

NERVES *News*

A Newsletter from the Neurosurgery Executives' Resource Value & Education Society

Summer 2007

PRESIDENT'S LETTER

Dear NERVES Members:

September will mark the fifth anniversary of the inaugural meeting of NERVES. As we approach this milestone, I would like to take the opportunity to reflect on what has been accomplished in a few short years as well as look to the future of the organization.

For those of you new to NERVES, the AANS and CNS identified a need for neurosurgical practice administrators to form a professional society, with the primary goal of obtaining neurosurgical specific benchmarking data. An organizational meeting was held in Philadelphia in September 2002 with less than forty individuals in attendance. During that meeting the organization was named, bylaws were adopted, and our first officers were elected. The neurosurgical societies pledged financial support during the early years of operation.

It is truly amazing to consider what has been accomplished in less than five years. NERVES has grown from that small group in Philadelphia to an organization boasting a roster of over 250 members. Although all NERVES members are involved in neurosurgical practice, our membership is as diverse as the specialty. We have members from private, academic, and hospital-based practices varying in size from solo practice to large, multidisciplinary clinics.

NERVES has hosted six educational meetings. Each year attendance at the annual meeting increases. Our most recent meeting in Washington, D.C. was no exception with a record 130 in attendance. I'm sure that those of you who have attended a NERVES meeting will agree that they are not only very educational, but provide excellent networking opportunities as well.

We have also met our goal to obtain benchmarking data for neurosurgery. After conducting three surveys, the NERVES data is the only significant benchmarking data available to neurosurgeons and their practice administrators. We have a response rate of 28% and the survey results represent 62 practices and 343 neurosurgeons. Options for publishing this data are currently being explored.

Since that first, small gathering NERVES has lived up to its name. With nominal membership and meeting registration fees, the education and resources provided to our members are truly a

value. And we are financially sound, without utilizing any of the seed money pledged from the physicians' societies.

Despite our success, NERVES is still a young organization. We need to continue to grow, both in number and resources offered to the membership. As your President, my goals for the upcoming year are to increase membership, increase survey participation, implement the practice administrator mentor program, and provide an annual meeting with interesting topics and quality speakers.

An organization is only as strong as its members. And NERVES members are a very knowledgeable and talented group of individuals. I encourage each of you to utilize your expertise in support of NERVES. Here is a list of some of the ways you can help:

- ◆ Renew your membership each year
- ◆ Attend the annual meeting
- ◆ Participate in the data collection survey
- ◆ Recruit a new member
- ◆ Share your ideas
- ◆ Serve on a committee
- ◆ Be a mentor for a new practice administrator
- ◆ Write an article for the newsletter
- ◆ Speak or serve as a facilitator at the annual meeting
- ◆ Run for office

I look forward to working with you in the coming year.

Johanna Hartigan, President

NEW BOARD ELECTED

The 2007 – 2008 NERVES Board was introduced during the Business Meeting held Saturday, April 14, 2007 in Washington, D.C. as part of the NERVES annual educational meeting. The 2007 – 2008 Board members are:

Johanna Hartigan, President
Barbara Hurlbert, Past President
Mary Cloninger, Vice President – President Elect
Lisa Beebe, Secretary
Linda Griffin, Treasurer
Scott Butler, Southeast Regional Director
Cherie Rynerson, Northeast Regional Director
Glenda Gideon, Western Regional Director
Tresa Sauthier, PhD, Washington Liaison

The Board also has two new CSNS representatives, Robert Schwetschenau, M.D. and Theodore Jacobs, M.D.

Legislative Update – April 2007

Tresa Sauthier, PhD

NERVES Washington Committee Liaison

Greetings Fellow Administrators and Managers:

Since some members were not able to attend the NERVES conference, we thought a summary of the legislative update information might be of interest. Following are the high points from the Washington Committee Update presentation, as delivered at the NERVES 2007 Conference.

