible process, it is necessary to check the submission reports for " transmission failures" or accepted electronic receipt.

Track: The collection process should begin immediately with a confirmatory receipt of the electronic claim or a strict timetable of follow up on paper claims. Commercial carrier follow up should begin at three weeks with a call to confirm receipt of the claim. Basic information should be noted: All claims received for the case; date received; all documentation necessary for payment is available; expected date of payment. Follow up calls should be considered at two weeks and adhere to the same protocols for documentation of the reimbursement process.

Collect: Pursuing the funds will sometimes present a more difficult situation than expected. Persistence in the collections area helps one achieve reimbursement goals. Specific collection processes are beneficial to resolving the issues that delay payment more than necessary. Early intervention alleviates issues involving several obstacles such as coordination of benefits confirmation, requests for additional medical documents, etc, and allows the flow to continue to completion. If there are continued difficulties, then escalating the case to higher levels of management for resolution will happen sooner than later.

Audit: Payments need attention in order to ensure that all funds due on the case have been received. Auditing the case often provides the opportunity to check the coding once again, allowing the practice to evaluate the reimbursement and promotes an active appeals program.

Appeal: If reimbursement received is not within the guidelines for all of those involved in billing services, then the appeal process begins. Following a standard of appeal selection and submission will force the practice to identify documentation issues, protocols and carrier idiosyncrasies. Tracking the appeal will be similar to the collection process with tiers of escalation to be considered in order to ensure that the results of additional funds or further explanation of denial is provided and accepted.

Review for Close: Accounts need to be formally closed, especially when significant revenue is involved. The formal review process recommended for high dollar claims helps build the program that incorporates compliance, completion and correction in areas that may need adjustment. The first review to close will provide the initial move to close. This suggests that all coding is compliant and correct, that the collection process has been completed and, to the level expected, accepted by the practice. It also provides the opportunity to correct or modify the process in the office in order to enhance the practice policies and, eventually, the bottom line.

Close: This is the final component in the Reimbursement process. Closing a claim allows for a check of all the documents by another person who agrees or disagrees with the initial reviewers position to close.

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Business Dynamics Online and *Business Dynamics Consulting* have merged as the new company

The Business of Spine

On December 1, 2010, The Business Dynamics Companies: *Business Dynamics Online and Business Dynamics Consulting*, known for spine specific education and consulting services for the entire industry, have merged to form ***The Business of Spine.*** Throughout 2011, we will be unveiling our fresh new look including new logos, graphics and products.

The Business of Spine will serve as the spine industry's go-to company for all of your spine training, education and consulting needs, offering new products, including our **one of a kind "Spine Reimbursement Specialist Accreditation Series"**

An Accreditation Series for The Spine Reimbursement Specialist

APPROVED BY
THE AMERICAN ACADEMY OF PROFESSIONAL CODERS

THE FOUNDATION

Spine Coding and Reimbursement
APPROVED FOR 10.5 CEU
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Spinal Anatomy

Spinal Diseases & Surgical Procedures

The Four Elements Spine Coding

Spine Coding For The Reimbursement Specialist

Mastering Modifiers

Coding Applications

THE FRAMEWORK

Spine Reimbursement and Appeals
APPROVED FOR 12 CEU
Credits From the AAPC

Coding Scenarios for the Spine Reimbursement Specialist

Surgeon's Compensation, Documentation & Reimbursement Process
Part 1 - The Anatomy of an Operative Note
Part 2 - Advanced Modifier Calculations
Part 3 - Developing an Auditing Process

The Appeals Process

THE FOCUS

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Insurance Dependency

What to Consider When Contracting with Insurance Carriers

Contract Review and Negotiations

Non-Contracted Reimbursement Considerations

SAVE THE DATE!

September 14 - 16, 2011
Houston, Texas

Presented by:
Barbara Cataletto, MBA, CPC, Chief Executive Officer
Mauro M. Cataletto, MD Medical Director

Tuition for each session (each day):

$595.00 per person (Breakfast & Lunch included)

Early Bird Special: $495.00 per person (Before August 1, 2011)

Don't delay …Seats are limited.

