Eastern Association for the Surgery of Trauma

Leadership Development Workshop Part III
A Formula for Success as a Division Chief

January 10, 2012
Disney's Contemporary Resort
Lake Buena Vista, Florida

Course Faculty:
Lawrence Lottenberg, MD
John McCauley, Esq.
R. Lawrence Reed,MD
Michael Rotondo, MD
Thomas Scalea, MD

Course Directors:
William Chiu, MD
Stanley J. Kurek, Jr., DO

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EAST Leadership Development Workshop Part III:
A Formula for Success as a Division Chief (A Self-Assessment Activity)
Tuesday, January 10, 2012
1:00 – 5:00 pm
Presented by the EAST Careers in Trauma Committee

Workshop Overview:
This exciting workshop is the third of a multi-year, three-part course focusing on the career development of the young trauma surgeon. This year's workshop will explore job contracts, ways to achieve academic success, and what to do if faced with a malpractice suit. It will also address ways to run a trauma/surgical critical care practice and new strategies for obtaining legitimate reimbursement for providing patient care. The knowledge and skills gained at the course can be applied not only at one's own medical center, but also at an organizational level. The faculty members include distinguished trauma leaders known for excellence not only in the EAST organization but throughout the world.

Learner Objectives:
At the conclusion of the workshop, the participant should be better able to:
1. Achieve academic success within his/her institution.
2. Discuss what's involved as he/she goes through a malpractice case.
3. Define how to set up and direct a trauma and surgical critical care practice.
4. Cite principles governing coding and billing and strategies for obtaining legitimate reimbursement for care provided during surgical global periods.
5. Describe the critical tangible and intangible factors to consider in a new employment opportunity and list the advantages and disadvantages in contracting for services

Workshop Directors: William Chiu, MD and Stanley Kurek, Jr., DO

Credit:
The Wake Forest School of Medicine designates this live activity for a maximum of *4 AMA PRA Category I Credits*™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Workshop Faculty:

William Chiu, MD	Lawrence Lottenberg, MD
John McCauley, Esq.	R. Lawrence Reed, MD
Michael Rotondo, MD	Thomas Scalea, MD

Workshop Schedule:

1:00 pm	Introduction – William Chiu, MD
1:05 pm	Achieving Academic Success – Thomas Scalea, MD
1:50 pm	How to Deal with a Malpractice Lawsuit – John McCauley, Esq.
2:35 pm	How to Utilize Advanced Practitioners in Setting up a Trauma Practice – Lawrence Lottenberg, MD
3:20 pm	Break
3:30 pm	Coding & Billing Strategies for Trauma & Surgical Critical Care During Global Packages – R. Lawrence Reed, MD
4:15 pm	Landing the Next Job: Where Preparation Meets Opportunity – Michael Rotondo, MD
5:00 pm	Adjourn

EAST LEADERSHIP DEVELOPMENT WORKSHOP

William C. Chiu, MD, FACS
Chair, EAST Careers in Trauma Committee
Associate Professor of Surgery, UMMC/RACSTC

Stanley J. Kurek, DO, FACS
Past Chair, EAST Careers in Trauma Committee
Associate Professor of Surgery, UTMCK

January 10, 2012

THANKS

- Faculty:
  - Thomas M. Scalea, MD, FACS
    Francis X. Kelly Professor of Trauma Surgery
    Director, Program in Trauma
    Physician-in-Chief, R Adams Cowley Shock Trauma Center
    University of Maryland Medical Center
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  - John C. McCauley, Esq.
    Senior Vice President & Chief Risk Officer
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THANKS

- Faculty: (continued)
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  - R. Lawrence Reed, II, MD, FACS
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    Director of Trauma Services
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THANKS

- Faculty: (continued)
  - Michael F. Rotondo, MD, FACS
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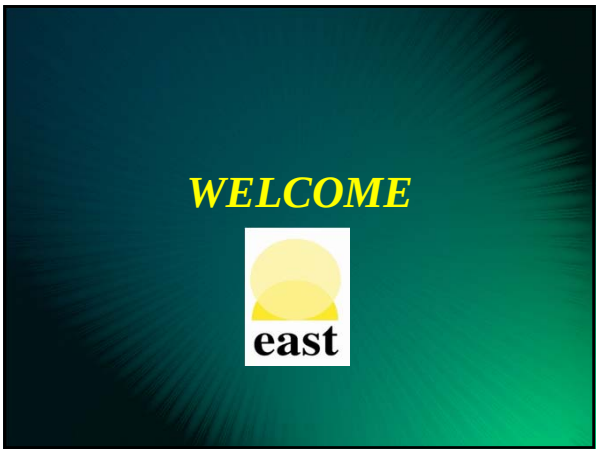
    The Brody School of Medicine
    East Carolina University
    Chief of Surgery and Director
    Center of Excellence for Trauma and Surgical Critical Care
    Pitt County Memorial Hospital
    Greenville, North Carolina

INTRODUCTION

- Topics:
  - Achieving Academic Success
  - How to Deal with a Malpractice Lawsuit
  - How to Utilize Advanced Practitioners in Setting up a Trauma Practice
  - Coding & Billing Strategies for Trauma & Surgical Critical Care During Global Packages
  - Landing the Next Job: Where Preparation Meets Opportunity

INTRODUCTION

- Part III of a 3-part program: Goals
  - Present course content specific to leadership in ACS which includes administrative pearls in both health care organizations and academic societies
  - Fulfilling the EAST Leadership Core Strategic Goal of preparing young surgeons to become leaders, the BOD established the annual nomination of several members to attend the 3y curriculum


WELCOME
east

Achieving Academic Success: Getting the Right Job and Having Early Success

Thomas M. Scalea, M.D.
Baltimore, Maryland

Wilson's Way

- Have a vision for where you want to go
- Work hard
- Be honest
- Know your strengths and weaknesses
- Put yourself in the other guy's shoes
- Don't waste valuable time complaining
- Exceed expectations

Achieving Academic Success

- Academic success can exist anywhere. It really depends on how you want it to look. Some community programs look more like medical school departments than many medical school departments. Moving back is possible

Achieving Academic Success

- Close your eyes and dream about the job you really want. Make it the job you want, not the job someone says you ought to have. Your first job cannot get in the way of your long-term goal

Achieving Academic Success

- There is no such thing as a triple threat anymore. It is far more complicated now. Clinical medicine takes too much time. Everybody has to help pay the bills

Achieving Academic Success

- Academic success is now defined in many different ways. Before you take a job, know the rules.
- Interviewing goes both ways
- The fact that it is good for them does not necessarily make it good for you. If they say it louder, it still is not good for you.

Achieving Academic Success

- There is no shame in being a really good doctor and retiring as an Assistant Professor

Achieving Academic Success

- Your goals have to match the program's goals. If they do not, then it is a bad fit. Nothing can change that.
- Believe it or not, they really are not going to change the entire program's goals to make you happy

Achieving Academic Success

- A good fellowship does not necessarily make that place good job
- A good fellow is not necessarily a good potential partner for the group

Achieving Academic Success

- A great job is a lot like pornography. It is hard to define but you know it when you see it

Achieving Academic Success

- Good leaders recruit personalities, not a specific skill set.
- If it is a lousy fit, it does not matter how good the job seems.
- Everything, you, your boss, and the job are subject to change without any notice. That can be OK if you are in the correct place.

Achieving Academic Success

- If your boss does his/her job, they will place you with a good personality fit
  - Size of division/department
  - Geography
  - Style of the chief
  - Divisional/departmental history
  - Divisional/departmental stability

Achieving Academic Success

- Bosses come in all sorts of flavors. Each has advantages depending on who you are
  - Young and eager but no credibility
  - Well established but may be too tired to help
  - Established, confident, accomplished and believes that promoting you is better than promoting him/herself

Achieving Academic Success

- A great mentor lasts forever

Achieving Academic Success

- When you get to your first job, your only objective is to be a clinical monster
- Resist all temptation to be in charge of anything your first year out. You are not qualified, it soaks up a lot of time and it diverts you from your prime focus

Achieving Academic Success

- Never make the boss's phone ring
  - Keep your mouth shut. Do your job
  - Keep surprises to a minimum – confess early
  - Ask for help. It really is not a sign of weakness
  - Never make it about the money
  - Pay your dues – it takes longer than you think

Achieving Academic Success

- You do not have to be your bosses friend. You do have to perform. Bring solutions, not problems. Recognize that it may just be your turn to get screwed

Achieving Academic Success

- Look for opportunities to build bridges. The number of times you go to war is almost exactly equal to the number of times you lose. It does not matter who is right. It is quicker to solve a problem than to fight about it and it keeps your boss happier.

Achieving Academic Success

- If you have a good boss, he/she will take care of you. Say yes, even if it seems silly. A great opportunity may not look so great at first.

Achieving Academic Success

- Learn from everybody and everything. Never say no to the short, fat Italian guy. Be gracious

Achieving Academic Success

- It is okay to make one mistake. If it is not working out
  - Try again. Maybe you did not understand.
  - Try to understand why it did not work
  - Call your mentor
  - Try again. These things take time.
  - Call again
  - Do not make the same mistake twice

Achieving Academic Success

- It is hard to really achieve academic success without any publications

Achieving Academic Success

- If you do not write as a resident or fellow and you want to achieve traditional academic success, go find a job where you can fit into a machine

Achieving Academic Success

- Bullshit can masquerade as research but in the end it is still bullshit. Do your homework before wasting a lot of time. There has to be a research question for there to be research

Achieving Academic Success

- There are a million great projects. Do not be afraid.
  - Make the first one dirt simple
  - Write a case report
  - A small case series about something rare is great
  - Do not waste time reinventing the wheel
  - Find a senior partner

Achieving Academic Success

- The answer to a great question asks five more questions

Achieving Academic Success

- Find a niche. Eventually you must declare a major if you want to be successful. It can be clinical, educational, research or some combination

Achieving Academic Success

- Get involved locally and regionally. The national stuff is so unpredictable
  - ATLS
  - ATOM
  - COT
  - TEAM
  - Regional Critical Care Societies

Achieving Academic Success

- Everybody talks about being an educator. Actually do something! It can be in the basement, but it is a start
  - Medical student small groups
  - Intro to physical exam/case presentations
  - Resident/fellow lectures

Achieving Academic Success

- Promotion is based on education, service, reputation and scholarly work. In most places, you need at least three of the four.

