



BRAINS

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Don't Miss This Opportunity to Get the Latest Updates in Practice Management and Much More—In Just One Weekend!

Even if you missed the 2007 AAN Fall Conference, you can still attend the 2008 AAN Winter Conference to get the latest updates in practice management—encourage your neurologists and staff to do the same!

Set for January 18 through 20 at the Doral Golf Resort and Spa in beautiful Miami, the three-day conference offers something for everyone, including a unique and convenient opportunity to improve your practice with the latest technological advice, codes to help improve your bottom line, and information on how to plan for the future.

Register by December 28, 2007, and receive early registration discounts. Register today at www.aan.com/wc.

The Winter Conference is an excellent opportunity to get the latest updates in neurology and tips for improving your practice, meet and network with colleagues—all in one weekend! And its smaller conference size allows ample opportunity for personal instruction and Q&A with experts and faculty.

New this year is a series of three programs geared specifically to all levels of practice management:

Friday, January 18

Practice Management 101: Basics
9:00 a.m.–1:00 p.m.
Program Director: Neil A. Busis, MD, FAAN
CME Credits: 3.5 hours

Practice Management 201: Work Smarter: Strategic Planning for 2008
2:00 p.m.–6:00 p.m.
Program Director: Orly Avitzur, MD, MBA, FAAN
CME Credits: 3.5 hours

Saturday, January 19

Practice Management 301: Towards Neurology Practice in 2012
9:00 a.m.–1:00 p.m.
Program Director: Marc Raphaelson, MD
CME Credits: 3.5 hours

A detailed description of each course is available on the [AAN website](#).

AAN and AMA Conducting Physician Practice Information survey

For the first time in nearly a decade, AAN, the American Medical Association (AMA), and more than 70 other medical specialty societies, have worked together to coordinate a comprehensive multi-specialty survey of America's physician practices. The purpose of the survey is to collect up-to-date information on physician practice characteristics in order to positively influence national decision makers. Thousands of practices will be surveyed in 2007 and 2008, from virtually all physician specialties to ensure accurate and fair representation for all physicians and their patients.

This project is unique because it explores both the clinical and business side of medical practice. This information is important for the nation's policy-makers to learn what is truly involved in running a practice that provides expert patient care, while operating a business that is sustainable. A complete understanding of the landscape and the requirements for today's care is critical. These data will allow medicine to articulate practice concerns to national policy-makers that will lead to policy initiatives that not only help in the short-term but will allow future generations of doctors to continue providing superior care to their patients.

There is a small section in this study pertaining to practice expenses and the amounts that are attributable to you. Please encourage your staff to make these numbers available. The Centers for Medicare and Medicaid Services recently announced that the results of this study are considered critical to update physician payment. This is a vital part of the research and we need to have accurate and complete data. This information remains confidential. The survey firm will not identify any individuals or entities participating in this research to any of the participating organizations.

Dmrkynetec has been retained to conduct the Physician Practice Information survey among a representative random sample of practices in each of the participating specialties. The survey is an important and necessary vehicle for positive change. Please watch for this survey and do your part in completing it in a thorough and accurate manner if selected to represent our specialty.

EHR Chart Challenge

Please join the EHR Work Group for the first ever EHR Chart Challenge on Tuesday, April 15, 2008 from 1:00 p.m. to 4:00 p.m. at the 2008 Annual Meeting in Chicago in the Exhibit Hall. Six EHR vendors will each have 20 minutes during which they will follow a script devised by the work group, so that they may demonstrate the capabilities and functions of their system. According to recent surveys 26 percent of medical groups have an EHR, while another 40 percent are 'considering' purchasing one in the next two years. If you are thinking about EHR, the EHR Chart

Challenge will benefit you and your practice. You will be able to see some of the current vendors and their products in a controlled 'neurological' test setting. Attendance is free and no registration is required.

Prolonged Services with Direct (Face-To-Face) Patient Contact May Add Revenue to Your Bottom Line

Physicians frequently ask how they can get compensated for the increasing time that they must spend with patients in the office. Neurologists in particular are spending more time with an increasingly aged and chronically ill patient population-counseling them about their condition. In certain circumstances, physicians may be able to use the prolonged services codes to report the significant increased time spent directly, face-to-face with the patient. These prolonged services are reimbursed by CMS and most third-party payers.