For more information contact us at:
The Business of Spine
888-337-8220 ext 7
contact@businessdynamicslimited.com

Announcing "The Business of Spine Accreditation Series"
By: Diane DiGregorio
Education and Event Coordinator

We are proud to announce The Business of Spine's Accreditation Series for The Spine Reimbursement Specialist and staff, recognized by the American Academy of Professional Coders.

Our "Steps for Success," **The Foundation**, **The Framework**, and **The Focus**, were developed with spine in mind. Ten years in the making, these educational seminars offer all members of the spine community the chance to increase their knowledge of the spine reimbursement arena.

The first course in the series, **The Foundation**, a prerequisite for **The Framework and the Focus**, was held on February 12, 2011 in New York City. This one day educational event covered a full spectrum of topics, including spinal anatomy, spinal diseases, coding applications, and the importance of modifiers.

The second in the series, **The Framework**, launched in New York City, on April 9th, along with a repeat of the first course, **The Foundation**, takes the spine reimbursement specialist to the next level of coding and reimbursement, detailing the auditing and appeals process, advanced modifier calculations, surgeon's compensation, op reporting and actual hands on work with case presentations.

The launch of the third and final course in the series, **The Focus**, was held on May 20th, 2011, at the same venue, New York's Executive Conference Center. This course focused on insurance dependency, what to consider when contracting insurance carriers, contract review and negotiations and non contracted reimbursement.

All courses include tests to ensure comprehension and receive multiple CEU credits from the AAPC. Supporting materials, such as presentation handouts, workbooks, glossaries, sample cases and valuable resources for use on the job, are given to each attendee. Attendees are also afforded the opportunity to speak one-on-one with our presenters.

If you missed our New York City courses, we will be repeating the series in September 2011 in Houston, Texas.

We are also expanding the Accreditation Series to include webinars, for the spine reimbursement specialist to expand their education conveniently from their home or office.

For more information on the Accreditation series, the webinars, the online courses or any of our other services, please contact us at **888-337-8220 Option #7 and let one of our educational coordinators help you further your education in the area of spine.**

FUTURE PRODUCTS

Other educational programs in development as part of our ***Spine Education Series*** include the following, with more workshops in development:

Spine Business Specific Webinar Series
The Women in Spine Education Series
The Entrepreneur in You: Physician Series
The Spine Reimbursement Landscape for the Spinal Sales Consultant
Coffee Break Sessions for the Spinal Sales Consultant

Pre Authorization Considerations for your Spine Practice

By Kelli Tota, MBA
Strategic Marketing Manager

Surgical spine procedures have seen rapid increase based on statistics from the Agency of Healthcare Research and Quality, the representative information source from The United States Department of Health and Human Services.

Federally funded and CMS insurance carriers and programs are forced to reconsider where their healthcare dollars are spent. The new healthcare reform's goal is to provide affordable healthcare and to meet these demands. All citizens are responsible to meet established criteria, whether it is physician, patient or facility, in order for third party reimbursement to be considered as long as stringent protocols are implemented.

Spine practices and facilities will be required to provide the necessary documentation to support the treatment decisions with cost effective solutions to the patients' ailments more than before.

Insurance carriers' rights include scrutinizing medical records, considering independent medical exams, conferencing with both patient/surgeon, and participating in arbitration hearings determining appropriate treatment for the primary condition and treatment requests. Parameters for conservative versus surgical treatment are clearly defined, as demonstrated by the information presented by the respective insurance carrier guidelines. Failure to follow through on these requirements may lead to denial of pre-surgical authorization or denial of reimbursement of part or all of the insurance claim post-surgical.

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 surgeon 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 Practice/Facility can ensure compliance with carrier protocols if a structured plan is devised to promote effective authorization programs.

Detailed documentation should include:

1) Common diagnosis and conditions that present to the practice
2) Insurance carrier requirements for conservative care for the common diagnosis and conditions presented
3) Protocols for requests for conservative care options, imaging studies and rehabilitations possibilities. Insurance carriers' protocols and medical necessity guidelines for invasive treatment
4) The obligation of any spine practice or facility is to provide the highest level of treatment available to the patient to manage their condition properly
5) The involvement of outside reviews along with 3rd party reimbursement is an integral component in the management of the patient

Internal policies of the practice/facility need to understand and meet specific carrier guidelines of treatment. Any spine practice or facility should provide the highest level of treatment available to the patient to manage their condition properly. The involvement of outside review with third party reimbursement is an integral component in the management of the patient.

