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## MEDICARE RULES



### CMS reveals major meaningful use overhaul, but details are sketchy

The existing EHR Meaningful Use (MU) incentive program will be replaced by a new, more provider-friendly program that will focus on paying for patient outcomes rather than the reporting of government-specified usage data, top CMS officials announced in a Jan. 19 blog post.

The first signs that big changes were coming came from public remarks by CMS Acting Administrator Andy Slavitt, first during a public healthcare conference Jan. 11, then on his Twitter page, that the MU program will be eliminated and replaced.

“The Meaningful Use program as it has existed, will now be effectively over and replaced with something better,” Slavitt told a crowd at the J.P. Morgan Annual Healthcare Conference in San Francisco. “Since late last year we have been working side by side with physician organizations across many communities – including with great advocacy from the AMA – and have listened to the needs and concerns of many. We will be putting out the details on this next stage over the next few months.”

Many providers and practice executives rejoiced, taking Slavitt’s comments to mean that the MU program would end soon, and render Stage 3 requirements moot. CMS has since clarified Slavitt’s comments with a longer, [more formal statement](#) on its official blog.

This post includes four points about the new program and how it differs conceptually and philosophically from the current MU program (excerpted verbatim including emphasis):

1. Rewarding providers for the **outcomes** technology helps them achieve with their patients.
2. Allowing providers the **flexibility to customize** health IT to their individual practice needs. Technology must be user-centered and support physicians.

(continued on pg. 2)

3. **Leveling the technology playing field** to promote innovation, including for start-ups and new entrants, by unlocking electronic health information through open APIs – technology tools that underpin many consumer applications. This way, new apps, analytic tools and plug-ins can be easily connected to so that data can be securely accessed and directed where and when it is needed in order to support patient care.
4. **Prioritizing interoperability** by implementing federally recognized, national interoperability standards **and focusing on real-world uses of technology**, like ensuring continuity of care during referrals or finding ways for patients to engage in their own care. [CMS] will not tolerate business models that prevent or inhibit the data from flowing around the needs of the patient.

CMS has the legal authority and obligation to make this change thanks to the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), which is also known as the law that eliminated the sustainable growth rate (SGR) payment formula that imposed ever more draconian payment cuts to providers. MACRA creates a single overarching new incentive program, called the “Merit-Based Incentive Payment System” or MIPS, that was already slated to encompass the MU incentive program, along with the Physician Quality Reporting System (PQRS).

If meaningful use goes away, it’s not going away until 2019, when MIPS will be implemented, says Bradley Coffey,

government affairs specialist for the American Academy of Orthopaedic Executives (AAOE) in Indianapolis, Ind. “You should continue reporting as CMS requires, including stage 2 measures pursuant to the stage 2 modifications rule, and then transition to stage 3 in 2017 or 2018. In the short term, nothing’s changing.”

Look for much more specific details in March, when CMS is expected to unveil its proposed rule for MIPS, Coffey says. The final MIPS rule is expected on Jan. 1, 2017.

### Don’t forget: Hardship exemption for 2015

One of the last acts of Congress in 2015 was to grant CMS wider authority to issue hardship exemptions to providers who failed to attest to meaningful use last year under its Stage 2 requirements. This wider authority, which has been described as a license to give providers “blanket exemptions,” has resulted in CMS releasing a new, streamlined [application form](#) on Jan. 22.

The agency has also released guidance on the application process, which you can [read online here](#). You have until March 15 to complete the application and submit it to CMS via email or fax. **Note:** CMS strongly suggests that you send the form electronically because faxes can result in processing delays. Full details are available in the form itself.

This hardship exemption application is for eligible providers who did not successfully attest to Stage 2 MU in 2015, but



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did intend to attest. The application form contains both an individual and a group option on one form.

### Who should apply for the exemption?

CMS is offering the hardship exemption for 2015 (which impacts this year's payments) partly because the agency had originally required a year-round reporting period, only to revert the period back to any contiguous 90-day period in 2015. This change was made in response to vigorous lobbying by provider advocacy groups and was officially implemented as part of a modifications rule for the MU program in October 2015, leaving providers very little time to adjust their attestation plans.

While the hardship exemption does cover this circumstance, it shouldn't be seen as an opportunity to escape Medicare payment penalties for everyone, says Coffey, the AAOE official. "I would say to err on the side of caution," he says. "If you had every intention of attesting in 2015, but couldn't or didn't, then you should apply. If you didn't intend to attest, then you shouldn't apply for this hardship exemption."