Achieving Academic Success

- Depending on where you work, hospital points and medical school points may be very different. Educate yourself on the rules

Achieving Academic Success

- Make a plan with your boss. Review it at least once a year. Be sure to accrue the skills you need for "the next step." It is okay to plan to leave.

Achieving Academic Success

- No job lasts forever. Sometimes the job changes and sometimes you change. Your boss is supposed to guide you. Your new job can be at the same institution

Achieving Academic Success

- When you get ready to leave for your second job, be open. Talk to your boss and be realistic

Achieving Academic Success

- If the job required Einstein, we would all be unemployed. Relax. Do not sweat the small stuff and almost everything is small. Be flexible. Have a sense of humor. You worked hard to get here.

Summary

- Academic success can be many things
- Match your goals and talents to the program
- A great mentor is invaluable
- Research does not have to be hard
- Declare a major
- Know the rules
- Make a plan

Surviving a Medical Malpractice Lawsuit

John C. McCauley, Esq..

EAST Annual Meeting

January 10, 2012

According to a recent study in NEJM, the risk of getting sued for medical liability in any given year for neurosurgeons is:

a) 5%
b) 9%
c) 12%
d) 19%
e) 25%

The American Tort Reform Foundation ("ATRF"), a D.C. nonprofit, annually designates "Judicial Hellholes". These are jurisdictions where judges systematically apply laws and court procedures in an unfair and unbalanced manner, generally against defendants in civil lawsuits.

Which of the following is not classified as a "Judicial Hellhole" by ATRF?

a) West Virginia
b) Texas
c) California
d) So. Florida
e) Cook Co., Illinois

Medical Malpractice Climate

- Nationally

- State
  - Florida
  - Texas
  - Tennessee
  - Others

Medical Malpractice Insurance

- Coverage
  - Physician Mutual
  - Captive
  - Others

Types of Coverage

- Occurrence
- Claims Made

Consent to settlement clause

A provision (also known as the “hammer clause” and “blackmail clause”) found in professional Liability insurance policies, that requires an insurer to see an insured’s approval prior to settling a claim for a specific amount. However, if the insured does not approve the recommended figure, the consent to settlement clause states that the insurer will not be liable for any additional monies required to settle the claim or for the defense costs that accrue from the point after the settlement recommendation is made by the insurer.

Chronology of a Medical Malpractice Case

Pleadings (Court Findings)	Discovery (Gather Information)	Resolution Attempts
Notice of a Potential Claim Complaint Answer of Defendant Possible Motion for Summary Judgment using affidavit that doctor complied with standard of care. Pre-Trial Motions	Written Discovery- Interrogatories; Request for Documents; Request for Admissions Depositions of Parties Expert Disclosures By Plaintiff By Defendant Expert Depositions	Settlement discussions or Mediation session at any point in the cae from pre-suit into trial.
	Trial	

Anatomy of a Malpractice Claim

- Physician-patient relationship
- Breach of the standard of care
- Injury/damages
- Causation - the breach caused by the injury

Litigation Causes Stress to All Parties Involved

- Plaintiff and family
- Physicians and other medical professionals

Stress to Physician

Sources of Stress:

- Grief and/or concern for well-being of patient
- Re-living the facts and decision making
- Isolation
- Fear of future implications
- Fear of media coverage
- Anger at being wrongly accused

Stress to Physician by Malpractice Claim/Lawsuit

Sources of Support and Advice:

- Attorneys
- Risk Managers
- Counselors
- Employee Assistance Program
- Physician Wellness Committee

Investigation by Counsel

• Interview all involved - ascertain facts and circumstances

• Does obvious error exist?

• What is extent of injuries/damages, if any?

• Do physicians involved believe he/she complied with the standard of care?

•Engage outside experts to opine:

- if compliant with the standard of care
- if an error existed, whether the error caused any injury

Role of Counsel

Being Physician's advocate means:

• in face of obvious error that unquestionably caused harm, recommending early settlement

• in the face of an adverse outcome, but no violation of the standard of care, recommending vigorous litigation

• where experts differ on the standard of care was violated, may litigate and attempt to resolve

Medical Error and Causation?

Medical Error and Causation

- 17 year old involved in a single-vehicle MVA
- Transported by Life Flight - Type IIIB tibia/fibula/fx
- Surgery #1 - fixation (intramedullary nail)
- Pt. dehisced month later, required additional surgeries
- (#2 and #3)

Medical Error and Causation

- Attending out of town when patient experienced infection of tibial wound
- Intramedullary antibiotic nail place in surgery #4, but not correctly
- Error identified next day on x-ray
- Attending (still out of town) talked with the family about the error and ordered leg be stabilized

Medical Error and Causation?

- Attending returned and place new antibiotic rod
- Patient later required surgeries #5 and #6 (unrelated to the misplaced rod)
- At conclusion of treatment, Patient displeased with appearance of her leg and infection/antibiotics

Medical Error and Causation?

• Because of the error, an attempt was made to resolve with family pre-suit; attempt failed

• Family engaged counsel and filed suit - misplaced rod and infection/antibiotics

Medical Error and Causation?

• Affidavit from attending trauma surgeon stated in part:

"The antibiotic rod was in the wrong position for less than six days… The misplaced antibiotic rod did not cause Plaintiff to suffer any long-term injury…Except for requiring one additional surgery, her ultimate outcome was neither altered nor affected by the misplaced antibiotic rod."

Medical Error and Causation?

• Affidavit provided to Plaintiff's counsel prior to filing.

• Resolution reached - Plaintiff ended up with less than she would have received pre-suit.

• Error existed, but error did not cause the injury Plaintiff's counsel had hoped to prove.

How To Utilize Midlevels Setting Up a Trauma Practice

Physician Extenders in Trauma Care

Eastern Association for the Surgery of Trauma

Lawrence Lottenberg, MD FACS
Associate Professor of Surgery and Anesthesiology
Division of Acute Care Surgery
Department of Surgery
University of Florida College of Medicine
Gainesville, FL

Challenges to Trauma and Critical Care 2009

- Reimbursement
- Productivity
- Constraints on resident work hours
- Conception of "overworked" staff adversely affecting patient care
- Non-operative management requiring closer "bedside" observation
- The need for operative general and vascular surgical procedures to enhance income and maintain skill levels
- Necessity for support during in-house call in centers without training programs

Physician Assistant Curriculum

- Two year program
  - First year didactic classroom anatomy, physiology, etc.
  - Second year entirely clinical
- Post Baccalaureate
- Many Programs include Masters Degree
- Surgical rotation in major center
  - Direct patient encounters – office, ED, ICU, OR
  - Mentoring by senior surgical residents
  - Procedure check-list – S/G, a-lines, intubation, tubes
- Medical Informatics
- Cultural Competencies
- Communication Skills

ARNP Curriculum

- 1. Airway management
  A. Basic principles B. Endotracheal intubation C. Patient safety D. Documentation
- 2. Hemodynamic management
  A. Basic principles B. Pulmonary artery catheter insertion techniques C. Pulmonary artery catheter monitoring/trends D. Regulation of common medications and fluids E. Patient safety F. Documentation
- 3. Mechanical ventilation management
  A. Basic principles B. Initiation and maintenance of ventilation and oxygenation C. Weaning and discontinuation of mechanical ventilation D. Patient safety E. Documentation
- 4. Emergent chest tube insertion
  A. Basic principles & techniques B. Local anesthetic administration principles & techniques C. Patient safety D. Documentation
- 5. 96 Hour Practicum with Acute Care Surgery Service

Easing Physician Workloads

- Pas/ARNPs can shift a physician's workload
- AMA Socioeconomic Monitoring System Survey
  - Measured benefits of hiring "nonphysician practicioner's"
  - Net increase in income 18%
  - Work one week less on average
  - PAs rated highest in terms of patient productivity and patient acceptance

Physician Assistant vs. ARNP

- Physician Assistant
  - Procedure oriented
  - Specific operative training
  - Mimics surgical house staff roles
  - Diverse backgrounds
  - Complements physician's goals and directions
- Nurse Practioner
  - Bedside patient care orientation
  - Hospital based
  - Only specific programs offer training in surgical procedures
  - Excellent communication skills prior to training

Cost Effectiveness and Reimbursement

- *Physician Compensation and Production Survey*
  - Medical Group Management Association
- Surgical PAs cost $.38 per $1.00 generated
- Medicare and most private insurers pay 85% of the physician's fee in ALL settings
- Reimbursement is 100% if the physician is in direct attendance for procedures
- Reimbursement in the OR is 85% of the usual 22% assistant's fees
- Surgical PAs can work as W-2 employees or as independent contractors
- Entry level PAs are salaried in the range of $70,000 with the more experienced (3-5 years) PAs/ARNPs salaried at $85,000 in our practice.

What's the message?

Physician Extenders more than pay for themselves ….

What's The Data?

