The Business of Spine

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THE SPINAL COLUMN

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OUT OF NETWORK POSITIONING: THE CONVERSATION CONTINUES

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Recently there has been a "loud" conversation involving out of network physicians, their patients and fees charged for these highly specialized services. Some would have us believe that the out of network position a surgeon selects is immoral, unethical and this is the reason our medical system is in the state that it's in. Others believe that it is only fair and reasonable for medical professionals to choose their own path of patient and insurance relationship and not be obligated to engage in contractual relationships with anyone except the patient. Regardless of which side you are on, there is certainly a need for discussion about pricing on both sides.

There is an argument for supporting the in-network option as it reduces service costs and guarantees care to a certain degree. The in-network participation model also helps to maintain many practices that could not service their community if patients had to pay for all medical services directly. Providing service at a rate that supports the practice and community is good for both parties.

But there are certain programs that reimburse at rates which are not able to sustain a practice or promote a reimbursement rate that is considered acceptable to the practice or practitioners who service the patients. These rates are often non-negotiable, leaving few options.

These decisions often result in a debate as to the right or wrong of this position, but this is not the purpose of this article. The purpose of this article is to encourage physicians and practices to promote transparency in charges, proper fee schedule development and a patient advocacy position that aid patients through the very difficult revenue cycle that is part of the spine industry.

First, *Transparency*; what does this entail? It is imperative that practices disclose their non-contracted position from the initial discussion about payment, financial obligations and the patient's responsibilities. The practice is often aware of co-surgeon or assistant surgeons when surgery is considered as well as other costs involved, such as neuromonitoring, bracing and other additional services that the patient would not be aware of as a necessary component to the surgical success. Providing a list of those professionals involved and contact information is a way to promote disclosure and connection for the patient to reach out to other necessary contributors. This conversation should be supported by documentation which fully discloses the relationship and the expectation of practice and patient involvement in working with insurance carriers in the reimbursement process. This information is vital to share with the patient so that he/she fully understands the agreed upon relationship before services are rendered.

Second, *Fee Schedule Development*; what is that process? There are several ways of developing a fee schedule. Options include the Relative Value Measurements, Medicare multipliers, organization such as Fair Health or publications such as Physician Fee Reference. Each practice should choose its methodology and document this process before implementing a fee schedule. Encouraging a discussion of the rates for services is recommended and presenting the patient with the charges for services for each procedure prevents sticker shock when receiving the statement of charges after the fact. You can discuss payment options, financial considerations based on hardships as well as case rate options if they apply.

Third and most critical, *Patient Advocacy*; who is assisting the patient through the reimbursement process? Many patients look to the practice to assist in managing the reimbursement process, and in the non-contracted business, the practice still has an obligation to perform this service. The challenges are significant for patients utilizing their out of network benefits, even though they have paid extra to use them. There are many cases where the benefits are not paid properly, requiring extensive levels of appeals or complaints to ensure that the benefits paid match the policy requirements. This requires a sophisticated staff and a patient willing to support the team. Balance billing is not an option; although the patient may have some financial responsibility for deductible and coinsurance portions.

If practices wish to remain non-contracted and patients choose to utilize their out of network benefits, they should do so. Formatting a respective relationship with full disclosure and agreement is expected in any good business, even in the business of spine.

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CODING UPDATES 2015

New Codes

22510 Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; cervicothoracic

22511 Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; lumbosacral

+22512 each additional cervicothoracic or lumbosacral vertebral body

Codes 22510, 22511, 22512 are inclusive of fluoroscopic guidance and CT guidance; codes 72291 and 72292 have been deleted. Codes 22510, 22511, 22512 include moderate sedation.

22513 Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; thoracic

22514 Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; lumbar.

+22515 each additional thoracic or lumbar vertebral body
Codes 22513, 22514, 22515 are inclusive of fluoroscopic guidance and CT guidance; codes 72291 and 72292 have been deleted. Codes 22513, 22514, 22515 include moderate sedation.

22858 Total disc arthroplasty, anterior approach, including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdissection); second level, cervical. **Do not report in conjunction with 0375T.**

0375T Total disc arthroplasty, anterior approach, including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdissection), cervical, 3 or more levels. **Do not report in conjunction with 22851, 22856, 22858.**

27279 Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization),with image guidance, includes obtaining bone graft when performed, and placement of transfixing device.

Deleted Codes

22520 Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection; thoracic.
See new code 22510

22521 Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection; lumbar.
See new code 22511

+22522 each additional thoracic or lumbar vertebral body
See new code 22512

22523 Percutaneous augmentation, including cavity creation using mechanical device, 1 vertebral body, unilateral or bilateral cannulation; thoracic.
See new code 22513

22524 Percutaneous augmentation, including cavity creation using mechanical device, 1 vertebral body, unilateral or bilateral cannulation; lumbar.
See new code 22514

+22525 each additional thoracic or lumbar vertebral body.
See new code 22515

72291 Radiological supervision and interpretation, percutaneous vertebroplasty, vertebral augmentation, or sacral augmentation, including cavity creation, per vertebral body or sacrum; under fluoroscopic guidance.
See new codes 22510, 22511, 22512, 22513, 22514, 22515

72292 Radiological supervision and interpretation, percutaneousvertebroplasty,vertebralaugmentation, or sacral augmentation, including cavity creation, per vertebral body or sacrum; under CT guidance.
See new codes 22510, 22511, 22512, 22513, 22514, 22515

0334T Sacroilliac stabilization for arthrodesis, percutaneous or minimally invasive (indirect visualization), includes obtaining and applying auograft or allograft (structural or morselized), when performed, includes image guidance when performed..
(See new code 27279)

0092T Total disc arthroplasty, anterior approach, including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdissection); each additional level, cervical.
(See new codes 22858 and 0375T)

Reference: CPT 2015 Professional Edition; American Medical Association (2014)

Disclaimer: The information provided is general coding information only - it is neither legal advice nor is it advice about how to code, complete or submit any particular claim for payment. It is always the provider's responsibility to determine and submit appropriate codes, charges, modifiers and bills for services rendered. This information is provided as of the date listed above and all coding and reimbursement information is subject to change without notice. Before filing any claims, providers should verify current requirements and policies with the payer. Thank you for your compliance.