### Deadline and application process for providers

Hardship application forms for previous years contain very specific hardship claims that the provider must select as their reason for claiming hardship. However, for 2015, one of the top reasons was CMS' delay in releasing its own rulemaking that reverted the reporting period from the entire year to just a 90-day period.

If this is the reason for your hardship, choose "Section 2.2.d EHR Certification/Vendor Issues (CEHRT Issues)" on the PDF application form as the reason for needing the hardship exception, Coffey says. While this language may seem vague because it doesn't explicitly reference CMS' delay of the final rule, it is the correct option according to the Congressional offices that AAOE worked with, Coffey explains.

The other options for hardship are longstanding ones, such as natural disaster, practice going of business, or lack of patient interaction, and you should choose one of them if they are more applicable.

### Don't confuse with reconsideration form

Finally, this new hardship application form is different from the "reconsideration" application form for providers, which CMS released several weeks ago. The reconsideration

form only applies to providers who have *already* received a payment adjustment letter from CMS informing them that their Medicare payments will be reduced in 2016. These reductions are based on the 2014 MU reporting year, while the just-released hardship application is for the 2015 MU reporting year. The reconsideration form for 2014 form comes in two flavors, you can find the one for [single providers here](#) and the one for [multiple providers here](#). No matter which you use, you have until 11:59 pm ET on Feb. 29 to email or fax them to CMS.

— Grant Huang, CPC, CPMA ([gghuang@drsmgmt.com](mailto:gghuang@drsmgmt.com)). The author is Director of Content at DoctorsManagement.

## CODING



### Now hear this: New code changes billing for cerumen removal

There's finally a new code to use in 2016 for the removal of impacted cerumen when instrumentation is not used. The new code comes with its own set of guidelines for proper usage, which will impact how your physicians code and document cerumen removal services.

The new code is **69209**, described as removal of impacted cerumen using irrigation/lavage, unilateral. The AMA did not make changes to CPT code **69210**, for removal of impacted cerumen using instrumentation, other than to clarify that 69209 cannot be reported with 69210 when performed on the same ear.

Previously, the removal of impacted cerumen using irrigation and/or lavage was considered to be part of the E/M service performed that day. The decision was made to add CPT code 69209 starting on Jan. 1, 2016, to prevent reporting errors with the reporting of code 69210 when the cerumen was removed using irrigation or lavage.

Before we talk about how the two ear removal codes work together, here are some key things to know about 69209:

- 1. Cerumen must be impacted:** Even though the cerumen is not so impacted that it cannot be removed via irrigation or lavage, the CPT rules for using the code state that the cerumen must

be impacted, so we would recommend that the cerumen be documented as impacted in the notes for the service. CPT further advises that when the cerumen is not impacted, its removal would continue to be considered part of the E/M service.

2. **Nurse may perform the service:** The clinical example provided by the AMA in *CPT Changes: An Insider's View* makes it clear that 69209, which has no physician work relative value units attached to it, can be performed by a nurse. It's generally the expectation that when the physician determines that impacted cerumen can be removed via irrigation or lavage, a nurse will come in and complete this component of the service. When instrumentation is required, the service would be done by the physician or non-physician practitioner.
3. **Bundled into an E/M service:** As with 69210, the expectation is that an E/M service is only separately billable with 69209 when a significant, separately identifiable service is rendered. However, it is not likely a patient would present just for ear irrigation and/or lavage and even need to see the physician. That said, documentation should still clearly show the need for a separate E/M service if that does occur.

In terms of how the two codes work together, there is a key distinction between CPT rules for how 69210 should be billed and the Medicare billing rules. This difference is not the same for new code 69209.

The AMA recognizes both impacted cerumen removal codes as being able to be billed bilaterally. In other words, by the CPT's guidance for these codes, you would bill

modifier **LT** for the left ear, modifier **RT** for the right ear, and modifier **50** for bilateral payment.

Medicare does not recognize 69210 as eligible for bilateral payment under its bilateral modifier rules. As a result, it's appropriate to bill Medicare for one unit of 69210, regardless of whether the lavage is performed on one or both ears.

Medicare does recognize bilateral modifiers for 69209, meaning that when both ears are cleaned using irrigation or lavage, modifier 50 can be used for 150% of the payment for the service. Remember, however that 69209 and 69210 cannot be billed for the same ear for the same date of service.