Use of Physician Assistants as Surgery/Trauma House Staff at an ACS-Verified Level I I Trauma Center

- *Miller, et al J Trauma 1998 February;44(2):372-6*
- Hurley Medical Center, Flint, MI
- 1994 PAs were employed
- 2 year retrospective study
- Acuity increased two times
- Decrease in
  - Time to OR by 43%
  - Time to ICU by 51%
  - Time to floor by 20%
- LOS in neurotrauma ICU decreased 33%
- Eight trauma surgeons rated PAs
  - Clinical assessments consistent with their own
  - First assistant activities very good or excellent
  - PAs saved each surgeon an average of 4 to 5 hours
- Summary – "Quality Care"

Outcomes of Tube Thorocostomies Provided by Advanced Practice Providers vs. Trauma Surgeons

- **Background** The role of advanced registered nurse practitioners and physician assistants in emergency departments, trauma centers, and critical care is becoming more widely accepted. These personnel, collectively known as advanced practice providers, expand physicians' capabilities and are being increasingly recruited to provide care and perform invasive procedures that were previously performed exclusively by physicians.
- **Objectives**To determine whether the quality of tube thoracostomies performed by advanced practice providers is com- parable to that performed by trauma surgeons and to ascertain whether the complication rates attributable to tube thoracostomies differ on the basis of who performed the procedure.
- **Methods** Retrospective blinded reviews of patients charts and radiographs were conducted to determine differences in quality indicators, complications, and outcomes of tube thoracostomies by practitioner type: trauma surgeons vs advanced practice providers.
- **Results** Differences between practitioner type in insertion complications, complications requiring additional interventions, hospital length of stay, and morbidity were not signifi- cant. The only significant difference was a complication related to placement of the tube: when the tube extended caudad, toward the feet, from the insertion site. Interrater reliability ranged from good to very good.
- **Conclusions** Use of advanced practice providers provides consistent and quality tube thoracostomies. Employment of these practitioners may be a safe and reasonable solution for staffing trauma centers. (American Journal of Critical Care. 2008;17:357-363)

Pitfalls of Implementing Acute Care Surgery

- Kaplan, et al. *J Trauma.* 2007;62:1264 1271.
- **Background**: **Incorporating emergency general surgery into the current practice of the trauma and critical care surgeon carries sweeping implications for future practice and training.**
- **Methods**: **Herein, we examine the known benefits of the practice of emergency general surgery, contrast it with the emerging paradigm of acute care surgery, and examine pitfalls already encountered in integration of emergency general surgery into a traditional trauma/critical care surgery service. A MEDLINE literature search was supplemented with local experience and national presentations at major meetings to provide data for this review.**
- **Results**: **Considerations including faculty complement, service structure, resident staffing, physician extenders, the decreased role of community hospitals in providing trauma and emergency general surgery care, and the effects on an elective operative schedule are inadequately explored at present. There are no firm recommendations as to how to incorporate emergency general surgery into a trauma/critical care practice that will satisfy both academic and community practice paradigms.**
- **Conclusions**: **The near future seems likely to embrace the expanded training and clinical care program termed acute care surgery. A host of essential elements have yet to be examined to undertake a critical analysis of the applicability, advisability, and appropriate structure of both emergency general surgery and acute care surgery in the United States. Proceeding along this pathway may be fraught with training, education, and implementation pitfalls that are ideally addressed before deploying acute care surgery as a national standard.**

Nurse practitioners and physician assistants in the intensive care unit: An evidence-based review

- Ely, et al. Crit Care Med 2008 Vol. 36, No. 10

•**Background:** Advanced practitioners including nurse practitioners and physician assistants are contributing to care for critically ill patients in the intensive care unit through their participation on the multidisciplinary team and in collaborative physician practice roles. However, the impact of nurse practitiners and physician assistants in the intensive care unit setting is not well known.
•**Methods**: We conducted a systematic search of the English- language literature of publications on nurse practitioners and physician assistants utilizing Ovid MEDLINE, PubMed, and the Cumulative Index of Nursing and Allied Health Literature data-bases from 1996 through August 2007.
•**Conclusions**: Although existing research supports the use of nurse practitioners and physician assistants in acute and critical care settings, a low level of evidence was found with only two randomized control trials assessing the impact of nurse practitioner care. Further research that explores the impact of nurse practitioners and physician assistants in the intensive care unit setting on patient outcomes, including financial aspects of care is needed. In addition, information on successful multidisciplinary models of care is needed to promote optimal use of nurse practitioners and physician assistants in acute and critical care settings-

Care of Critically Ill Surgical Patients Using the 80-Hour Accreditation Council of Graduate Medical Education Work-Week Guidelines: A Survey of Current Strategies

- Gordon, et al. AmSurg 72(6) June 2006
- **As a result of the recently mandated work-hour restrictions, it has become more difficult to provide 24-hour intensive care unit (ICU) in-house coverage by the general surgical residents. To assess the current state of providing appropriate continuous care to surgical critical care patients during the era of resident work-hour constraints, a national survey was conducted by the Association of Program Directors of Surgery. The results revealed that 37 per cent of programs surveyed have residents other than general surgery housestaff providing cross-coverage and writing orders for surgical ICU patients. surgery have Some found it necessary to use physician extenders (*i.e.*, nurse practitioners or physician assistants), thereby decreasing the burden of surgical housestaff coverage. The results indicated that 30 per cent use physician extenders to help cover the ICU during daytime hours and 11 per cent used them during nighttime hours.**
- **In conclusion, our survey found multiple strategies, including the use of physician extenders, a Night-float system, and the use of non-general surgical residents in an attempt to provide continuous coverage for surgical ICU patients. The overall outcome of these new strategies still needs to be assessed before any beneficial results can be demonstrated.**

Credentialing

- PAs/ARNPs are medical staff members
  - Application to medical staff
  - Delineation of Privileges – direct supervision
  - Appear at Credentials Committee
  - Appear at Executive Committee
- PAs/ARNPs are hospital employees
  - FTEs are assigned to nursing or departmental
  - Cost center can be ED, ICU, OR, or Trauma
  - Job Description must be created

Who is responsible for extenders?

YOU !!!!

Billing and Compliance

- A physician **MAY NOT COMBINE/SPLIT INPATIENT CONSULTS** with an ARNP or PA and bill MEDICARE/GA MEDICAID/CHAMPUS in the physician's billing number. If an ARNP/PA participates in services in any way, including dictating the note, then the service is considered combined/split.
- **In order for physicians to combine new patient or subsequent visits with an ARNP/PA and bill in the physician's number the following conditions must be met:**
  - Both the non-physician practitioner and the physician's notes must be SAME date
  - Co-signature is NOT sufficient
  - The Physician must provide a face-to-face portion of the E&M encounter with the patient and write a separate note:
  - o *I saw and evaluated the patient today. See today's PA/ARNP note*
  - o *Physician's Signature & Date*

Billing and Compliance FAQs

- **Q: Should ARNPs or PAs obtain a billing number?**
- A: According to COM policy, **ALL** ARNPs and PAs involved in any patient care activities **MUST** obtain both Medicare and Medicaid provider numbers.
- **Q: What if we never intend to submit a bill in the PA or ARNP's name?**
- A: You must obtain a provider (billing) number for all PAs or ARNPs involved in clinical care as soon as (or before, if possible) the PA or ARNP is hired, **even if** no bill is ever intended to be submitted under the PA's or ARNP's name.
- **Q: How do ARNPs and PAs bill for services they perform without any direct physician involvement in the particular service - under their own billing numbers or the physician's billing number?**
- A: Either is acceptable. In an outpatient or physician office setting, ARNPs and PAs can bill "incident to" a physician's services, under the physician's UPIN number, when the "incident to" rules are met. Alternatively, in either inpatient or outpatient/physician office settings, they may bill under their own billing numbers at a reduced rate.

Billing and Compliance FAQs

ASSISTING AT SURGERY

- **Q: Can a PA assist at surgery when a qualified resident is involved in a surgical procedure(s) as well?**
- A: YES, provided the surgical procedure(s) requires an assistant, the PA has direct supervision by the faculty member(s) he or she is employed by, and the PA's services are not being billed by the hospital. The operative report would need to state that the PA's services were required. No modifier would need to be attached to the service, however, the type of service would need to be indicated on the claim form. The type of service is "8". The Medicaid reimbursement rate for a PA assisting at surgery varies.
- **Q: Can a ARNPs bill for assisting at surgery?**
- A: NO, Medicare will not reimburse for an ARNP assisting at surgery.

Billing and Compliance FAQs

- **Q: Can ARNPs and PAs see new patients without the participation of a physician?**
- A: Yes, but Medicare rules state the ARNP or PA may ONLY bill under their own number and **cannot bill** under the physician's number when either 1) performing a service on their own or, 2) *for outpatient services only*, when combining or splitting an Evaluation and Management Service (E/M) with a physician for: a new patient; a consultation; or an established patient with a new problem; 3) *for inpatient services only*, when combining or splitting an inpatient consult with a physician. When combining E/M services with a physician that do not fall under the provisions of the "incident to" rules, the bill must be submitted under the name and provider number of the ARNP or PA. It is also important that the ARNP or PA always sign the encounter form when involved in a service.

The Future of Resident Work Hours

Comparison of IOM Committee Adjustments with Current ACGME Duty-Hour Limits.

