Ambulatory Surgery

COMPLIANCE & REIMBURSEMENT INSIDER®

Special Offer for Ambulatory Surgery Regulatory Update Subscribers, see coupon on last page!

MARCH 2007
VOL. 4 NO. 3

IMPLANTS
Don't miss these valuable tips to help you achieve accurate reimbursement for implants 4

REGULATORY ISSUES
If you're considering converting from an ASC to a specialty hospital, learn about the licensing and financial hurdles involved in this transition 6

CODING CORNER
Learn how the required use of National Provider Identifier numbers specifically affects the CMS-1500 claim form 7

NEW FEATURE

In this issue, we introduce a coding column written by Stephanie Ellis of Ellis Medical Consulting. Don't miss this new monthly feature, which will provide coding tips to help ensure that you receive proper reimbursement.

This newsletter has prior approval by the American Academy of Professional Coders for up to 10 CEUs per year. Granting this approval in no way constitutes endorsement by AAPC of the program, content, or the program sponsor. Go to *www.aapc.com* or call the AAPC at 800/626-2633 for more information.

Five steps to recruit a new specialist and ensure a good match

Looking to expand the mix of services at your ASC to absorb the impact of the significant reimbursement cuts from the 2007 outpatient prospective payment system (OPPS) Final Rule's ASC section? Planning to increase the number of procedures your facility can perform in 2008 and beyond with the potential growth of the Medicare-approved ASC procedure list? If you answered yes to either of these questions, then recruiting new specialists is going to rank high on your priority list this year.

Careful and thorough evaluation of candidates is important to ensure both your ASC's success and that your facility's existing culture continues to thrive with the addition of this new specialty and specialist.

Step #1: Weigh the pros and cons

Consider whether the specialty is a good complement to the services you already offer, says **Regina Boore, RN, BSN, MS,** president and CEO at Progressive Surgical Solutions in Poway, CA. For example, if your center offers ophthalmology services, can you accommodate gastroenterology services? Both services are low intensity and high volume, experience rapid turnover, and do not require general anesthesia.

Certainly, some specialties present more risk. Get input from specific staff to assess the big picture of how adding this new specialty will affect your ASC.

The medical director and chief of anesthesia should be part of the planning. Determine the operational and risk management implications of adding the procedure in terms of patient safety.

You may need to address specific patient selection or admission criteria. For example, when performing arteriovenous graft procedures, you would need to assess potassium levels and establish strict dialysis parameters, says **Debra Saxton Stinchcomb, RN, BSN, CASC,** director of surgical services at Progressive Surgical Solutions.

Involve nursing personnel in the assessment of new procedures to determine additional needs of the nursing staff, Stinchcomb says. If you add otolaryngology (ENT) services, should you add one-to-one nursing ratios in the mornings? Do you have pediatric advanced life support (PALS)–certified registered nurses and all of the emergency supplies and equipment necessary to manage a pediatric emergency?

Because it is difficult to anticipate which direction you'll take when

(continued on p. 2)

BOARD OF ADVISORS

Vickie Axsom-Brown
Medicus-Anderson Eye & Ear Associates
Anderson, SC

Scott Becker, Esq.
McGuireWoods, LLP
Chicago, IL

Kathy J. Bryant
FASA
Alexandria, VA

Linda L. Classic
Sharp Community Medical Group
San Diego, CA

Tom Ealey
healthcarethinktank.com, LLC
Findlay, OH

Stephanie Ellis, RN, CPC
Ellis Medical Consulting, Inc.
Brentwood, TN

Lolita M. Jones, RHIA, CCS
Lolita M. Jones Consulting Services
Fort Washington, MD

Lawrence D. Pinkner, MD
SurgiCenter of Baltimore
Baltimore, MD

Patricia O. Powers, Esq.
Waller Lansden Dortch & Davis
Nashville, TN

William A. Sarraille, Esq.
Sidley Austin Brown & Wood
Washington, DC

Robert J. Sauers, FACMPE
Surgical Specialty Center
Bethlehem, PA

Michael F. Schaff, JD
Wilentz, Goldman & Spitzer
Woodbridge, NJ

Caryl Serbin, RN, BSN, LHRM
Surgery Consultants of America
Fort Myers, FL

Jerry J. Sokol, Esq.
McDermott Will & Emery
Miami, FL

Dr. Lowell Scott Weil Sr.
Journal of Foot & Ankle Surgery
Des Plaines, IL

Ronald L. Wisor, Esq.
Hogan & Hartson, LLP
Washington, DC

Eric Zimmerman, Esq.
McDermott Will & Emery
Washington, DC

Doreen Bentley, Editor
Robert Kurtz, Managing Editor
Ilene MacDonald, Executive Editor
Lauren McLeod, Group Publisher

Ambulatory Surgery Compliance & Reimbursement Insider (ISSN: 1531-6025) is published monthly by HCPro, Inc., 200 Hoods Lane, Marblehead, MA 01945. Subscription rate: $249/year; back issues are available at $25 each.