Understanding the position of these external parties will promote a smoother process for both the patient and the practice.

CALIFORNIA FAIR PAY ACT

AB 1455 and Knox Keene Licensed Health Plans

In January of 2001, AB 1455 (Chapter 827, Statutes of 2000) established new requirements for prompt payment of provider claims by health plans. This legislation and the corresponding regulations, requires the payment of interest and in some cases penalties for delayed payments. The legislation and regulations direct the Department of Managed HealthCare (DMHC) to streamline provider claims-payment by establishing internal dispute resolution processes for payers. Health plans are required to submit a *Quarterly Claims Settlement Practices Report*, which contains information on whether the plan or any of its capitated providers failed to timely reimburse at least 95% of complete claims with the correct payment, including interest and penalties.

WHICH HEALTH PLANS ARE COVERED BY THE UNFAIR PAYMENT PRACTICES LAW?

The CMA-sponsored unfair payment practices regulations (AB 1455) apply to Knox-Keene licensed health plans that are regulated by the Department of Managed Health Care (DMHC), including their contracting claims processing organizations, medical groups, and IPAs with delegated claims adjudication responsibilities. The Knox-Keene Health Care Service Plan Act of 1975 regulates all California HMOs, as well as Blue Cross and Blue Shield PPOs.

PPOs (except Blue Cross and Blue Shield PPOs) and other non-HMO insurers are regulated by the Department of Insurance (DOI), and are therefore not subject to the DMHC's unfair payment practices regulations.

WHEN IS THE PAYMENT DUE ON CLEAN AND COMPLETE CLAIMS?

- Non-HMOs: 30 working days
- HMO's: 45 working days.

WHAT ARE THE INTEREST AND PENALTIES ON LATE PAYMENTS?

The interest payment on late payments is calculated at 15 percent a year. Health plans that fail to make automatic interest payments must pay an additional $10 penalty per claim.

WHEN DO PENALTIES BEGIN ACCRUING?

- For Non-HMOs: on the 31st day after receipt of the clean claim.
- For HMO's: on the 46th day after receipt of the clean claim.
  - Example: A clean claim received on March 1st would begin accruing interest on April 1st if not disputed or before March 31st (Day Zero = 3/1 plus 30 days = 3/31).

WHEN DO PENALTIES STOP ACCRUING?

Claims will stop accruing penalties once the claim has been fairly paid to the healthcare provider.

IS THERE A SEPARATE PENALTY INVOICE REQUIRED?

No penalty invoice is required; insurance carriers must automatically calculate and pay penalties as incurred.

For more information on the Fair Pay Act and the Knox Keene act, log onto http://www.healthhelp.ca.gov.

References: http://www.healthhelp.ca.gov/providers/clm/clm_default.aspx
http://www.calphys.org

OUR MISSION

At The Business of Spine, our mission is to provide the Spine Industry with professional development, training and customized education through spine specific consulting services, training programs and educational tools.

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.

THE BUSINESS OF SPINE
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CODING UPDATE INSIDE

Reverse the Decline in the Spine Industry

The medical industry has always been thought of as the "Recession Proof" industry. Medical treatment is a necessity, and people will not go without it… **Right?**

There are many effects that this economic recession has had on the medical industry. Many hospitals and practices are experiencing declines in many areas, from patient volume to profits. The rise in the unemployed means a rise in the uninsured. A rise in the uninsured means a decrease in the number of admissions in hospitals and visits in the doctor's office. Patients are delaying elective procedures and any other procedures that may include higher out-of-pocket fees. These are just a few of the immediate effects of the recession. We foresee many more declines to follow.

Our goal at Business Dynamics and The Business of Spine is to help you compete with the recession and **Reverse the Decline** in the spine industry. It is our priority to assist you in retaining and strengthening the financial health of your practice.

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.*

For more information, log onto www.thebusinessofspine.com or call us at 888-337-8220 #7