As a result, if removal of impacted cerumen using irrigation/lavage and instrumentation were to be performed on the same ear on the same date of the service, only the 69210 is reported. However, if one ear has instrumentation and one has lavage, both services are reported.

When both ears have impacted cerumen removed with instrumentation and one with irrigation or lavage, Medicare will recognize just one unit of 69210, as CPT does not allow both services to be reported for the same ear.

**Remember:** It's critical that the new code 69209 be reported only for impacted cerumen. When non-impacted cerumen is removed as a courtesy for the patient, or the patient is unable to self-remove non-impacted cerumen, 69209 is not an appropriate code to report.

— *Scott Kraft, CPC, CPMA (skraft@drsmgmt.com). The author is an Auditor and Consultant at DoctorsManagement.*

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June 9-12	<b>2016 American Academy of Orthopaedic Executives Annual Conference</b> , San Francisco, CA – Shannon DeConda
Oct. 27-28	<b>2016 American Medical Billing Association Conference</b> , Las Vegas, NV – Shannon DeConda

## HUMAN RESOURCES



### Feds delay new rule on overtime pay for employees

Employers have been scrambling to [prepare for a new rule](#) that will sharply increase the number of U.S. workers who are eligible for overtime pay. However, they may have more time than they thought.

Employers had been expecting the rule to go into effect late in 2015 or early 2016. It appears now that the final rule is delayed until mid to late 2016, and it is speculated that the changes may not go into effect until sometime in 2017.

#### Why the delay?

After the proposed rules came out in July, businesses and organizations flooded the Department of Labor with an estimated 290,000 comments. Solicitor of Labor Patricia Smith reportedly told attendees at the 2015 American Bar Association conference that the large volume of comments and the complex nature of the changes were the cause of the delay in issuing the final rules. Another explanation could be politics and the desire to wait to issue the new rules until after next year's presidential election.

#### What we know so far

Let's take a look at everything we currently know about the new rule and how its provisions would change things for businesses:

- **The minimum salary threshold will rise, and significantly.** The proposed rules raise the salary threshold for white-collar exemptions to an estimated \$970 per week/\$50,440 per year. This is up from the current weekly wage of \$455 per week/\$23,660 per year. The salary threshold for highly compensated exempt employees would go up from \$100,000 to about \$122,148 per year.
- **The threshold will automatically increase.** For the first time ever, the salary threshold will be tied to an automatic escalator so it can keep pace with inflation – and so major legislative changes are not needed every time lawmakers want it to increase.

- **The DOL is considering making changes to the duties tests.** The DOL has not suggested changing the executive, administrative, professional, computer or outside sales duties tests yet. However, the agency did specifically ask for comments on whether the tests should be changed and whether they are working to screen out employees who are not *bona fide* white-collar exempt employees.

#### Next steps

Employers may have more time to prepare for the expected overtime pay changes, but the timing remains uncertain despite the Solicitor's comments. The projected date for issuing the final rule could be as early as [July 2016](#). This would be consistent with the Solicitor's of Labor position on the importance of this regulatory initiative to the White House. The salary level has not been increased since 2004. Prior to that, it had not been increased since 1975. The 2004 salary level test of \$455 per week, which is currently in effect, is below the poverty level for a family of four.

It would behoove employers not to rely on speculation that the new rules are guaranteed to come late in the year, or to be shelved, as some believe. Instead, make plans now to review the employees you currently consider to be exempt and note those positions and persons being paid close to the current salary threshold (i.e. \$23,660 per year). Those will be the ones who may no longer be exempt after the salary thresholds go up.

— Philip Dickey, MPH, PHR ([pdickey@drsmgmt.com](mailto:pdickey@drsmgmt.com)).  
The author is a Partner and Director of Human Resources at DoctorsManagement.

## AUDITING



### How to audit NPPs and split/shared visits

Split/shared visits are one of the most common – and commonly misunderstood – areas of billing, a trend that our auditors at DoctorsManagement have discovered after countless hours working with non-physician practitioners (NPPs) around the country in both inpatient and outpatient hospital settings.

The related topic of incident-to billing gets far more attention, so in this article we'll take a deep dive into split/shared visits, which are just as important for NPPs and the providers who work with them.

We at DoctorsManagement have performed thousands of audits on NPP split/shared services where physicians feel that, as long as they sign off on the note or place a brief statement such as "agree with NPP on treatment plan," they have satisfied all requirements.