CPT® developed the prolonged services codes 99354-99357... "To be used when a physician provides prolonged service involving direct, (face-to-face) patient contact that is beyond the usual services in either the inpatient or outpatient setting".¹ These codes are designed to be used in addition to your evaluation and management code for the basic e/m service rendered that day. Other services such as testing may also be reported with these codes, but it is important to understand that these prolonged service codes must be reported in addition to an evaluation and management code, and may not be billed as stand alone services.

These codes are time-based codes, and you must meet certain time threshold requirements in order to bill them. Codes 99354-99355 (outpatient) and 99356-99357 (inpatient) are used to report the total duration of face-to-face time spent by the physician providing prolonged services and are based on the site of service where the services were rendered- even if the time on that date is not continuous. If for instance you see a patient 4 or 5 times during a given day on the ward of the hospital, you would aggregate all of the prolonged service face-to-face time spent during the course of the day to come up with the codes to be billed providing prolonged services. In this situation you need to make sure that the total face-to-face time is documented in each medical record entry throughout the day. This is the only way you'll be sure to capture the appropriate amount of billable time in your documentation so that it will withstand the scrutiny of a third-party auditor. Codes 99354 and 99356 are each billed once per calendar day, and codes 99355 and 99357 are add on codes each representing an additional 30 minutes.

In order to correctly bill prolonged face-to-face services, you must first have at least an additional 30 minutes of face-to-face time over and above the average

¹ CPT® 2007 Professional Edition, American Medical Association, pp28-29.

time associated with your evaluation and management code on that date. For a level 4 follow-up outpatient visit (CPT® 99214) with an associated average time of 25 minutes, you would have to spend at least an additional 30 minutes in providing direct face-to-face services in order to be able to also bill code 99354. This means that the provider (not the staff, not your RN) would need to spend at least 65 minutes face-to-face with the patient to bill the additional code. Don't count time your patient spends in the office when the provider of care is not in direct face-to-face contact with the patient. It's also important to remember that prolonged services lasting less than 30 minutes are not billable. The intent of the codes is that the provider spent face-to-face time actively treating or interacting with the patient on a care issue. You must make this very clear in your documentation.

These services can be billed direct by CRNP's and PA's as well, or as split shared services providing that the companion evaluation and management code is eligible to be billed as a split shared service. (Remember: for CMS, consultations can never be billed as split/shared services, which means when billing a consult together with the prolonged service codes, all of the services must be fully provided and billed by the same provider.)

Documentation is critical when providing these services. In order to withstand third-third-party payer scrutiny, it will be important for you to have documented your total face-to-face time spent directly with the patient. Time spent on the floor of the hospital—even if it is related to the patient's case, time spent speaking with relatives about the condition of the patient when the patient is not present and able to be a part of the discussion, or time spent discussing the case with other providers of care when the patient is not able to take part in the discussion cannot be counted towards prolonged services with direct patient contact. While this time represents valuable and important service to the patient, it cannot be reported using the direct face-to-face prolonged service codes because they are not direct face-to-face services.

CMS has some unique rules of its own when it comes to billing for extended services, and these rules will affect Neurologists ability to bill for prolonged services involving direct face-to-face services. In addition to meeting the time threshold requirement above, CMS requires that the *entire time* spent with the patient must be direct face-to-face time, including the evaluation and management service time that is being billed on the same day.² CPT® instructions tell you that you must provide 30 minutes above and beyond the average time associated with your evaluation and management code in order to bill for prolonged services. As an example, for a level 3 subsequent daily care service (CPT® 99233), if you meet the level of the code based on work, and you are able to

count floor time to achieve this code and you then spend an additional 30 minutes over and above the 35 minutes associated with the level 3 subsequent daily care code (CPT® 99233), providing additional direct face-to-face services, you can bill 99233 and 99356 to report these services.