Postmaster: Send address changes to **Ambulatory Surgery Compliance & Reimbursement Insider,** P.O. Box 1168, Marblehead, MA 01945.

Copyright 2007 HCPro, Inc. All rights reserved. Printed in the USA. Except where specifically encouraged, no part of this publication may be reproduced, in any form or by any means, without prior written consent of HCPro, Inc., or the Copyright Clearance Center at 978/750-8400. Please notify us immediately if you have received an unauthorized copy.

CPT codes, descriptions, and material only are Copyright © 2007 American Medical Association. CPT is a trademark of the American Medical Association. All Rights Reserved. No fee schedules, basic units, relative values, or related listings are included in CPT. The AMA assumes no liability for the data contained herein. Applicable FARS/DFARS restrictions apply to government use.

For editorial comments or questions, call 781/639-1872 or fax 781/639-2982. For renewal or subscription information, call customer service at 800/650-6787, fax 800/639-8511, or e-mail: *customerservice@hcpro.com*. Visit our Web site at *www.hcpro.com*. Occasionally, we make our subscriber list available to selected companies/vendors. If you do not wish to be included on this mailing list, please write to the Marketing Department at the address above.

Opinions expressed are not necessarily those of **Ambulatory Surgery Compliance & Reimbursement Insider.** Mention of products and services does not constitute endorsement. Advice given is general, and readers should consult professional counsel for specific legal, ethical, or clinical questions. **Ambulatory Surgery Compliance & Reimbursement Insider** is not affiliated in any way with The Joint Commission.

RECRUITING A NEW SPECIALIST (continued from p. 1)

adding a new specialty, your ASC's administrator should consistently network with area physicians.

"An administrator should always be recruiting and looking for procedures and specialties to add. This is an integral aspect of the job," says Boore. "All surgeons in the ASC area should be visited regularly. The administrator should know who is looking for a facility to perform procedures [and] who wants to do new procedures."

Step #2: Meet with the physician

Once you have decided on a group of candidates, the next step is to determine the best approach for those candidates. For example, is ownership attractive? You may ask them to bring in cases at first on a trial basis and then determine whether they would be interested in ownership.

"Your ASC administrator should routinely call on all surgeons in your area, even if they are owners in a competing ASC," Boore says. "Climates change, and you want to benefit from changes."

If equipment or supplies require a significant investment for your ASC during this trial period, research the possibility of renting equipment. This is a better option than purchasing equipment and facing a large capital outlay that the facility may or may not be able to pay back, considering this addition is on a trial basis.

"If you get someone whose personality conflicts with the mission of that surgery center—they're very demanding, for example—then it's nice to know that's how they work with people before you offer them ownership," says **Dawn Q. McLane, RN, MSA, CASC, CNOR**, chief development officer at Nikitis Resource Group in Broomfield, CO. "And it's good to know they're a good fit before you invest in equipment."

Get a sense of how cost-conscious they are, their punctuality, and how they treat the team in the operating room, as well as other ASC staff.

When you invite the physicians to tour the center, the administrator, medical director, and board members should participate. It's good to get feedback from everyone involved regarding whether this candidate would indeed be a good fit for the center and its staff.

Ask the specialist which cases or current procedural terminology (CPT) codes they are interested in handling and get case or physician preference cards that include particulars such as the staff, supplies, implants, and other resources and equipment the physician plans to use for these cases. "If the center is good at cost containment, for instance, is the physician willing to make changes to standardize with the rest of the physicians, or will he demand to use only what he wants even if no one else uses the products?" McLane asks.

Step #3: Attract the specialist

When meeting with the specialists, emphasize ways that joining your ASC can help improve their quality of life.

Consider offering attractive block time, for example. A successful, busy ASC most likely will have the most attractive surgery times already blocked out for the most senior physicians.

However, when a center reaches a certain point in maturity, one way to open up the attractive morning block is to ask established physicians to switch to a different block to free up that time for a new, incoming physician when the center is trying to attract.

"Founders should be dedicated to the success of the center and want to grow the center, so they may sometimes be willing to give up that time and make it available to physicians the ASC is trying to recruit," McLane says.