Since P4P marched down Constitution Avenue in December 2005 and the Democrats gained control of Congress in 2007, there hasn't been much good news from Washington concerning the business of Practice Management. From the ambiguous requirements for quality performance, to the halt in medical liability reform, the only certain prediction from D.C. is that the agendas on Capital Hill have shifted.

TRHCA 2006

The big news was about the Tax Reform and Health Care Act of 2006 (TRHCA). This legislation froze the 5% payment cut slated for 2007. However, other gimmickries in the bill actually reduced payments 3% for some practices, depending on your practice patterns and location. This payment freeze, with previous annual payment cuts, causes a predicted 10% payment reduction in 2008, if not addressed by the end of this year. We will be following this issue closely.

RAC Program

Another notable provision in TRHCA is the Recovery Audit Contractor (RAC) program, which was originally piloted in 3 states but is now expanded to all 50. This is basically a "bounty hunter" program that allows CMS contractors to review all paid claims for any "errors" in payment. The RAC would visit your practice, identify any billing errors and collect a percentage of what they find. Since the program has recouped \$280 million in 3 years, CMS has endorsed implementing it nationally. The common complaints about RAC visits are that they disrupt the practice and they do not share their findings. Therefore, you would not be educated about how not to make the same billing mistakes. CMS has also increased their edits in claims processing to facilitate review of more claims.

Pay for Performance

TRHCA addresses quality performance, but in reality P4P remains unworkable as defined. While it includes a 1.5% bonus paid in 2008 for reporting on quality measures during July 1, 2007 through the December 31, 2007 time period, the rules for the program have not been defined and the payments are capped. A busy practice would spend more resources to implement the program for six months than the program would pay. To qualify, you must report on all claims during that time period and 4 of the 12 quality indicators must be documented on 80% of all patients.

SGR Formula

The primary issue, of course, is that the SGR formula used to calculate reimbursements is volume based. Most agree that it should be scrapped and replaced with an inflation-based methodology. The cost of this restructuring is estimated at \$200 billion, so repealing the SGR is not likely. In the meantime, physicians lobby to stop payment cuts annually and beneficiary premiums, estimated at about \$100 monthly, continue to rise.

The AANS/CNS supports the change to the SGR structure and will continue to work with other medical specialty organization in that effort.

Coding and Reimbursement in Brief

CMS payment updates:

ProDisc is still in review. An initial recommendation is expected on May 28, 2007. Check the CMS Website after that date for more information.

The Vagus Nerve Stimulator for treatment of Resistant Depression is not supported for payment.

The General Accountability Office (GAO) has recommended that payments for Ambulatory Surgery Centers should be based on the Hospital Outpatient Payment System guidelines. CMS agreed.

“Never” events will not be reimbursed by CMS per NQF recommendations. Examples of “Never” events are those instances when a physician removes the wrong organ, operates on the wrong side, does surgery on the wrong patient, etc.

Emergency Services Update

There is major interest by Congress in insuring access to healthcare for every citizen. As part of that effort, many legislators (on both sides of the aisle) want to mandate Emergency Department (ED) call as a condition of Medicare participation. This mandate would require all specialties to participate in ED call. In support of that principle, the American College of Emergency Physicians has had legislation introduced to address ED over-crowding. This proposal would create a commission to exam crowding of patients in the ED, the availability of specialists, and medical liability issues as it affects Emergency Services. The bill would also require hospitals to report the amount of time a patient is “boarded” in the ED waiting on admission. Augmenting the bill, the Advisory Counsel for General Surgery has released a position statement advocating mandating participation by all specialties in local systems of emergency surgery care. The AANS does not support this legislation.

Another bill, The Trauma Care System Planning and Development Act, was introduced last year and was originally not funded this year. However, the Bill was resurrected earlier this year, passed in the House and Senate, and is expected to be signed by the President. It provides matching grants to states and localities for development and implementation of trauma systems. The details of the final version of this legislation will be announced later this year.

Medical Liability Reform

Tort reform this year will be difficult due to the changes in Congress. However, Doctors for Medical Liability Reform (DMLR) have announced their objectives this year. They are: to advance medical liability reform, continue grassroots networking efforts, and expand the national presence of the organization.