Variable	2003 ACGME Duty-Hour Limits	IOM Recommendation
Maximum hr of work per wk	80 hr, averaged over 4 wk	No change
Maximum shift length	30 hr (admitting patients up to 24 hr, then 6 additional hr for transitional and educational activities)	30 hr (admitting patients for up to 16 hr, plus 5 hr protected sleep period between 10 p.m. and 8 a.m., with the remaining hours for transitional and educational activities) 16 hr with no protected sleep period
Maximum in-hospital on-call frequency	Every third night, on average	Every third night, no averaging
Minimum time off between scheduled shifts	10 hr after shift	10 hr after day shift 12 hr after night shift 14 hr after any extended duty period of 30 hr, not returning until 6 a.m. of next day
Maximum frequency of in-hospital night shifts	Not addressed	48 hr off after 3 or 4 nights of consecutive duty
Mandatory time off	4 days per mo 1 day (24 hr) per wk, averaged over 4 wk	5 days per mo 1 day (24 hr) per wk, no averaging One 48-hr period per month
Moonlighting	Internal moonlighting counted against 80-hr weekly limit	Internal and external moonlighting counted against 80-hr weekly limit All other duty-hour limits apply to moonlighting in combination with scheduled work
Limit on hours for exceptions	88 hr for select programs with a sound educational rationale	No change
Emergency room limits	12-hr shift limit, at least an equivalent period of time off between shifts; 60-hr workweek with additional 12 hr for education	No change

Physician Extenders at UF & Shands

- **Emergency Department**
  - Scribing, chest tubes, introducers, arterial lines, FAST
- **OR**
  - PAs assist on days when residents in conference
- **ICU**
  - Rounds, family meetings, coordinating discharge, interacting with social services, setting up and participating in trachs, PEGs, IVC filters, VAC changes
  - Night coverage, hemodynamic monitoring, ventilator changes
- **Floor**
  - Rounds, tertiary surveys, discharge summaries and discharge planning, coordinating with physical therapy andrehabilitation, SBI, patient calls, family interactions and meetings
- **Clinic**
  - Patient visits, wound management, OR scheduling, radiology scheduling, pre-operative evaluations and work-up

Physician Extenders at UF & Shands

- 4/10 hour work days
- One always in the ICU (M-Thur)
- Two extenders on clinic day (both in clinic)
- Two extenders on resident conference day
- One 12 hours on Saturday (6A to 6P)
- One always on call from home nights/wkds
- Check out is 6P at night and extender handoff is at 4P - must be detailed

Information Resources

- University of Florida Physician Assistant Program
  - www.med.ufl.edu/pap
- University of Florida College of Nursing
  - www.nursing.ufl.edu
- Nova Southeastern University
  - www.nsu.org
- American Academy of Physician Assistants
  - www.aapa.org
  - *Hiring a Physician Assistant – 800-7087581*


N911UF
SHANDS
Thank You!!!
Go Gators!!!!

Indiana University Health

Coding & Billing Strategies for Trauma & Surgical Critical Care During Global Packages

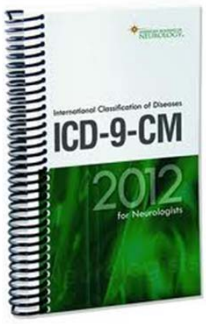
R. Lawrence Reed, II, MD FACS FCCM
Director of Trauma Services, IU Health Methodist Hospital
Professor of Surgery, Indiana University
Indianapolis, IN

General Requirements for Physician Reimbursement

- ICD-9 Code
- CPT Code
- ±Modifier

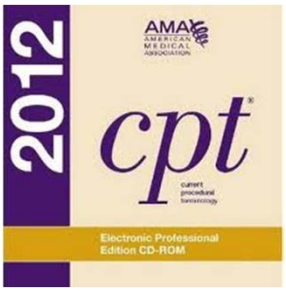
ICD-9 Codes

- ICD-9-CM
  - **I**nternational **C**lassification of **D**iseases, **9**th Revision, **C**linical **M**odification
  - Modified about every 10 years
  - Originally developed by the World Health Organization
  - This is the "why" of the billing process
  - Provides the reason for medical care and treatment



CPT Codes

- CPT = "Current Procedural Terminology"
- Produced by the American Medical Association since 1966, annually since 1983
- Descriptive terms and identifying codes for reporting medical services and procedures performed by physicians
- Types of CPT Codes
  - Evaluation & Management (E&M) Services
    - ~130 codes
    - Account for ~40% of Medicare's reimbursements to physicians
  - Procedures
    - >7,800 codes
    - Major surgical operations, minor procedures, radiological procedures, laboratory determinations
- This is the "what" of billing process
- Describes what medical care and treatment was actually done



Global surgical package

- Under CMS, payment for ***procedures*** (not E&M services) include a "global package" concept, ostensibly including payment for associated E&M services
  - Preprocedural H&P, postprocedural evaluations, etc.
  - Such services are not separately billable during the global period by
    - The physician who performed the procedure
    - Physicians in the same billing group & same specialty
    - Any other physician unless the surgeon bills only for surgical care only (Modifer "-54")
      - The other physician uses Modifier "-55" for postoperative management only

Global surgical package

- RVU table published annually by CMS also identifies "Global Days" associated with procedures
- Global package = Surgical tradition
  - i.e., suture removal
- Adoption by Medicare carriers in 1980s
  - Variable definitions
    - Services included in global surgery
    - Duration of surgical period
- National global surgery policy (HCFA) became effective for surgeries performed on and after January 1, 1992
- Defined services included in global surgical period
  - Routine postoperative care
- Different global periods for different procedures
  - 90 days
  - 10 days
  - 0 days
  - "YYY" – variability in global period can be determined by carrier

Global Surgical Payment in Group Practice Models

- Medicare denies payments during the global period to the operating surgeon for:
  - routine, uncomplicated postoperative care
  - treatment of complications that do not require a return to the operating room
- Physicians are considered to be the "same physician" as the operating surgeon if they
  - are part of the same (billing) group and
  - are designated as being in the same specialty

Specialty Codes

- 65 Specialties Defined by Medicare
  - includes Midwives, CRNAs, PAs & NPs
- Each physician can be defined as only one specialty code for Medicare reimbursement
  - General Surgery: 02
  - Neurosurgery: 14
  - Orthopedic Surgery: 20
  - Vascular Surgery: 77
  - Critical Care: 81
  - Surgical Oncology: 91
- NOTE: No Trauma Specialty Code exists

Specialty Codes

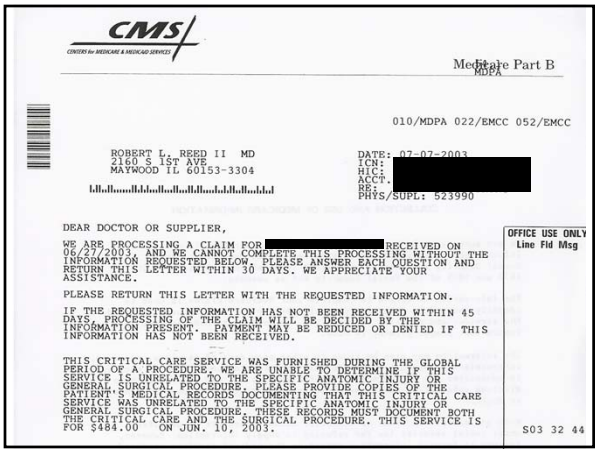
- Billing during the global package period for a patient requires a modifier in services provided by physicians sharing the same Specialty Code
- Practices that assign some surgeons as General Surgery (02) and others as Critical Care (81) are not immune from needing to use modifiers
  - Example: if a critical care surgeon performs a procedure in the ICU & the procedure has a global package, the other intensivists will need modifiers to bill their services in the post-procedural period

Special Concerns in Trauma Physician Billing

- **Problem:** How can a trauma surgeon get paid for care of a trauma patient during the global period?
- **Issues:**
  - Constant (24 x 7) attending surgeon coverage
  - Multiple injuries = multiple treatment issues
  - Critical care is a significant component
  - Most services are non-operative
  - Postoperative care billing problems
    - Global surgical payment in group practice models
      - (i.e., all surgeons are seen as being the same individual by Medicare)
    - Global surgical package & postoperative care

Can You Get Paid for Critical Care During a Global Surgical Period?

- 75 year old female with severe COPD presents with perforated diverticulum and massive peritonitis
- Undergoes colectomy, colostomy, & Hartmann's pouch formation – 22.99 Work RVUs (38.15 total RVUs)
  - Charge: $9,368.00
  - Payment: $1,951.00
  - 20.8% collection rate
- Spends 43 days in SICU on ventilator with critical care managed by operating surgeon – 172 Work RVUs (243.81 total RVUs)
  - Charges: $33,029.00
  - Payments: $9,676.00
  - 29.3% collection rate



CMS

Medicare Part B
MDPA

010/MDPA 022/EMCC 052/EMCC

ROBERT L. REED II MD
2160 S 1ST AVE
MAYWOOD IL 60153-3304

DATE: 07-07-2003
ICN:
HIC:
ACCT:
RE:
PHYS/SUPL: 523990

DEAR DOCTOR OR SUPPLIER,

WE ARE PROCESSING A CLAIM FOR [redacted] RECEIVED ON 06/27/2003, AND WE CANNOT COMPLETE THIS PROCESSING WITHOUT THE INFORMATION REQUESTED BELOW. PLEASE ANSWER EACH QUESTION AND RETURN THIS LETTER WITHIN 30 DAYS. WE APPRECIATE YOUR ASSISTANCE.

PLEASE RETURN THIS LETTER WITH THE REQUESTED INFORMATION.

IF THE REQUESTED INFORMATION HAS NOT BEEN RECEIVED WITHIN 45 DAYS, PROCESSING OF THE CLAIM WILL BE DECIDED BY THE INFORMATION PRESENT. PAYMENT MAY BE REDUCED OR DENIED IF THIS INFORMATION HAS NOT BEEN RECEIVED.

THIS CRITICAL CARE SERVICE WAS FURNISHED DURING THE GLOBAL PERIOD OF A PROCEDURE. WE ARE UNABLE TO DETERMINE IF THIS SERVICE IS UNRELATED TO THE SPECIFIC ANATOMIC INJURY OR GENERAL SURGICAL PROCEDURE. PLEASE PROVIDE COPIES OF THE PATIENT'S MEDICAL RECORDS DOCUMENTING THAT THIS CRITICAL CARE SERVICE WAS UNRELATED TO THE SPECIFIC ANATOMIC INJURY OR GENERAL SURGICAL PROCEDURE. THESE RECORDS MUST DOCUMENT BOTH THE CRITICAL CARE AND THE SURGICAL PROCEDURE. THIS SERVICE IS FOR $484.00 ON JUN. 10, 2003.