Making these kinds of offers can be a bit of a balancing act. As much as you may want a particular specialist to join your team and introduce new reimbursement opportunities, you want this physician to be willing to live within the ASC's existing culture.

As stated above, by getting specialists in the door for a trial period, you can usually prove to them that you can give them a better quality of life by freeing up more time for them as a result of your center's efficiency.

"For the same procedure, it could take your center less time than it typically takes in a hospital setting," says McLane. "Talk to them about how you move cases through the center, low complication rates, low infection rates, room turnover time—all these factors that can make the ASC environment different from a hospital environment."

Step #4: Know the payer mix

It is particularly important to try to gauge the payer mix the cases will bring to your ASC and determine whether the cases will be paid or whether it will be necessary to negotiate carveouts with payers, says McLane.

"Knowing the payer mix and how it will affect your revenue side is as important as knowing how a new physician will affect the expense side," says McLane. "Physicians have their own profile in terms of what kind of patients they attract."

> **"Talk to them about how you move cases through the center, low complication rates, low infection rates, room turnover time—all these factors that can make the ASC environment different from a hospital environment."**
>
> ***—Dawn Q. McLane, RN, MSA, CASC, CNOR***

From information the specialist provides, ASCs need to try to glean what percentage of his or her cases will be paid by Medicare, commercial payers, and cash pay. "You need to look carefully at what reimbursement will look like if you take on this new physician," says McLane.

Step #5: Conduct a case-cost analysis

Case-cost analysis is also a critical part of the decision to recruit a new specialist.

This kind of study is based on the resources—including personnel, supplies, implants, and equipment—that will be used for the new cases.

As you research what it costs to handle the new cases this specialist would bring, you can tell by the CPT codes whether all of the codes for this new specialist would be reimbursed in your current contract.

Base a cost-benefit analysis of any specialty on real numbers, Boore says. Ask yourself the following:

- How many procedures did the surgeon perform in the past six months?
- How many of these can be performed at your facility based on contracts?
- What is the bottom line profit of these procedures?
- How long will it take you to recognize profit on them?

Also, conduct a payback analysis for any equipment that will need to be purchased to perform the new specialist's cases.

For example, orthopedics requires that you purchase scopes and stock an initial set of implants, which can require a significant investment. Take into account the costs of disposables as well. Include your medical supplies and staffing expenses.

All of this will help your ASC determine whether it will be able to perform these cases successfully and make a profit.

"It's not wise to add new specialties without doing the cost-benefit analysis first. New case volume is usually a good thing, but not every case is good," McLane says. "It's imperative to conduct this thorough analysis before committing to new equipment and supplies." ■

Insider *sources*

Dawn Q. McLane, RN, MSA, CASC, CNOR, chief development officer, Nikitis Resource Group, 4962 Democrat Dr., Broomfield, CO 80020, 720/320-6577; *daquay@aol.com*.

Regina Boore, RN, BSN, MS, president and CEO, Progressive Surgical Solutions, LLC, 13327 Bronco Way, Poway, CA 92064, 858/487-7515; *rboore@progressivesurgicalsolutions.com*.

Debra Saxton Stinchcomb, RN, BSN, CASC, director of surgical services, Progressive Surgical Solutions, LLC, 11641 Charles Ct., Farmington, AR, 479/267-2756; *dstinchcomb@progressivesurgicalsolutions.com*.

© 2007 by HCPro, Inc. Any reproduction is strictly prohibited. For more information, call 800/650-6787 or visit *www.hcmarketplace.com.*

IMPLANTS

Implants 101: Tips to ensure accurate reimbursement

If your ASC service mix involves the use of implants, you know that getting proper reimbursement is sometimes a challenge. **I. Naya Kehayes, MPH,** managing principal and CEO at Eveia Health Consulting & Management in Issaquah, WA, sheds light on the subject and tackles some of your questions.

Q: How do you define an implant?

A: In the absence of a contractual definition, most payers define implants as hardware, screws, plates, anchors, or medical devices. However, they could also be defined as the "permanent replacement of a body part," such as an allograft that may be used in an anterior cruciate ligament reconstruction.

Q: Is there a code to use for implants?

A: Refer to the Healthcare Common Procedure Coding System manual for the appropriate code. When there is not a definitive code, L8699 is typically used for nonspecified prosthetics and implants.

The appropriate revenue code also needs to be selected and is often defined in the contract. In addition, contractually, a payer may define the code to be used as 99070, which is actually a physician supply code used in offices. It is not uncommon to see this in the payment policy or contractual language of an ASC contract.

Q: Should we preauthorize the use of implants? What do we do if we didn't have prior knowledge of the use of one?