Health Insurance Coverage

This hot topic is on the agenda of Corporate America and most Americans. The fact that the most prosperous country in the world has citizens who do not have access to healthcare is a national shame. Over the last few decades there has been a thinning of employer provided insurance, requiring the employee to pay a larger percentage of their medical costs in addition to absorbing rising premiums. At the forefront of the Democratic agenda, the uninsured is estimated at 46 million.

The AANS has issued a position statement supporting coverage for every American. The American Medical Association (AMA) and several specialty societies have agreed on eleven “Principles for Reform of the US Health Care System”. This lengthy document advocates the need to insure quality care to everyone, without unreasonable financial barriers, defines this concept as a public and private cooperative, encourages us to become good stewards of our health care resources and calls for a less complicated administrative system.

The next Washington Committee Meeting is in July. An update will be issued later this summer.

Opportunity is often disguised as an obstacle.

Author: Stacey M. Lambeth, ACMPE

Georgia Spine and Neurosurgery Center

The Physician Voluntary Reporting Initiative (PQRI) begins July 1, so let’s review the basics. PQRI establishes a financial incentive for physicians and other eligible professionals – which include most physician assistants – to participate in a voluntary quality-reporting program. Eligible professionals who successfully report quality measures on claims for dates of service from July 1 to December 31, 2007, may earn a bonus payment, subject to a cap, of 1.5% of all allowed fees based on the Medicare physician fee schedule, not just those associated with the quality measures. There is no enrollment hassle; you merely start reporting with filed claims. There are, however, reporting thresholds that must be met to receive the “bonus”.

Currently, there are 74 measures approved by CMS. There are four measures that apply to most neurosurgical practices. There are several other measures (i.e. stroke, osteoporosis, fall risk, etc.), which may warrant consideration. The PQRI quality measures are reported using corresponding CPT II codes on the standard electronic or paper claim. You do not have to file a separate claim or report. Below is a grid developed for a spine practice. There are other eligible CPT codes, such as the acoustic neuroma codes, that may need to be added to the grid in order to reflect non-spinal neurosurgical cases.

In conclusion, the bonus payment may not be large, but the implications of the new program are: Will other payers adopt similar initiatives? Will the CMS program have a greater impact in the future? What is going to happen in 2008? Will reporting measures soon become mandatory? There are no clear answers at this point. Although the bonus payment at this time may be relatively small, this is a good time to get accustomed to collecting and reporting the measures. This might be considered a building block, rather than a stumbling block.

Quality Reporting Grid for Surgical Patients

Measure #20: Perioperative Antibiotic Ordered

Is there an order (verbal, written, standing order) for antibiotic to be given within one hour prior to incision?

If these CPT codes occur	Yes, it is documented	No, not given for medical reason	No, not given and reason not specified
22325, 22524, 22554, 22558, 22600, 22612, 22630, 22800, 22802, 22804, 35301, 61154, 61312, 61313, 61315, 61510, 61512, 61518, 61548, 61697, 61700, 61750, 61751, 61867, 62223, 62230, 63015, 63020, 63030, 63042, 63045, 63047, 63056, 63075, 63081, 63267, 63276	4047F	4047F with modifier 1P	4047F with modifier 8P

Measure #21: Selection of antibiotic

Is the antibiotic ordered 1st or 2nd generation Cephalosporin?

***at Ga Spine, answer is same as #20

If these CPT codes occur **codes same as measure #20	Yes, it is documented	No, not given for medical reason	No, not given and reason not specified
22325, 22524, 22554, 22558, 22600, 22612, 22630, 22800, 22802, 22804, 35301, 61154, 61312, 61313, 61315, 61510, 61512, 61518, 61548, 61697, 61700, 61750, 61751, 61867, 62223, 62230, 63015, 63020, 63030, 63042, 63045, 63047, 63056, 63075, 63081, 63267, 63276	4041F	4041F with modifier 1P	4041F with modifier 8P

Measure #22: Perioperative discontinuation of antibiotic

Is there an order (verbal, written or standing order) to stop the antibiotic ordered within 24 hours of surgical end time?