OFFICE USE ONLY
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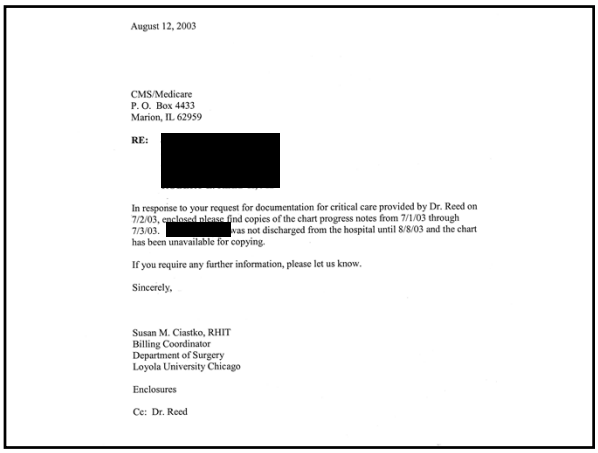


August 12, 2003

CMS/Medicare
P. O. Box 4423
Marion, IL 62959

RE: [redacted]

In response to your request for documentation for critical care provided by Dr. Reed on 7/2/03, enclosed please find copies of the chart progress notes from 7/1/03 through 7/3/03. [redacted] was not discharged from the hospital until 8/8/03 and the chart has been unavailable for copying.

If you require any further information, please let us know.

Sincerely,

Susan M. Ciastko, RHIT
Billing Coordinator
Department of Surgery
Loyola University Chicago

Enclosures

Cc: Dr. Reed

Requirements for Billing During the Surgical Global Period: Essential for Trauma Surgeons

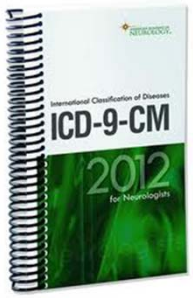
- Use of diagnoses unrelated to the operation with the global package
- Effective documentation
- Modifiers

ICD-9 Code Use for Billing During Global Periods

- The ICD-9 code used for any E&M service in the postoperative period should not relate to the operative diagnoses
  - i.e., a patient you operate on for an abdominal aortic aneurysmorrhaphy should not be coded for postoperative management as having the diagnosis of an abdominal aortic aneurysm
    - That care is already paid for through the global fee
    - Any care that is for something other than the aneurysm itself is separately billable
- Usually there are multiple possible non-operative diagnoses that can be used

Requirements for Billing During the Postoperative Period: ICD-9 Code

- ICD-9 provides over 14,000 diagnostic codes
- Global fee concept excludes all services related to the operation within the global period (0, 10, or 90 days)
  - Only the operation and the operative diagnoses are affected
- Non-operative diagnoses require services not covered by the global fee
  - Anything which is not a "usual, customary, and reasonable" component of the operation



Common Postoperative Diagnoses Not Directly Related to the Operation

- Respiratory failure (ICD-9 code 518.81)
  - Should be applied to all patients being mechanically ventilated
- Posthemorrhagic anemia (ICD-9 code 285.1)
- Observation for trauma (ICD-9 code V71.4)
  - Is one of the few "V-codes" that can be used as a primary diagnosis for a service or procedure
  - Should be used in the trauma patient, especially during the initial observation period (24-72 hours or longer)
- Atelectasis (ICD-9 code 518.0)
- Fever of unknown etiology (ICD-9 code 780.6)

Fluid & Electrolyte Abnormalities

- Hypernatremia (ICD-9 code 276.0)
- Hyponatremia (ICD-9 code 276.1)
- Hyperkalemia (ICD-9 code 276.7)
- Hypokalemia (ICD-9 code 276.8)
- Hypercalcemia (ICD-9 code 275.42)
- Hypocalcemia (ICD-9 code 275.41)
- Hyper/hypomagnesemia (ICD-9 code 275.2)
- Hyper/hypophosphatemia (ICD-9 code 275.3)
- Hypervolemia (ICD-9 code 276.6)
- Hypovolemia (ICD-9 code 276.5)

Documentation Requirements for Billing During the Global Period

- Unrelated perioperative E&M service billing:
  - Ensure that documentation focuses primarily – possibly exclusively – on issues unrelated to the operation
    - Mention the operation only in passing, if at all
  - Provide specific diagnoses (ideally the ICD9 codes) that are not the primary surgical diagnosis
- Perioperative critical care billing
  - Must also strongly indicate the nature of critical care as offsetting organ failure and death

Documentation for E&M Service Billing During the Global Period

This note will likely be considered as part of a bundled surgical global package (and payment will be denied):

"POD 2. BP 198/110, P 116, Tmax 37.8°.
I/O: 2400/1800
CV: RRR, no M, R, G
Chest: Breath sounds clear throughout
Abdomen: Bowel sounds hypoactive. ML wound with no signs of infection
Ext: SCDs in place

138	102	16	242	10.2	7.2
3.4	25	1.2			22

228K

Imp: S/P Colectomy
P: 1) Increase antihypertensives
2) Insulin sliding scale
3) Transfuse 2 U PRBCs"

Documentation for E&M Service Billing During the Global Period

This note should be paid even though a surgical global package is in effect:

"POD 2. BP 198/110, P 116, Tmax 37.8°.
I/O: 2400/1800
CV: RRR, no M, R, G
Chest: Breath sounds clear throughout
Abdomen: Bowel sounds hypoactive. ML wound with no signs of infection
Ext: SCDs in place

138	102	16	242	10.2	7.2
3.4	25	1.2			22

228K

Note: The focus is on the unrelated problems that need management. Operative issues are mentioned in passing.

Imp: 1) Uncontrolled hypertension; 2) Hyperglycemia; 3) Anemia with resultant tachycardia
P: 1) Increase antihypertensives
2) Insulin sliding scale
3) Transfuse 2 U PRBCs"

Documentation for E&M Service Billing During the Postoperative Period

- Think of the note as your invoice
  - Don't focus so much on the operative issues (i.e., wound, S/P surgery status)
    - Payment for those conditions is incorporated into the global payment for the surgical procedure
- Concentrate on those conditions that are
  - unrelated to surgical diagnosis
  - underlying conditions
  - responsible for added course of treatment that is not part of normal recovery from surgery

Documentation Issues: Underlying Rules

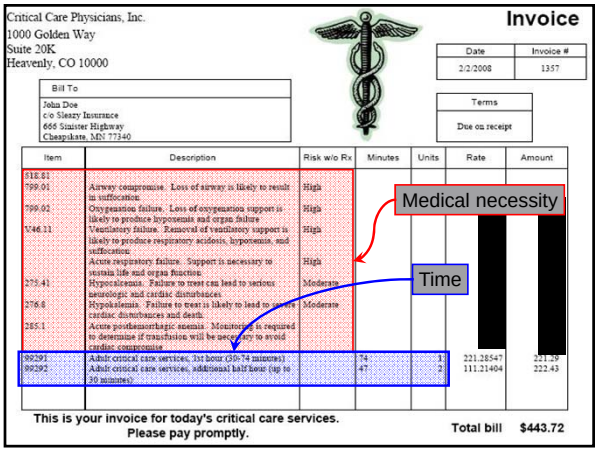
- The Coding Prime Directive
  - Document what you did
  - Document why you did it
  - Code only what you have documented
- The Coding Prime Directive Corollary
  - They're paying you for what you document, not for what you do
  - If you do something, make sure you document it so you can get paid

Documentation of Procedures vs. Services

- Documentation requirements for procedures are less stringent than those for evaluation & management (E&M) services
- Performance of procedures is more objectively verifiable; less opportunity for fraud except for whether or not procedure was necessary
- E&M services less verifiable; therefore more capable of fraud & abuse
  - Has led to stringent documentation requirements
- Documentation requirements for E&M services must be understood and applied to optimize reimbursement

Documentation for adult critical care CPT codes: 99291 & 99292

- Requirements for critical care billing using 99291 & 99292
  - Medical necessity
  - Time
- Your note must reflect these items to justify payment
- Think of your note as your invoice



Your Note is Your Invoice: Medical Necessity

- Critical care is defined as the care of critically ill or critically injured patients who require the full & exclusive attention of a physician
- Critical illness or injury is defined as one that acutely impairs one or more vital organ systems such that there is high probability of imminent or life threatening deterioration in the patient's condition.
- The mere presence of a patient in an ICU or CCU, or the patient's use of a ventilator, is not sufficient to warrant billing critical care services
- Documentation should support that patient is critically ill and receiving critical care
- ***Wherever possible, indicate the consequences if the patient were not receiving critical care***

Your Note is Your Invoice: Time

- Adult critical care daily visits are time-based codes
- Physician progress note must contain documentation of the total time involved providing critical care services
- Must be the actual time spent by the physician, not a resident, fellow, or allied health provider
- The time must be personally documented by the billing physician
- Teaching time ***does not*** count toward critical care time
  - Asking questions of the team for diagnostic and treatment options ***does*** count
- Critical care of less than 30 minutes duration on any given day is reported with an evaluation and management code.

Your Note is Your Invoice: Time

- 99291 and 99292 are used to report the total duration of time spent in critical care E&M
- Time must be exclusive
  - Time cannot be shared with another patient
  - Time cannot include time spent on procedures that are billed separately
- Time does not need to be continuous; should total all interrupted segments
- Total time must be documented in the chart

Your Note is Your Invoice: Time

- Includes time spent while immediately available to the patient (i.e., bedside or elsewhere on the floor or unit):
  - reviewing test results or imaging studies,
  - discussing the critically ill patient's care with other medical staff,
  - documenting critical care services in the medical record, or
  - with family members or surrogate decision makers
    - obtaining a medical history
    - reviewing the patient's condition or prognosis
    - or discussing treatment or limitation(s) of treatment
    - conversation should bear directly on the medical decision making
- Separately billable services or procedures cannot be used to support critical care time

A poor note on an unstable ICU patient

"Pt. w/severe resp. failure. ↑F_IO_2 to 80% w/PEEP 15. CXR w/diffuse bilat. infiltrates. Still bleeding d/t coagulopathy. Xfused 4U PRBCs over 24°, along with FFP & cryo. On Epi & dobs w/BP in 90s. Will supp K^+, Ca^{++} & Mg^{++}. Consider Xygress."