A: You can typically verify benefits on prosthetics and implants. However, if a payer states that the prosthetic and implant are allowed, it does not necessarily mean it is a covered service. Thus, it's important that the payer confirms that it is a covered service and that it provides a benefit amount.

If you do not have prior knowledge of the use of an implant, and you have already performed the case, you should bill for the prosthetic and implant. If it is denied, then you should appeal. Regardless of whether the prosthetics and implants are included in the rate, all payers should be billed using uniform billing practices.

In addition, if you do not bill for the prosthetics and implants, then it weakens your argument in the future if you are trying to negotiate with the payer for inclusion of prosthetics and implants or increased rates on surgical case rates that are inclusive of prosthetics and implants.

If the payer does not see the charge, you will have difficulty proving that you are losing money on every case requiring a prosthetic and implant that the payer does not allow for reimbursement.

Q: How can we determine what payers pay when they do not break down their reimbursement on the explanation of benefits (EOB) by our billed CPT codes?

A: Request the detail from the payer. If you do not attain a positive response, create internal contract compliance tools that provide the business office with the ability to backtrack to the original bill to determine whether the EOB provides correct payment for the CPT codes and for prosthetics and implants.

This involves having a comprehensive understanding of the reimbursement methodology, which outlines payment allowances on multiple procedures; a clear definition of the grouper methodology, if applicable; as well as other items that may be allowed or paid for separately under the contract terms.

Q: It is a challenge to be reimbursed for implants—at least it seems to be for ASCs. Our goal is to be reimbursed for the implants at least at cost or at 5% above costs, or to carve out the CPT code for higher reimbursement to include the cost of the implant. Do you have any suggestions for how to make either of these scenarios happen?

A: It is critical that the ASC build the cost argument and present it to the payer.

One way to do this is to put together a prosthetic and implant table outlining the CPT codes that are affected by prosthetics and implants, the cost, and worse case scenarios. For example, if a shoulder repair requires three to six anchors, put that range on the table and show the cost of the six anchors, which is the worst-case

© 2007 by HCPro, Inc. Any reproduction is strictly prohibited. For more information, call 800/650-6787 or visit *www.hcmarketplace.com.*

scenario, because this is the risk to the ASC financially.

In addition, to argue for percentages above cost, demonstrate to the payer that there is cost associated with procurement of the implants, such as freight and handling, which are not typically considered part of the cost of the implant.

Show the most powerful cost information available. For example, consider showing cost information of implants illustrating that the surgical rate of reimbursement is inadequate because the cost of the implant might actually exceed the negotiated rate for the CPT code. This example provides for the argument that it is not economically viable to provide a service in which the compensation for the surgery is far below the cost of the implant.

Q: We are a multispecialty center running a 26% orthopedic mix, and we have a huge problem. Payer #1 pays anything over $325 (we have to absorb the $325 cost before they begin paying); payer #2 pays 56% of billed charges; payers #3 and #4 pay us at cost; payer #5 pays up to a ceiling of $1,500; and payers #7–#35 do not pay for implants.

The huge issue is that our orthopedic implants are very expensive. At this time, we lose money on 75% of our shoulder cases. The only reason why we let the physicians continue to do these cases is because they typically bring in three or four knee cases in the same day that are profitable. If we turn away their shoulder cases, they will take all of their cases to a hospital for their own convenience.

What can we do to keep the physicians bringing their cases here, but minimize our losses?

A: Collect the cost data and demonstrate to the payer that the ASC is losing money and cannot continue to provide these services without reasonable and adequate compensation. Demonstrate to the payer that these cases will be leaving the ASC and going to the hospital if they're not reasonably compensated.

You may need to encourage the physician to take the cases to the hospital so the payer can review its own claims data indicating that the ASC is not doing theses cases because it cannot afford to and, therefore, it would be to the payer's advantage to work with the ASC to provide reasonable and adequate reimbursement to move the case back to the ASC.

Q: Wrist implants for open reduction and internal fixation fractures are often denied. A hand innovations kit is about $1,500, so I usually break even or lose money, depending on the payer. Is it possible to make money on these kits?

A: It is possible to attain reasonable and adequate compensation with respect to cost. The payer must be educated and provided with cost data to make the case for increased reimbursement. However, it may not be reasonable to assume that the ASC can attain profit margins on the kits. This depends on prosthetic and implant payment methodology, and most payer methodologies are based on cost.

However, some payers will compensate for prosthetics and implants based on a percentage of billed charges. An opportunity to attain a profit margin on the kits could exist if there are no caps on the percentage of billed charges not to exceed cost. You also can sometimes negotiate rates at cost plus some percentage above cost, which also may allow for a profit margin.