***at Ga Spine, answer is same as #20

If these CPT codes occur **codes same as measure #20	Yes, it is documented	No, not given for medical reason	No, not given and reason not specified
22325, 22524, 22554, 22558, 22600, 22612, 22630, 22800, 22802, 22804, 35301, 61154, 61312, 61313, 61315, 61510, 61512, 61518, 61548, 61697, 61700, 61750, 61751, 61867, 62223, 62230, 63015, 63020, 63030, 63042, 63045, 63047, 63056, 63075, 63081, 63267, 63276	4049F AND 4046F	4049F with modifier 1P AND 4046F	4049F with modifier 8P AND 4046F

Measure #23: Perioperative VTE prophylaxis

Is there an order (verbal, written or standing order) for VTE prophylaxis (medical or mechanical) or documentation it was given?

If these CPT codes occur	Yes, it is documented	No, not given for medical reason	No, not given and reason not specified
22558, 22600, 22612, 22630, 61313, 61510, 61512, 61518, 61548, 61697, 61700, 62230, 63015, 63020, 63047, 63056, 63081, 63267, 63276	4044F	4044F with modifier 1P	4044F with modifier 8P

Quality Reporting Grid for Vertebral Compression Fractures

Measure #24: Osteoporosis: Communication with managing MD, post fracture

Is there documentation that we communicated with PCP or referring MD regarding need for osteoporosis treatment?

**Faxing office encounter (should be dictated in plan) or documentation of verbal with PCP is acceptable

If these CPT/ICD-9 codes occur	Yes, it is documented	No, not given for medical reason	No, not given and reason not specified
ICD-9 805.00, 805.01, 805.02, 805.03, 805.04, 805.05, 805.06, 805.07, 805.08, 805.10, 805.11, 805.12, 805.13, 805.14, 805.15, 805.16, 805.17, 805.18, 805.2, 805.4, 805.6, 805.8 <u>AND</u> CPT 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242,	5051F	5051F with modifier 1P OR 5051F with modifier 2P if the patient said do not communicate	5051F with modifier 8P

99243, 99244, 99245			
OR CPT 22523 or 22524			

For more information on PQRI visit www.cms.hhs.gov/PQRI

Common Questions:

(some questions and answers are from the FAQs on the CMS website)

- How do I collect the data? Especially when the measures (#20-23) occur in the hospital! Physician support is critical for this program to work. Option 1: Develop a data capture tool to be completed by the provider and turned in. Option 2: Providers can get in the habit of dictating the measures in the OP note. Example: *Ancef ordered and given prior to the incision. SCD hose placed.* This example fulfills requirements for measure #20, 21 & 23. Option 3: For the measures on the grid, have a dialogue with the providers to see if there are standing orders in place. If yes then develop a method of communicating the exceptions.
- Do I report the measure on the claim form? Yes, should go on a claim form that has the qualifying code on it. The charge should be \$0.00 but some clearinghouses are having difficulty reconciling the \$0 charge. If that is the case then charge \$0.01. CMS will deny the line item and you will then adjust off the penny.
- If I forget to report the measure, can I re-file the claim? No, you cannot re-file a claim just to add the measurement code. It would be viewed as a duplicate claim and may not capture the measure.
- Can more than one eligible provider report on the same measure, for the same patient on the same date of service? Yes. CMS recognizes that more than one eligible professional may report on measures for the same patient. So, the surgeon and the assistant (MD or PA) can report. Remember, the bonus is based on the individual NPI not the tax id of the practice.
- Will we receive feedback from CMS to know they are capturing our measurements? At this time, the only feedback you will receive will be on the EOB. The CPT code will be a denied line item and have remarks stating something like “This procedure code is not payable. It is for reporting/information purposes only.” This remittance advice will confirm for the provider that the quality-data code has been captured by the CMS data infrastructure for PQRI analysis.
- How do we choose what measures to report on? Choose measures you are most likely to be able to capture consistently and easily. Use these last six months of 2007 as a trial period and add more measures as you are comfortable.
- What qualifies as “successful reporting”? CMS defines successful reporting as If there are no more than three quality measures applicable to the services provided by the eligible professional, then each measure must be reported for at least 80% of the cases in which the measure was reportable. If there are four or more quality measures applicable to the services provided by the eligible professional, then at least three measures, selected by the eligible professional, must be reported for at least 80% of the cases in which each measure was reportable. Eligible professionals are encouraged to report on as many quality measures as are applicable to the services provided. Reporting