Avoid abbreviations!!!

A poor note on an unstable ICU patient

"Pt. w/severe resp. failure. ↑F_IO_2 to 80% w/PEEP 15. CXR w/diffuse bilat. infiltrates. Still bleeding d/t coagulopathy. Xfused 4U PRBCs over 24°, along with FFP & cryo. On Epi & dobs w/BP in 90s. Will supp K^+, Ca^{++} & Mg^{++}. Consider Xygress."

What are the critical care conditions or diagnoses?

How much time was spent managing this patient?

What did the author do in that time?

A better note: same unstable ICU patient

"Mr. Jones remains in critical condition requiring constant attention. While immediately available to the patient, I examined him and reviewed his recent events, ICU flowsheet data, laboratory analyses, and imaging studies. His current critical care problems include:

1) Severe respiratory failure. I have had to increase his inspired oxygen concentration (FIO2) to 80% to maintain his arterial oxygen (PaO2) above 60 while on positive end-expiratory pressure (PEEP) of 15. Clearly, he needs continuous mechanical ventilation to sustain life. His chest XRay shows diffuse bilateral infiltrates, consistent with Acute Respiratory Distress Syndrome (ARDS).

2) Coagulopathy with hemorrhage. I transfused him 4 units of packed red blood cells over the past 24 hours, along with fresh-frozen plasma & cryoprecipitate. Continuous assessment and supplementation is necessary to prevent uncontrolled hemorrhage and hypovolemia.

3) Hemodynamic instability. He requires continuous infusions of vasoactive agents (epinephrine and dobutamine) to maintain his systolic arterial blood pressure in the 90s. Otherwise, he would progress into circulatory shock, organ failures, and death.

4) Multiple electrolyte disturbances. Today's laboratory data reveal a low potassium of 3.3, a low ionized calcium of 1.08, and low magnesium of 1.5. We will administer supplements of these electrolytes in order to forestall further deterioration and circulatory disturbances.

The overall picture is that of overwhelming sepsis with septic shock, unresponsive to current broad-spectrum antibiotic management. He is a good candidate for Xygress, although his prognosis remains grim. I spent a total of 80 minutes in the critical care of this patient."

A better note: same unstable ICU patient

"Mr. Jones remains in critical condition requiring constant attention. While immediately available to the patient, I examined him and reviewed his recent events, ICU flowsheet data, laboratory analyses, and imaging studies. His current critical care problems include:

1) Severe respiratory failure. I have had to increase his inspired oxygen concentration (FIO2) to 80% to maintain his arterial oxygen (PaO2) above 60 while on positive end-expiratory pressure (PEEP) of 15. Clearly, he needs continuous mechanical ventilation to sustain life. His chest XRay shows diffuse bilateral infiltrates, consistent with Acute Respiratory Distress Syndrome (ARDS).

Standard phrases like these can be templated.

A better note: same unstable ICU patient

"2) Coagulopathy with hemorrhage. I transfused him 4 units of packed red blood cells over the past 24 hours, along with fresh-frozen plasma & cryoprecipitate. Continuous assessment and supplementation is necessary to prevent uncontrolled hemorrhage and hypovolemia.

3) Hemodynamic instability. [illegible] infusions of vasoactive agents (epi[illegible] to maintain his systolic arterial blood [illegible] Otherwise, he would progress into circulatory shock, organ failures, and death.

These phrases justify critical care billing

4) Multiple electrolyte disturbances. Today's laboratory data reveal a low potassium of 3.3, a low ionized calcium of 1.08, and low magnesium of 1.5. We will administer supplements of these electrolytes in order to forestall further deterioration and circulatory disturbances."

A better note: same unstable ICU patient

"The overall picture is that of overwhelming sepsis with septic shock, unresponsive to current broad-spectrum antibiotic management. He is a good candidate for Xygress, although his prognosis remains grim. I spent a total of 80 minutes in the critical care of this patient."

This note generates $332.29 from Medicare/Medicaid in 2012 (currently)
Or $237.83 after the 2-month physician payment cut

A poor note on a stable ICU patient

Pt. still on vent. PO_2 65 on 60%. RSBI 160. CXR no change. Na+ = 130. Ionized Ca++ = 1.07. Will supp both. Hgb 9.2, seems stable.
35 minutes.

Silll with the abbreviations!!!

A poor note on a stable ICU patient

Pt. still on vent. PO2 65 on 60%. RSBI 160. CXR no change. Na+ = 130. Ionized Ca++ = 1.07. Will supp both. Hgb 9.2, seems stable.
35 minutes.

What's this??

What did the author do in that time?

What are the critical care conditions or diagnoses?

A better note on a stable ICU patient

Mr. Jones remains in critical condition requiring constant attention. While immediately available to the patient, I examined him and reviewed his recent events, ICU flowsheet data, laboratory analyses, and imaging studies. His current critical care problems include:

1) Respiratory failure requiring continuous mechanical ventilation (ICD-9 518.81). No adjustments can be made to reduce his ventilatory requirement as this time; his inspired oxygen concentration (FIO2) of 50% resulting in an arterial oxygen (PaO2) of 60 makes his current PaO2/ FIO2 equal to 120 (ICD-9 799.02); thus, he needs no lower than this level of oxygenation support to prevent hypoxemia and organ failure. Also, his Rapid Shallow Breathing Index (RSBI) is 115, indicating a high likelihood that he would not ventilate adequately on a spontaneous basis were he to be extubated (ICD-9 V46.11). As his PaCO2 is 43 on these ventilator settings, lowering his mechanical minute ventilation is likely to increase his respiratory acidosis further.
2) Multiple electrolyte abnormalities, currently consisting of hyponatremia (Na+ = 130) (ICD-9 276.8) and hypocalcemia (ionzed Ca++ = 1.07) (ICD-9 275.41). We will supplement these electrolytes in order to forestall further deterioration and circulatory disturbances. These will need continuous monitoring.
3) Acute posthemorrhagic anemia (ICD-9 285.1): He is not demonstrating and tachycardia and only mild vasodilation (pulse pressure of 62 with diastolic BP =58). I do not believe there is any current need for transfusion, but this will need to be monitored.
I spent a total of 35 minutes in the critical care of this patient, exclusive of procedures."

A better note on a stable ICU patient

"Mr. Jones remains in critical condition requiring constant attention. While immediately available to the patient, I examined him and reviewed his recent events, ICU flowsheet data, laboratory analyses, and imaging studies. His current critical care problems include:"

The same standard phrase describes the situation and the work.

A better note on a stable ICU patient

"1) Respiratory failure requiring continuous mechanical ventilation (ICD-9 518.81). No adjustments can be made to reduce his ventilatory requirement as this time; his inspired oxygen concentration (FIO2) of 50% resulting in an arterial oxygen (PaO2) of 60 makes his current PaO2/ FIO2 equal to 120 (ICD-9 799.02); thus, he needs no lower than this level of oxygenation support to prevent hypoxemia and organ failure. Also, his Rapid Shallow Breathing Index (RSBI) is 115, indicating a high likelihood that he would not ventilate adequately on a spontaneous basis were he to be extubated (ICD-9 V46.11). As his PaCO2 is 43 on these ventilator settings, lowering his mechanical minute ventilation is likely to increase his respiratory acidosis further."

Note the inclusion of ICD-9 codes

A better note on a stable ICU patient

"2) Multiple electrolyte abnormalities, currently consisting of hyponatremia (Na^+ = 130) (ICD-9 276.8) and hypocalcemia (ionzed Ca++ = 1.07) (ICD-9 275.41). We will supplement these electrolytes in order to forestall further deterioration and circulatory disturbances. These will need continuous monitoring.

3) Acute posthemorrhagic anemia (Hgb = 9.2) (ICD-9 285.1): He is not demonstrating and tachycardia and only mild vasodilation (pulse P =58). I do not believe there is any current need for transfusion, but this will need to be monitored.

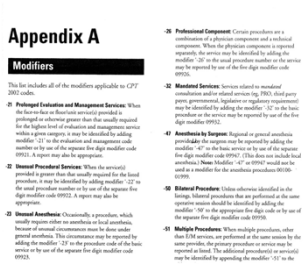
Another useful phrase!!

"I spent a total of 35 minutes in the critical care of this patient, exclusive of procedures."

This note generates $221.19 in 2011, or $158.39 after the pay cut delay

Modifiers

- Modifiers are used to indicate that the basic assumptions about a charge have been changed
- The CPT system currently contains 34 modifiers.
  - 6 modifiers are applied to CPT codes for E&M Services
  - 27 modifiers are applied to procedural CPT codes
  - 1 can be applied to both
- Modifiers are listed in Appendix A of the CPT book



Appendix A

Modifiers

This list includes all of the modifiers applicable to CPT 2002 codes.

-25 Prolonged Evaluation and Management Services: When the face-to-face or floor/unit service(s) provided is prolonged or otherwise greater than that usually required for the highest level of evaluation and management service within a given category, it may be identified by adding modifier '-21' to the evaluation and management code number or by use of the separate five digit modifier code 09935. A report may also be appropriate.

-22 Unusual Procedural Services: When the service(s) provided is greater than that usually required for the listed procedure, it may be identified by adding modifier '-22' to the usual procedure number or by use of the separate five digit modifier code 09922. A report may also be appropriate.

-23 Unusual Anesthesia: Occasionally, a procedure, which usually requires either no anesthesia or local anesthesia, because of unusual circumstances must be done under general anesthesia. This circumstance may be reported by adding the modifier '-23' to the procedure code of the basic service or by use of the separate five digit modifier code 09923.

-26 Professional Component: Certain procedures are a combination of a physician component and a technical component. When the physician component is reported separately, the service may be identified by adding the modifier '-26' to the usual procedure number or the service may be reported by use of the five digit modifier code 09926.