From CMS' standpoint you must spend 65 minutes providing direct face-to-face services to be able to bill both the 99233 and the 99356 codes. Floor time in this example will not count towards getting you to the 65-minute threshold. So if you spent 15 minutes of the time associated with the 99233 in reviewing the patient's medical records and labs in the physician work area on the floor- do not count this time towards meeting your threshold time, as it was not a direct face-to-face service. For CMS you must document total time spent face-to-face providing prolonged services and you must describe what was done during the prolonged service. It's best to be very descriptive of what's being done and why the prolonged services were necessary. This will ensure you get to keep the revenue generated from this service if you are audited.

Physicians are often at odds over how to bill for services that take an inordinate amount of time, such as discussing the care of a sick patient with relatives, consoling the family during end of life care, or making phone calls to the patient's family because the family was not around when the physician was available to speak with them during the day. Bear in mind that these types of services cannot be billed using the prolonged service codes with direct (face-to-face) patient contact. There are codes developed for the purpose of reporting Prolonged Physician Service without direct, face-to-face patient contact. Codes, 99358-99359 have the same time threshold guidelines that govern the use of these codes as the direct, face-to-face codes, but simply speaking, they are not reimbursed by CMS and are not recognized by many third-party payers. CMS warns you not to bill the patient for these types of services because they are considered bundled to the face-to-face services provided within your evaluation and management code.

Knowing the ins and outs of how to correctly bill for prolonged services with direct (face-to-face) patient contact can mean additional revenue for your practice. Knowing the rules, what they mean, and how to adhere to them will make your practice audit proof when payers review your documentation.

Highlights from the 2007 AAN Fall Conference

Written by William Henderson, FACMPE

Upstate Neurology Consultants, LLC

Practice Management and Technology Subcommittee member

What a difference 10 years makes! When I went to my first AAN conference in 1996 and attended sessions on

² Trailblazer Health Enterprises LLC. Primary Care Manual, Revised July 2007, pp46-50.

Practice Management, there were relatively few people present—mostly naïve residents thinking about private practice. But the AAN Fall 2007 Conference was a full-house in Las Vegas. The people who attended the all day Saturday session who I talked with, indicated that with declining revenue and increasing costs, physicians and staff had to be masters of this material.

The Fall sessions were presented over one and a half days, and were the first Practice Management Series to be graded in three levels: 101 (Basics), 201 (Advanced), and 301 (Special Topics).

Practice Management 101: Basics

Course Director: Neil Busis, MD, FAAN

In the Practice Management 101 Series there were presentations on four critical topics. The ICD-9-CM provided the basic information needed to properly code for neurological diagnoses. The session also included a discussion of the 2007 and 2008 new codes. In the 'sister' session, the focus was on CPT coding for neurological procedures. This course discussed the key CPT codes and modifiers that are necessary to understand to code properly. Relevant changes for 2008 were also reviewed. A third session dealt with the crucial Evaluation and Management Documentation topic. Since 80 percent or more of all charges submitted by neurologists are E&M codes, it is essential for neurologists to know how to accurately code for those visits. The fourth session dealt with reducing claims denials and avoiding coding pitfalls. The message of this session was direct—if you don't understand how to bill properly, you can go out of business.

Practice Management 201: Advanced

Course Director: Orly Avitzur, MD, MBA, FAAN

The Practice Management 201 Series focused on more intense, but crucial, topics in practice management. The first presentation handled the rationale for seriously considering and purchasing an Electronic Health Record. The elements of an EHR were reviewed as well as sources of reference that should be reviewed before making a purchase. A second presentation dealt with adding an advanced practice provider to a neurology practice and how such a person can increase the bottom line of a practice or department. The third presentation reviewed the 'Pay for Performance' programs that have been developed nationally and how this is becoming the means of transparently benchmarking neurologists in a community or by a health plan. The fourth presentation covered how AAN resources can assist a neurology practice keep up to date, with special attention to the Academy's website, www.aan.com.

Practice Management 301: Towards Neurology Practice in 2012

Course Director: Marc Raphaelson, MD

The Practice Management 301 Series encompassed four specialized topics: emerging technologies for communications management, moving patient safety into the practice environment, opportunities to learn how to

influence lawmakers via advocacy efforts, and a future look at what neurology might look like in five years. If you were not able to attend the Fall Conference contact AAN member services at (800) 879-1960 about purchasing the course syllabi.