However, in most instances the percentages are just enough to cover the overhead cost associated with procurement of the prosthetic or implant. ■

Insider *source*

I. Naya Kehayes, MPH, managing principal and CEO, Eveia Health Consulting & Management, 371 NE Gilman Blvd., Ste. 320, Issaquah, WA 98027, 425/657-0494; *NayaK@eveia.com*.

More coding resources for your facility!

We've heard your wishes for more coding guidance in the pages of **ASCRI**, so we went out and recruited one of the best ambulatory coding experts to provide you with weekly and monthly coding information.

Each month, **ASCRI** will feature a coding-related column written by Stephanie Ellis and the staff of Ellis Medical Consulting, Inc. Don't miss the first column on p. 7.

In addition, Ellis Medical Consulting, Inc., will provide weekly coding tips in every issue of the new **Ambulatory Surgery Reimbursement Update** e-zine.

We know you will find this extra coding coverage valuable to help ensure that you receive proper reimbursement and to prepare for any coding developments in the coming months.

If there are any particular coding questions or topics you would like to see addressed in future issues of the newsletter or e-zine, please contact Editor Doreen Bentley at *doreenbentley@yahoo.com*.

© 2007 by HCPro, Inc. Any reproduction is strictly prohibited. For more information, call 800/650-6787 or visit *www.hcmarketplace.com.*

REGULATORY ISSUES

Know the hurdles involved in a specialty hospital conversion

You might be drawn to the idea of converting your ASC into a specialty hospital to be eligible for higher reimbursement dollars. However, this transition is not a simple switch facilitated by paperwork. Bear in mind the obstacles you will face in such a conversion.

Regulatory and licensing concerns are the most significant tasks you face, says **Robert Sauers, FACMPE,** CEO of Surgical Specialty Center in Bethlehem, PA. Each state has different requirements to be considered a hospital. For example, find out whether your state requires a certificate of need (CON) as a prerequisite to obtaining a hospital license, says Sauers, who recently lead the conversion of his facility from an ASC to a surgical specialty center in October 2006.

CON laws date back to the 1970s and require that, for certain types of healthcare services, you apply to a planning board and get a CON to show that there is indeed a genuine need for that service in that particular community.

"You can certainly expect that local hospitals are going to oppose your conversion," says healthcare attorney **Ronald L. Wisor,** partner at Hogan & Hartson, LLP, in Washington, DC.

"You will face opposition and perhaps not be able to succeed, especially if obtaining higher reimbursement is the only basis for the conversion," he adds.

Obtaining a state license to operate as a hospital and getting Medicare certified are additional hurdles to overcome, Wisor says. Check whether your state has different licensure standards for specialty hospitals.

Regulatory concerns

Historically, a lot of controversy has surrounded the idea of specialty hospitals. Because physicians own them, some have questioned whether these physicians are inclined to cherry-pick better-insured patients or steer more profitable procedures away from local hospitals.

Depending on the politics of your state, you could see similar questions from state regulators, who also may take a more stringent approach in evaluating your facility's compliance with hospital regulatory standards.

Over the past few years, the American Hospital Association and the Federation of American Hospitals have urged Congress to revisit the "whole hospital" exemption to the Stark Law, which allows physicians to refer Medicare patients to a hospital in which they have an ownership interest, as long as the ownership is in the whole hospital, rather than in just a component part or department of the hospital.

In 2003, under the Medicare Prescription Drug, Improvement and Modernization Act of 2003, Congress imposed an 18-month moratorium—which ultimately extended far longer than 18 months—on the development of new specialty hospitals by prohibiting any new specialty hospitals from taking advantage of this Stark Law exemption.

Meanwhile, Congress asked CMS and the Government Accountability Office to generate reports and develop a strategic plan to address the concerns.

CMS ultimately decided that it

ASCRI Subscriber Services Coupon

❑ Special discount for **Ambulatory Surgery Regulatory Update** subscribers!

Options:	No. of issues	Cost	Shipping	Total
❑ Print & Electronic 1 yr	12 issues of each	$224.10 (ASCRIPE)	$24.00	
❑ Electronic	12 issues	$224.10 (ASCRIE)	N/A	
		Sales tax *(see tax information below)**		
		Grand total		

Order online at *www.hcmarketplace.com.* Be sure to enter source code EZINEADN10 at checkout!

For discount bulk rates, call toll-free at 888/209-6554.