-32 Mandated Services: Services related to mandated consultation and/or related services (eg, PRO, third party payer, governmental, legislative or regulatory requirement) may be identified by adding the modifier '-32' to the basic procedure or the service may be reported by use of the five digit modifier 09932.

-47 Anesthesia by Surgeon: Regional or general anesthesia provided by the surgeon may be reported by adding the modifier '-47' to the basic service or by use of the separate five digit modifier code 09947. (This does not include local anesthesia.) Note: Modifier '-47' or 09947 would not be used as a modifier for the anesthesia procedures 00100-01999).

-50 Bilateral Procedure: Unless otherwise identified in the listings, bilateral procedures that are performed at the same operative session should be identified by adding the modifier '-50' to the appropriate five digit code or by use of the separate five digit modifier code 09950.

-51 Multiple Procedures: When multiple procedures, other than E/M services, are performed at the same session by the same provider, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending the modifier '-51' to the

Modifiers should be applied when:

- the modifier adds more information regarding the anatomic site of the procedure;
- the modifier helps to eliminate the appearance of duplicate billing; or
- a modifier will help to eliminate the appearance of unbundling.

Requirements for Billing During the Global Period: Modifiers

Period	Type of CPT Code Being Modified:	
	Evaluation & Management	Procedure
Same day as global procedure	-25 (Unrelated; for 0- & 10-day globals) -57 (Decision for surgery; for 90-day globals)	-51 (Multiple) -59 (Distinct)
Post-procedure day global period	-24 (Unrelated)	-79 (Unrelated) -78 (Related) -58 (Staged)

Modifier 25: Significant, Separately Identifiable E&M Service By Same Physician on Same Day of Procedure

- Applied to E&M Services only
  - E&M performed on the same day as the procedure (pre-op or postop)
- Usually applied to E&M services done on the same day as minor procedures (i.e., procedures with a global package period of 0 or 10 days)
- Designates that patient required E&M services above and beyond the normal preoperative or postoperative care covered by the global surgical package
- May be prompted by the same condition that required the procedure
  - But easier to justify if ICD-9 code(s) applied should not be the same as those applied for the operation

Modifier 25

- The default concept is that if you are performing a procedure on a patient, that is the only reason you are seeing the patient that day. Any other issues need to be distinguished with documentation & the modifier
- Examples
  - Do a central line (36556) on the same day as a daily ICU visit (99291): the daily visit code needs a "-25" modifier or it doesn't get paid
  - Do an ED abdominal ultrasound (76700) on the same day as an ED evaluation (99285): the ED evaluation needs a "-25" modifier or it doesn't get paid

Modifier 57: Decision for Surgery

- Applied to E&M Service that results in the initial decision to operate on the patient
- Typically applied when E&M is performed on the same day as a major procedure having a 90-day global package
- Example:
  - You are consulted on a patient in the ED with c/o abdominal pain and perform a comprehensive examination.
  - You determine that he likely has appendicitis and take him immediately to the operating room to perform an appendectomy
  - Bill the inpatient consultation as CPT 99285-57: ICD-9 789.03 (RLQ abdominal pain)
  - Bill the appendectomy as 49550: ICD-9 540.9 (appendicitis w/o peritonitis)

Same-Day E&M Modifiers

- Both the –25 & -57 modifiers are known as "Same Day E&M" modifiers
- Applied to E&M services performed on same day as procedures
  - 25 in case of minor procedures (0 or 10 day global periods)
  - 57 in case of major procedures (90 day global periods)
- Denial of payment can occur for the initial examination of a trauma patient if the trauma surgeon operates on the patient that same day and fails to use either a "-57" or a "-25" modifier
  - Without the modifier, the service is considered a part of the procedure and its global fee

Modifier 24: Unrelated Evaluation & Management Service by the Same Physician During a Postoperative Period

- Applied to E&M Services only
- Designates that the E&M services provided are for conditions that are unrelated to the operation
  - ICD-9 code(s) applied should not be the same as those applied for the operation
- Occurs during the postoperative period
- i.e., you operate on a patient for a GSW to the colon. If that patient has conditions respiratory failure (ICD-9 518.81) and anemia (ICD-9 285.1), conditions that are not "usual, customary, and reasonable" following a hole in the colon, billing the critical care services (CPT 99291/99292) would need the –24 modifier

Modifier 51: Multiple Procedures

- Applies to procedures, not E&M services
- Applied when multiple procedures are performed in the same encounter, site, incision
- Logic:
  - each procedure's value includes routine perioperative care
  - Routine care is theoretically not altered when multiple procedures are performed through the same incision at the same time
- Applied to all procedures performed except for the procedure with the highest reimbursement

Modifier 51 Examples

- Perform a hepatorrhaphy for a major liver laceration, a splenectomy, and small bowel resections x 3:
  - 47361 (liver; 73.46 RVUs)
  - 44120-51 (small bowel resection; 27.59 RVUs)
  - 38100-51 (splenectomy; 23.82 RVUs)
  - 44121 x 2 (additional small bowel; add-on code)
- Modifier 51 not applied in cases of add-on codes and 51-exempt codes

Modifier 59: Distinct Procedural Service

- Applies to procedures, not E&M services, performed on same day by same physician as other procedure(s)
- Used to identify procedures/services that are not normally reported together, but are appropriate under the circumstances
- Different session, operation, site, organ system, incision, lesion, or injury from that involving the other procedure(s)
- Example: You place a central line (36556) on the same day as a non-therapeutic laparotomy (49000): the central line needs a "59" modifier or it doesn't get paid
  - If you place a chest tube (32020) on the same day, it too needs a "59" modifier

Modifier 58: Staged or Related Procedure by the Same Physician During the Postoperative Period

- Procedure not requiring a return trip to the operating room (see modifier 78)
- For procedures that are
  - Planned prospectively
  - More extensive than the original procedure
  - For therapy following a diagnostic surgical procedure
- Example: Diagnostic endoscopy leading to decision to perform more extensive open procedure. Identify endoscopy with –58 modifier.

Modifier 79: Unrelated Procedure by the Same Physician During the Postoperative Period

- Applies to procedures
- Not a routine part of the postoperative care of the original procedure, therefore unrelated to it
- May or may not require a return to the OR
- Examples
  - Central line insertion (CPT 36556-79) for hypovolemia (ICD-9 276.5), a condition that is not "usual, customary, and reasonable" following a hole in the colon
  - Return to the OR for tracheostomy (CPT31600-79) for respiratory failure (518.81), a condition not routinely encountered following splenectomy

Modifier 78: Return to OR for Related Procedure During Postoperative Period

- Applies to procedures done in the OR
- Example:
  - Initial damage control laparotomy (49000)
  - Followed by relaparotomy 2 days later for pack removal (49002-78)
  - The relaparotomy is related to the original laparotomy and requires a return to the OR
  - Ensures full payment of relaparotomy
  - Starts new global period

Modifier 58: Staged or Related Procedure or Service by the Same Physician During the Postoperative Period

- Indicates that the performance of a procedure or service during the postoperative period was:
  - planned or anticipated (staged)
  - more extensive than the original procedure
  - for therapy following a surgical procedure.
- Example:
  - Initial close management of 8 rib fractures (21800 x 8), such as analgesia, pulmonary toilet, etc.
    - Carries a 90-day global package period
    - 1.01 wRVUs per rib
    - 3.41 total RVUs per rib
  - Followed 4 days later by chest wall reconstruction with rib plating (CPT 32820 with modifier -58)
    - 22.51 wRVUs
    - 39.93 total RVUs
  - Total payments of $2,287.67 (or $1,658.15 after the pay cut delay expires)

Modifier 22: Unusual Procedural Service

- Used for procedures
- When service(s) provided greater than usually required
- Separate report may be appropriate

Requirements for -22 modifier

-American Academy of Procedural Coders Independent Study Program, Module 2, pp. 3-3 to 3-4, 1996.

- Work and effort should have been increased 30-50% over the routine procedure.
- -22 claims are usually kicked out of automated process and sent to medical review.
- The operative report should describe in *specific* detail the entities justifying the -22 modifier.
- The operative report should be included with the claim.
- Medicare payment increases are rarely over 20%.
- Commercial payers will typically allow an additional 20-30% reimbursement.

Requirements for -22 modifier

-American Academy of Procedural Coders Independent Study Program, Module 2, pp. 3-3 to 3-4, 1996.

- Increased risk
- Difficult procedure
- Hemorrhage
- Severe respiratory distress
- Extended services
- >600 ml EBL
- Unusual findings
- Complications
- Prolonged operation
- Obesity
- Unusual contamination control

The operative report should describe in *specific* detail any of these items that complicated the procedure, and the operative report should be included with the claim.

An Extreme (But True) Example of the Inherent Flaw in Global Bundling

- 70 y/o male seen in clinic for suture sinus
- Suture removed without difficulty
- Sudden severe abdominal pain
- Admitted
- Peritoneal signs
- CT scan: intraabdominal fluid & free air
- Emergency laparotomy
- Findings: avulsion of adherent small bowel & rupture

An Extreme (But True) Example of the Inherent Flaw in Global Bundling

- Procedure: segmental small bowel resection with 1° anastomosis (CPT 44120) and recurrent ventral herniorrhaphy (CPT 49565)
- Total professional charges for surgical procedure: $6,836.00
  - Total RVUs 41.45
  - Medicare Payment Expected: $1,199.35

An Extreme (But True) Example of the Inherent Flaw in Global Bundling

- Denial notice received 8 months postoperatively: Services were considered previously paid in bundled service
- Review revealed charge for CPT 10061 (I&D – i.e., suture removal) on the day before abdominal surgery
  - 2.4 Work RVUs
  - 3.84 Total RVUs
  - Medicare payment of $140.50
  - Global Package Period of 10 DAYS!!!