Important Changes to CMS Application of Modifier 59

Effective January 1, 2015

In order to counteract "the abuses" in the application of Modifier 59, CMS has created 4 new HCPCS modifiers to define subsets of modifier 59. CMS states that incorrect modifier usage was a major contributor to overpayments each year.

Modifier 59 represents a Distinct Procedural Service and is used to identify a separate procedure from another procedure that would typically be bundled together. CMS guidelines for Modifier 59 usage indicates that this modifier can only be used for very specific procedures; much more restrictive than AMA CPT guidelines. CMS has developed another adjunctive modifier set to ensure that claims submitted with Modifier 59 follow their specifications.

These modifiers are collectively referred to as –X-{EPSU} modifiers. CMS will not stop recognizing the -59 modifier, but may selectively require a more specific –X{EPSU} modifier:

- XE Separate Encounter: A service that is distinct because it occurred during a separate encounter.
- XS Separate Structure: A service that is distinct because it was performed on a separate organ/structure.
- XP Separate Practitioner: A service that is distinct because it was performed by a different practitioner.
- XU Unusual Non-Overlapping Service: The use of a service that is distinct because it does not overlap usual components of the main service.

CPT guidelines state that the -59 modifier should not be used when a more descriptive modifier is available. While the -59 modifier or a more selective modifier may be initially accepted by the CMS, the rapid migration to more selective modifiers is strongly encouraged.

For complete information, please visit the following link:
http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/downloads/modifier59.pdf

Coming Soon:

- Information on Assistant Surgery Denials

2015 DRG Descriptors with NAP

DRG	Descriptor	National Average Payments ($)
028	Spinal Procedures with MCC	29,103
029	Spinal Procedures with CC or Spinal Neurostimulator	17,026
030	Spinal Procedures without CC/MCC	9,618
453	Combined Anterior/ Posterior Spinal Fusion with MCC	60,202
454	Combined Anterior/ Posterior Spinal Fusion with CC	43,240
455	Combined Anterior/ Posterior Spinal Fusion without CC/MCC	33,705
456	Spinal Fusion except Cervical with Spinal Curvature/ Malignancy/Infection or 9+ Fusions with MCC	50,712
457	Spinal Fusion except Cervical with Spinal Curvature/ Malignancy/Infection or 9+ Fusions with CC	37,249
458	Spinal Fusion except Cervical with Spinal Curvature/ Malignancy/Infection or 9+ Fusions without CC/MCC	28,385
459	Spinal Fusion except Cervical with MCC	35,961
460	Spinal Fusion except Cervical without MCC	21,569
471	Cervical Spinal Fusion with MCC	26,282
472	Cervical Spinal Fusion with CC	15,728
473	Cervical Spinal Fusion without CC/MCC	12,217
518	Back and Neck Procedures except Spinal Fusion with MCC or Disc Device/Neurostimulator	16,516
519	Back and Neck Procedures except Spinal Fusion with CC	8,880
520	Back and Neck Procedures except Spinal Fusion w/o CC/MCC	6,145

Source: Optum DRG Expert 2015

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CODING UPDATE INSIDE

Save the Dates! • March 23-26 in NYC

Revenue Cycle Dynamics for the Spine Reimbursement Specialist Education Series

The Exclusive Training Program of Business Dynamics RCM

The Foundation - Monday, March 23

Provides your "foundation" for the spine coding and reimbursement process with topics covered including spinal anatomy and diseases, as well as spine procedures as they pertain to your reimbursement. Other topics include The Four Elements of Spine Coding, Spine Coding for the Reimbursement Specialist, Mastering Modifiers and Coding Applications.

The Framework - Tuesday, March 24

Builds the "framework" needed to maximize your reimbursements through claims, payment auditing and appeals. Topics covered include Coding Scenarios, The Anatomy of an Operative Report, Advanced Modifier Calculations, Mind your "P"s and "E"s (Primary and Exempt Codes), Developing an Auditing Process, Medical Policy Guidelines and Your Reimbursement, The Appeals Process.

The Fusion - Wednesday, March 25

Work session that "fuses" what you have learned and applies it to real-life spine cases. This session will include case studies and scenarios which provide the opportunity to code your cases, audit your payments and build your appeal claim applying what you have learned in your sessions. Our experts will be on-site and available to provide immediate feedback to your questions and concerns. All attendees are invited to bring examples of their toughest cases to work through.

SRS Boot Camp - Thursday, March 26

Advanced training course for those who have successfully completed the SRS series in the past OR who will be attending the 2015 series. It will allow attendees to use what they have learned and ask any questions they may have, while covering more advanced cases and working claims through the entire revenue cycle in workshop groups.

Take advantage of early registration pricing. Contact us to reserve your seat!

Prices Per Attendee Per Seminar:

- 1 Day: **$495.00**
- 3 Day Package - The Foundation, The Framework and The Fusion: **$1,195.00**
- 4 Day Package - The Foundation, The Framework, The Fusion & SRS Boot Camp: **$1,595.00**

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