on as many applicable measures as is practical will increase the opportunities to reach the 80% successful reporting level as well as increasing the bonus cap.

- How and when will CMS calculate the cap, which may be applied to the 1.5% bonus? The bonus cap calculation is defined as follows: (the individual's instances of reporting quality data) multiplied by (300%) multiplied by (the national average per measure payment). The third factor, the "national average per measure payment amount" can only be calculated after the reporting period ends because it is equal to (the total amount of allowed charges under the Physician Fee Schedule for all covered professional services furnished during the reporting period on claims for which quality measures were reported by all participants in the program) divided by (the total number of instances where data were reported by all participants in the program for all measures during the reporting period.)

Because the "national average per measure payment amount" is not yet available, the following is a hypothetical example:

Example:

§ Dr. Smith had \$400,000 in allowed charges during the PQRI reporting period.

§ The 1.5% potential bonus is \$6000.

§ Dr. Smith reported quality data codes in 500 instances.

§ The national average per measure payment amount for 2007 was calculated in CY 2008 and turned out to be \$100 (\$100 M total national allowed charges claims submitted from July through December, divided by, 1 million instances of PQRI quality data codes being reported in the same time period).

§ The cap for Dr. Smith is \$150,000 (500 x 3 x \$100).

§ The bonus paid to Dr. Smith in early CY 2008 is \$6,000.

And remember, this is applied to all eligible providers submitting measures even if it is the same patient, measure and service date. So, Dr. Smith may receive \$6,000, Dr. Jones may receive \$6,000 and the PA, John, may receive \$3,000. That would be a total of \$15,000 to the practice.

Job Opportunities

Looking for a change? Check out the Job Opportunities section on the NERVES website. A job opportunity can be posted on the site at a cost of \$300 for 30 days.

Mentoring Program Available

NERVES offers a mentoring program to new practice administrators or those new to the specialty. If you would like to be matched with a mentor, please contact Barbara Hurlbert by phone (904) 388-6518 or email bhurlbert@lyleryneuro.com. Please contact Barbara if you would be willing to serve as a mentor.

AANS to offer Webinars

NERVES members to serve as faculty

The AANS will offer a series of three web-based conferences this fall and NERVES members will serve as faculty for this pilot program. The courses are:

October 3rd Ways to Collect Every Dollar Your Neurosurgical Practice is Due
Barbara Hurlbert

October 17th Financial Reporting Can Enhance the Management of Your
Neurosurgical Practice
Barbara Hurlbert

November 7th Managing and Controlling Practice Overhead Cost
Bill Hamilton

Watch for your brochure in the mail or contact Barbara Hurlbert at bhurlbert@lyleryneuro.com for more information

2007 NERVES SURVEY

The NERVES Survey Committee will meet July 27, 2007 to plan for this year's data collection. Following the meeting, a schedule will be released. Please plan to participate in this year's data collection. The better the participation – the better the data. If you have comments or suggestions regarding the survey, please email them to Hiroshi Nakano at hnakano@southsoundneurosurgery.com prior to the committee meeting.

If you have suggestions for upcoming newsletters or are interested in writing an article, please contact Deb Schultz at dschultz@aunsc.com

Mark Your Calendar!!!

**Plan to attend the 2008 NERVES Annual Meeting
April 24 –26, 2008 – Chicago, Illinois**