An Extreme (But True) Example of the Inherent Flaw in Global Bundling

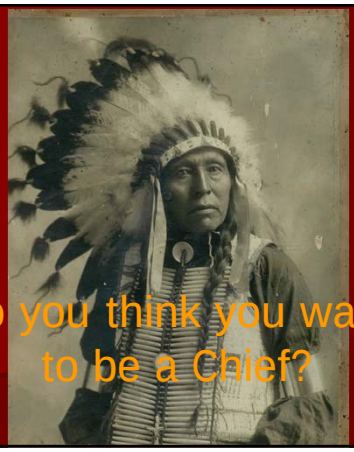
- How do 41.45 RVUs (which means "Relative Value Units") get "bundled" into 3.84 RVUs?
  - What's wrong with Medicare's computers?
  - To accept this concept as logical obliterates the principal of "relative values"
- What was necessary was a "-79" modifier (procedure unrelated to primary procedure)
  - Resubmitted
  - Payment of $1,150.33 received
  - -Personal losses of $900.00
  - -Institutional tax of 28%
  - Net revenue of $144.24

Conclusions

- Proper billing for E&M and of procedures in the postoperative period requires documentation and coding of
  - distinct diagnoses that are different from the primary diagnoses for the procedure(s)
    - Many surgical patients (especially critically ill patients) have several diagnoses (and codes) that can be used
  - Critical care documentation should spell out what the critical care services are doing to warrant the service
    - Such as what would happen to the patient if the service were not provided
- Use of modifiers helps to ensure that your billable services are not denied payment on their first submission

Landing the Next Job: Where Preparation Meets Opportunity

Michael F. Rotondo MD FACS
Professor and Chairman
Department of Surgery - The Brody School of Medicine
East Carolina University



So you think you want to be a Chief?

Objectives

- Review General Considerations
- Name the Overarching Principles
- Discuss Academic vs. Private Environments
  - Models of Compensation
- Explain Tangible vs. Intangible Value
- Know the Factors in the Deal
- Learn How to Make the Deal
  - Power vs. Leverage
- Discussion

Training with the best of the best

...the problem of bias...

Clear Vision

...have you really decided what you want to do next...

Overarching Principles

- People
- Place
- Priorities
- Project

Environmental Differences

- ACADEMIC
  - More hierarchical
  - More job diversity
  - Teaching
  - Research
  - Administration
  - Less autonomy to more
- PRIVATE
  - Rule by consensus
  - Health care delivery business
  - Market guise teach
  - Moves for the money
  - Run the business
  - More autonomy to less

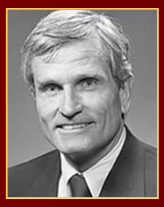
Traditional Practice Models

- Minus Direct Cost - Operating Margin
- Minus Tax
- Minus Overhead - Net Margin

YOU OWN THE BUSINESS!

The Faculty

Question: "*So Steve....how do you run the money up at Vermont?"*



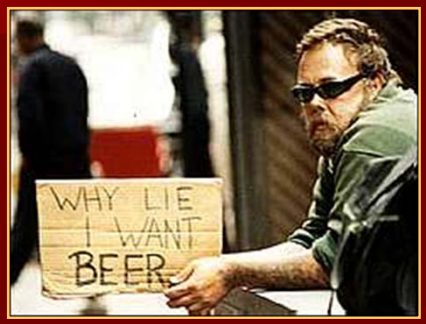
Answer: " Listen, I've been through 4 Deans in 17 years. The money is draining out of surgery....everybody gets paid a base and then its eat what you kill. We basically pay a dollar amount per RVU based on what we have leftover at the end of the year. Of course, there are always exceptions and you just have to work your way through these...it works really well."

Provider Based Practice Models

- Minus Direct Cost - Operating Margin
- Minus Whatever } - Net Margin
- Minus Overhead }

THE BUSINESS OWNS YOU !

The Employee



Standard Operating Definitions

- **Base Salary** – minimum university academic salary that is based on rank and set annually by the school of Medicine

... pay for being a professor ...

Standard Operating Definitions

- **Supplement** – determined on an annual basis by the Division Chief and the Chair base on overall performance including clinical productivity, teaching, research leadership, and citizenship relative to the Division/Department and institution at large

... payola to make you feel like a surgeon ...

Standard Operating Definitions

- **Variable Component** – a compensation component based on the current year's productivity which by definition puts some portion of Supplement at risk and allows for additional compensation for reaching specific targets

... gotta' make the numbers to earn the geld ...

Standard Operating Definitions

- **Stipend** – compensation for a specific task carried out on behalf of the organization based on specific duties and performance criteria – usually a job that benefits the whole in some way

... it's a dirty job but , somebody has to do it ...

Standard Operating Definitions

- **Bonus** – compensation above all other definitions based on meritorious performance

... boy this better be really good ....

Standard Operating Definitions

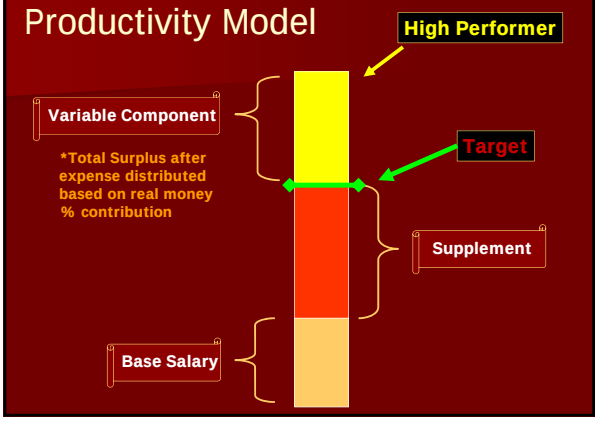
- Salary
  - Base Salary
    - + Supplement
      - + Variable Component
        - + Bonus *
          - + Stipend *
- Total Compensation
  - Benefits (Health, Life, Disability, Retirement)

Classifications of Compensation Plans

- Salary – flat salary basis
- Production – flat salary with a productivity bonus usually based on an RVU system, a percentage of gross charges, a percentage of gross collections, a percentage of collected revenues
- Partnership – based on practice profit sharing (also referred to "gainsharing")
  - sharing the financial and the academic gain for achieving agreed upon targets

Rolf, *ACMPE Paper*, October 2003
Sadowski et al, *APA Matrix*, January 2000

Productivity Model



Partnership/Productivity model

Other Modifications:
(If you have money laying around and/or if you have budgeted properly)

- Bonus – Just add this on the top
- Stipend – Pay for specific duties
- Research Credits – Set clear goals

... pay into the pot ...

Standard Operating Definitions

- What is "Performance"
  - Clinical Productivity
  - Excellence in Education
  - Research Productivity and Scholarly Activity
  - Organizational Service
  - Citizenship and Leadership
- Clinical Educator vs. Physician Scientist

Tarquinio et al, *Academic Medicine* July 2003

Objectives of the Plan

- Support the research, teaching and clinical mission
- Enable the Department to recruit and retain excellent faculty and achieve their personal goals
- Founded on consistently applied principles that can be understood by all
- Encourage individual commitment to productivity and foster collegiality
- Strengthen the link between faculty compensation and contribution to the Department

Kaiser 2003, The Department of Surgery – University of Pennsylvania

Critical Negotiating Value

- TANGIBLE
  - Produce Widgets
  - Take Shifts
  - Provide Widget Framices
- INTANGIBLE
  - Teach
  - Research
  - Innovate
  - Lead
  - Administer
  - Develop

Setting Benchmarks
(Thresholds, Targets and High Performance)

- Benchmark to:
  - The individual (previous year)
  - The Division
  - The Department
  - The School
  - Outside Sources:
    - MGMA
    - AAMC
    - UHC

Question: "*So Dick….how do you run the money up at Loyola?"*

Answer: " Who you got working for ya' ?
Reply: "Er…a…we have a senior administrator who….um…."
Answer: "What is that…a senior administrator? (disdainfully)… I got a Harvard MBA with years of experience workin' for me. His office is right next to mine and we communicate through a hole in the wall…I have all the data at my fingertips. When a Division Chief comes to talk to me, I can tell em' how much their gettin' back on a Blue Cross Blue Shield inguinal hernia…it works really well"

The Things You Need…Support

- Clinical Operations
- Research Enterprise
- Educational Mission
- Administrative Responsibilities
- Financial Support
- Personnel Management

Making the Deal

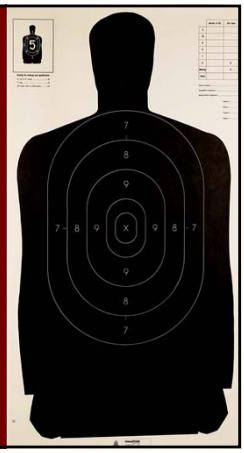
- Preparation is the key to Power
  - Read Mission Statements
  - Read Financial Statements
  - Ask Tough Questions
  - Get the Real Information
  - Find Vulnerabilities in Terms of Solutions That You Can Provide
- From this you find your Leverage Points

Making the Deal

- Open with the Highest Justifiable Request
  - Read Mission Statements
  - Read Financial Statements
  - Ask Tough Questions
  - Get the Real Information
  - Find Vulnerabilities in Terms of Solutions That You Can Provide
- Prepare a Strategic and Tactical Document

Game Time!

- Have a Clear Target
- Have Some Prepared Concessions
- Know your BATNA
  - Best Alternative to a Negotiated Settlement
- DON'T BURN A BRIDGE
- GO FOR IT



What else is on the list?

- Life Insurance
- Health Insurance
  - Dependent Care
  - Dental
- Long Term Care
- Retirement Plans
- Tuition Benefits
  - Dependents
  - You!
- Travel
- Books
- Dues
- Subscriptions
- Loan Forgiveness
- Personal Time
- Other

The Last Item to Discuss is Your Own Compensation!

Conclusions

- Do your home work….when preparation meets opportunity…great things happen!