***Tax Information**
Please include applicable sales tax. Electronic subscriptions are exempt. States that tax products and shipping and handling: CA, CT, FL, GA, IL, IN, MA, MD, MI, MN, NC, NJ, NY, OH, PA, SC, TN, TX, VA, VT, WI. State that taxes products only: AZ. Please include $27.00 for shipping to AK, HI, or PR.

Your source code: EZINEADN10

Name

Title

Organization

Address

City State ZIP

Phone Fax

E-mail address
(Required for electronic subscriptions)

❑ Payment enclosed. ❑ Please bill me.

❑ Please bill my organization using PO #

❑ Charge my: ❑ AmEx ❑ MasterCard ❑ VISA

Signature
(Required for authorization)

Card # Expires
(Your credit card bill will reflect a charge to HCPro, the publisher of **ASCRI.**)

Mail to: **HCPro,** P.O. Box 1168, Marblehead, MA 01945 ***Tel:*** 800/650-6787 ***Fax:*** 800/639-8511 ***E-mail:*** *customerservice@hcpro.com* ***Web:*** *www.hcmarketplace.com*

© 2007 by HCPro, Inc. Any reproduction is strictly prohibited. For more information, call 800/650-6787 or visit *www.hcmarketplace.com.*

would do a combination of actions. It would not prevent physicians from owning specialty hospitals, but it would try to ensure that physician ownership was bona fide. CMS said it would try to fix the hospital payment systems to adjust the financial incentives and more closely align hospital and ASC reimbursement.

As part of this strategic plan, CMS also intends to put closer scrutiny on new and existing specialty hospitals to make sure they meet the regulatory definition of what qualifies as a hospital—a facility that primarily provides inpatient care.

"This could be a real hurdle," Wisor says. "If you're an outpatient surgery center, you'll have to grapple with what it means to provide a meaningful level of inpatient care."

It could be difficult to persuade state and Medicare officials that you satisfy the definition of a hospital, unless you're really going to change the nature of what you do, Wisor says.

Aside from regulatory concerns, keep in mind practical obstacles that go along with any business expansion.

Costs

Consider construction issues, adds Sauers. Do you have the property to expand? Do you have the financial means to do so? Can you meet the requirements to comply with hospital construction regulations?

Your local community also influences your ability to convert from an ASC to a specialty hospital. Do you need zoning approval, and is a hospital permissible in your current ASC location? Do you have community support for what you want to do?

Do you have a hospital partner or management company that supports your concept?

Take into account the costs you will face, such as the following:

- **Construction and renovation costs.** This will be the bulk of the capital you will need.
- **Capital costs of supplies.** This consists of equipment, instruments, and any other additional supplies and products.
- **Operational costs.** This includes everything from human resources expenses to the daily costs of running a hospital.

Benefits

ASCs considering a conversion to a specialty hospital should not be motivated by higher reimbursement alone. Go forward with this transition only if

- you can provide better and more services to your patient population
- you can provide your surgeons and physicians with the best environment to provide both inpatient and outpatient services
- the reimbursement is worth the additional effort it will require to supply better service to your patients and surgeons

"Even though it is more work, more involvement, and a bigger project, the rewards are equally bigger. You reach more patients, provide a higher level of healthcare, and make a positive impact in the community," Sauers says.

"It is a worthwhile venture, and ASCs should at least consider it. It is not for everyone, but it can make an impact for many," he adds. ■

Insider *sources*

Robert Sauers, FACMPE, CEO, Surgical Specialty Center, 2310 Highland Ave., Bethlehem, PA 18020, 610/691-4300; *rsauers@coordinatedhealth.com.*

Ronald L. Wisor, Esq., partner, Hogan & Hartson LLP, 555 13th. St. NW, Washington, DC, 202/637-5658; *rlwisor@hhlaw.com.*

CODING CORNER

Stay up to date with CMS-1500 claim form changes

by Stephanie Ellis, RN, CPC, and Tammye Harber, CPC, CPC-H, of Ellis Medical Consulting, Inc.

Whether you file your provider claims on a CMS-1500 (formerly HCFA-1500) or on a UB-92 facility claim form, you'll notice big changes this year related to the National Provider Identifier (NPI) number. You could start reporting a provider's NPI as of January 1, but you're required to use it by May 23.

This two-part article will help you navigate through the changes to these two forms. This month we will address the CMS-1500 form; next month we will cover the UB-92.