Some Things I Learned—or Re-Learned at the Conference

I learned many years ago that if I pay \$300 tuition to attend a conference like this [or even \$1,500 for all expenses], I will learn one new thing. The conference pays for itself at least twice over in the first 3 months. Now, more than ever, neurologists need to be at the forefront of knowing what is happening in the coding, reimbursement and management world and how it impacts their practice.

Here are some of things I learned in Las Vegas:

1. Add a PA or NP: Although most of the AAN member surveys show a decline in practices using physician extenders, the reality is that a properly trained PA can generate a contribution of at least \$50,000 to the bottom line after covering their own expenses and overhead share.
2. Pay for performance programs are increasing dramatically and insurers are ranking physicians and making those rankings available to the general public. To counter inaccurate data, which will potentially decrease referrals or revenue, consider purchasing an EHR or develop a method to record the necessary clinical data to appeal incorrect rankings. It is hard to know how much this will save—likely thousands of dollars a year per neurologist.
3. In E/M coding the two key things that physicians often overlook are documenting decision making complexity and face-to-face time spent with a patient. It is only proper to be reimbursed for the level of work a neurologist does.
4. Remember to consult Appendix J in the CPT manual so that you are absolutely certain you and your staff know how to count units of NCS.
5. You save money and get money quicker if you only send out clean claims to an insurer—one of the key factors is to check insurance eligibility and coverage for patients before they walk in the door of your office. Each denied claim will cost you at least \$25 to rework or resubmit.
6. The AAN sponsors some great programs to train neurologists to be better governmental advocates on behalf of our specialty—for example, Neurology on the Hill.
7. You need to check the AAN website at least monthly. There are new things there all the time and new features are being introduced regularly. Go to aan.com, customize your AAN web page profile, and see the things that matter most to you.

- [Six-month Delay Announced on Medicaid Tamper-Resistant Prescription Pad Mandate](#)

Payment Policy Subcommittee Recent Activity

The Payment Policy Subcommittee (PP) has been very active since its appointment in October, 2006. The group has given feedback on several medical policies for HealthNet, WellPoint, and Blue Cross Blue Shield of Arizona.

Recently, the group elected to sign on to a letter with MGMA addressing a number of administrative burdens associated with UnitedHealth Care's Premium Designation Program website.

The PP would like to remind BRAINS members that the American Medical Association (AMA) is currently requesting people to send examples of intrusion by third parties in medical care. Visit www.aan.com/go/practice/coding/intrusion for more information on this topic.

The group has been working hard on a new Payment Policy and Decision-making page on aan.com that it hopes to launch before the end of the year. The page will feature Private Payer news as well as a place for individuals to submit payer grievances.

For more information on P4P actions, please contact Katie Kuechenmeister at kkuechenmeister@aan.com or (651) 695-2873.

Tools Available on the AAN Website

- [AAN's On-Call Policy](#)
- [Stroke Coding Guide](#)
- [ICD-9 Coding for Stroke](#)
- [Coding Frequently Asked Questions](#)
- [2007 EHR Vendor Report](#)
- [Patient Safety Tips and Tools](#)
- [Clinical Practice Guidelines](#)

News on the AAN website

- [New Measures for Medicare Pay-for-Reporting Program](#)
- [HHS Announces Electronic Health Record Demonstration Project](#)
- [2008 Medicare Physician Fee Schedule Released](#)
- [AAN and AMA Conducting Physician Practice Information Survey](#)
- [AMA Invites Physicians to Share Concerns About Insurers' Physician Profiling Programs](#)
- [New Guideline Recommends When Emergency Departments Should Use CT Scans for Seizures](#)
- [CMS and Noridian to Offer Workshop for Physicians Electing Into 2008 Part B CAP](#)
- [AAN, CNS, Epilepsy Organizations Work with Industry to Address ACTH Access Concerns](#)
- [New Audio Slide Presentation for AAN Parkinson Disease Guideline Now Available](#)