CMS-1500 claim form

Although the changes to the CMS-1500 are not as extensive as those made to the UB-92 form this year, you will need to obtain a supply of the new forms and retrain billing staff on the field changes. If you haven't

(continued on p. 8)

© 2007 by HCPro, Inc. Any reproduction is strictly prohibited. For more information, call 800/650-6787 or visit *www.hcmarketplace.com.*

CODING CORNER (continued from p. 7)

done so already, you might want to contact your practice/facility management software company to arrange for testing of the new forms and determine a timeline to ensure compliance with required dates.

If you're not sure how to tell the two versions of the CMS-1500 form apart, here's how to differentiate between them: The old form had "Approved OMB 0938-0008 Form CMS-1500 (12/90)" in the lower righthand corner. The revised form has "Approved OMB 0938-0999 Form CMS-1500 (08/05)" in the lower righthand corner. The old form also had a bar code at the top, which was removed for the new version.

One major difference between the old and new 1500 forms is the addition of split provider identifier fields (fields 17a and 17b).

Field 17a is a place for legacy numbers, which would include the group or facility's carrier or payer-assigned provider number.

Payers issue providers legacy numbers, which are unique identifying numbers, to distinguish those providers in their system when the payer files claims for the providers.

For Medicare, this would be the provider's Medicare Provider number or the physician's Unique Provider Identification Number (UPIN).

Field 17A is also the place for the provider identification number, UPIN, Online Survey Certification and Reporting System Number, or National Supplier Clearinghouse Number (for durable medical equipment regional carrier claims). The new NPI number goes in field 17b.

The specific fields in which the changes occur are as follows:

- **Field 17B**—Allows for entry of the provider's 10-digit NPI number.
- **Field 24C**—Enter the EMG, or emergency indicator. Check with your trading partner (i.e., claims clearinghouse) to determine whether this element is necessary. If it is required, enter a Y for yes or leave it blank if this does not apply to your provider entity.
- **Field 24I**—Enter the two-digit qualifier code that identifies whether the number is a non-NPI. If the provider does not have an NPI number (i.e., locum tenens physician), enter the appropriate qualifier and identifying number in the shaded area.
- **Field 24J**—Enter the identification (ID) number for the individual provider performing/rendering the service. The qualifier indicating if the number is a non-NPI is entered in field 24I.
- **Field 32A**—Enter the NPI number of the service-facility location.
- **Field 32B**—Enter the two-digit qualifier code identifying the non-NPI number, followed by the ID number.
- **Field 33A**—Enter the billing provider's NPI number.
- **Field 33B**—Enter the two-digit qualifier code identifying the non-NPI number, followed by the ID number.

Note: Do not use spaces, hyphens or other separators between the qualifier and the number. ■

Insider *sources*

Stephanie Ellis, RN, CPC, and **Tammye Harber, CPC, CPC-H,** work for Ellis Medical Consulting, Inc., a 15-year-old healthcare consulting firm that provides such services as coding and billing the audits of providers for compliance and documentation issues, interim coding services, reimbursement research, litigation support services for attorneys, and development and implementation of billing compliance programs for physicians, hospitals, and various healthcare provider types, including ASCs. Learn more about Ellis Medical Consulting, Inc., by visiting *www.ellismedical.com*.

CMS-1500 requirements

CMS requires health plans, claims clearinghouses, and vendors to be ready to handle and accept the revised CMS-1500 form as of January 2. However, until March 30, providers can use either version of the 1500 claim form to file their claims. HIPAA regulations allow for an additional year for small health plans to comply with the NPI guidelines, due to their cost. Small health plans may need to receive legacy provider numbers on coordination of benefits (COB) claims transactions (secondary claims). Through May 23, 2008, CMS will issue requirements for reporting legacy numbers in COB transactions with dates of service after May 22, 2007.

Helpful CMS-1500 Web sites

- *www.nucc.org* (for a CMS-1500 *Claim Form Instruction Manual* and access to the revised form)
- *www.cms.hhs.gov/ElectronicBillingEDITrans/16_1500.asp* (more information on CMS-1500)
- *www.cms.hhs.gov/NationalProvIdentStand/03_apply.asp* (for information on NPIs)
- *www.cms.hhs.gov/MLNMattersArticles/downloads/MM5060.pdf* (*MLN Matters* article on NPIs)

© 2007 by HCPro, Inc. Any reproduction is strictly prohibited. For more information, call 800/650-6787 or visit *www.hcmarketplace.com.*

ENROLLMENT FORM

P.O. Box 1168 | Marblehead, MA 01945

MARCH 2007
VOL.4 NO.3

IMPLANTS
Don't miss these valuable tips to help you achieve accurate reimbursement for implants.......... 4

REGULATORY ISSUES
If you're considering converting from an ASC to a specialty hospital, learn about the licensing and financial hurdles involved in this transition....... 6

CODING CORNER
Learn how the required use of National Provider Identifier numbers specifically affects the CMS-1500 claim form 7

NEW FEATURE
In this issue, we introduce a coding column written by Stephanie Ellis of Ellis Medical Consulting. Don't miss this new monthly feature, which will provide coding tips to help ensure that you receive proper reimbursement.

This newsletter has prior approval by the American Academy of Professional Coders for up to 10 CEUs per year. Granting this approval in no way constitutes endorsement by AAPC of the program, content, or the program sponsor. Go to *www.aapc.com* or call the AAPC at 800/626-2633 for more information.

Five steps to recruit a new specialist and ensure a good match

Looking to expand the mix of services at your ASC to absorb the impact of the significant reimbursement cuts from the 2007 outpatient prospective payment system (OPPS) Final Rule's ASC section? Planning to increase the number of procedures your facility can perform in 2008 and beyond with the potential growth of the Medicare-approved ASC procedure list? If you answered yes to either of these questions, then recruiting new specialists is going to rank high on your priority list this year.

Careful and thorough evaluation of candidates is important to ensure both your ASC's success and that your facility's existing culture continues to thrive with the addition of this new specialty and specialist.

Step #1: Weigh the pros and cons

Consider whether the specialty is a good complement to the services you already offer, says **Regina Boore, RN, BSN, MS,** president and CEO at Progressive Surgical Solutions in Poway, CA. For example, if your center offers ophthalmology services, can you accommodate gastroenterology services? Both services are low intensity and high volume, experience rapid turnover, and do not require general anesthesia.

Certainly, some specialties present more risk. Get input from specific staff to assess the big picture of how adding this new specialty will affect your ASC.

The medical director and chief of anesthesia should be part of the planning. Determine the operational and risk management implications of adding the procedure in terms of patient safety.

You may need to address specific patient selection or admission criteria. For example, when performing arteriovenous graft procedures, you would need to assess potassium levels and establish strict dialysis parameters, says **Debra Saxton Stinchcomb, RN, BSN, CASC,** director of surgical services at Progressive Surgical Solutions.

Involve nursing personnel in the assessment of new procedures to determine additional needs of the nursing staff, Stinchcomb says. If you add otolaryngology (ENT) services, should you add one-to-one nursing ratios in the mornings? Do you have pediatric advanced life support (PALS)–certified registered nurses and all of the emergency supplies and equipment necessary to manage a pediatric emergency?

Because it is difficult to anticipate which direction you'll take when

(continued on p. 2)

Sign up today and SAVE 10%

Enrollment Options	No. of Issues	Price	Code	Quantity	Shipping	Total
☐ Print and Electronic Versions	12 issues of each	**$ 224.10** *(reg. $ 249)*	ASCRIPE		**$ 24.00***	**$**
☐ Electronic Version	12 issues	**$ 224.10** *(reg. $ 249)*	ASCRIE		**N/A**	**$**
For online orders: Please go to ***www.hcmarketplace.com*** and enter your source code (located below) at checkout. ***Your order is fully covered by a 100%, money-back guarantee.***			**Sales Tax** *(see information below)***			**$**
			Grand Total			**$**

Your Source Code: EZINEADN10

SHIP TO:

Name | Title

Organization

Street Address

City | State | ZIP

Telephone | Fax

E-mail address (Required for electronic subscription)

***Shipping Information**
Shipping to AK, HI, PR is $27.00.

****Tax Information**
Please include applicable sales tax. States that tax products and shipping and handling: CA, CO, CT, FL, GA, IL, IN, KY, LA, MA, MD, ME, MI, MN, MO, NC, NJ, NM, NY, OH, OK, PA, RI, SC, TN, TX, VA, VT, WA, WI, WV.

State that taxes products only: AZ.

BILLING OPTIONS:

☐ Bill me. ☐ Check enclosed (payable to HCPro, Inc.) ☐ Bill my (✔ one): ☐ VISA ☐ MasterCard ☐ AmEx

☐ Bill my facility with PO #

Signature	Account number	Exp. date
(Required for authorization)	(Your credit card bill will reflect a charge to HCPro, Inc.)	

5 easy ways to place your order:

MAIL: HCPro, Inc.
P.O. Box 1168
Marblehead, MA 01945

PHONE: 800/650-6787

FAX: 800/639-8511

E-MAIL: *customerservice@hcpro.com*

ORDER ONLINE: *www.hcmarketplace.com*

©2007 HCPro, Inc. HCPro is not affiliated in any way with The Joint Commission, which owns the JCAHO and Joint Commission trademarks.