However, this is a complete fallacy. The physician must document the point at which they became involved in the visit and the full extent of that involvement, which means the physician must have a face-to-face visit with the patient on the same day as the NPP. Should the physician fail to meet any of the requirements of the split/shared service, the visit must instead be billed by the NPP, which typically results in a 15% payment reduction (by Medicare and most commercial payers).

## Review: What is a split/shared visit?

A split/shared visit is a medically necessary encounter with a patient in which the physician and a qualified NPP each personally perform a substantive portion of the E/M service. Again, they must both have a face-to-face encounter with the same patient on the same date of service.

"Substantive portion" is a phrase that can seem vague, so let's clear it up. A substantive portion of an E/M visit "involves all or some portion of the history, exam or medical decision making key components of an E/M service," according to Medicare's online Claims Processing Manual, publication 100-04, chapter 12, section 30.6.1(B).

Medicare has issued a number of clarifications on both split/shared visits and "incident-to." It's important to understand that in many cases, a visit simply can't be billed as a split/shared visit because it doesn't meet the guidelines, and must instead be billed under the NPP's identifier with

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Client	Services provided
Urgent care group, VA	Practice assessment, monthly managed care
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Solo practitioner	New provider enrollment
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Family practice, TX	HR Simply Kit
Solo provider	Employee handbook webinar
Solo provider	Custom employee handbook
Ophthalmology group, TN	OSHA compliance program
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Dental practice, VA	OSHA training
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the reduced payment. If only the physician provides the entire service, then the physician may bill under his or her identifier for full payment. The guidelines of other payers such as the Blues or Cigna may be more or less relaxed than Medicare, but they must be reviewed carefully based upon individually negotiated contracts.

NPPs can act as scribes, meaning they can go and gather information but the note can't state that the patient was seen by Dr. Smith and his PA, Jane Doe, and the doctor signs off on the note and gives a brief statement such as "have personally met with the patient and agree with treatment plan." This is not compliant. The physician must provide the key elements of the history and exam, as well as establish the treatment plan.

#### **Split/shared visits are allowed in these settings only:**

- Office/clinic (with incident-to requirements met)
- Hospital Inpatient/Outpatient
- Emergency Department
- Hospital Observation
- Hospital Discharge

#### **Split/shared visits are not allowed in the following areas:**

- SNF/NF setting
- Consultation services
- Critical care services
- Non-E/M procedures
- At a patient's home and/or domiciliary sites

#### **General requirements for split/shared visits**

The service provided must be reasonable and medically necessary, must be within the NPP's scope of practice as defined by state law in the state where he/she practices; and must be performed in collaboration with a physician. The physician and NPP must be from the same group practice or employed by the same employer. The physician must provide any face-to-face portion of the E/M encounter with the patient. If the physician's participation in the service is limited to simply reviewing the patient's medical record, then the service may only be billed under the NPP's UPIN/PIN). In the office and non-facility clinic setting, the "incident-to" rules apply, so it must always be an established patient.

In hospital settings (inpatient, outpatient, and ED) "incident-to" rules do not apply, and therefore there is no distinction between new and established status in the inpatient and ED settings. As we've mentioned before, the physician habit of simply writing "seen and agree" or just countersigning is not enough; he/she must specifically document what he/she has personally done.

— Sean M. Weiss, CPC, CPC-P, CPMA, CCP-P, CMCO, ACS-EM ([sweiss@drsmgmt.com](mailto:sweiss@drsmgmt.com)). The author is a Partner, Vice President and Chief Compliance Officer at DoctorsManagement. His column appears monthly in *The Business of Medicine* newsletter. Questions regarding the law in your state should be directed to your company attorney.

## **COMPLIANCE**

### **OIG Work Plan: 9 physician targets you need to know about in 2016**

In this brand new year, your practice should be wary of increased government scrutiny of physicians with enrollment issues, E/M codes for home visits, prolonged E/M services, anesthesia services, ambulatory surgical centers (ASCs), and more.

The HHS Office of Inspector General (OIG), which is the top federal watchdog tasked with oversight of the healthcare industry, publishes its annual work plan towards the end of each year. The work plans are public documents that spell out, often in considerable detail, the specific compliance issues that the OIG will be focusing on in a given year.

Let's take a look at the OIG's [official 2016 Work Plan](#) and dive into those targets with the greatest relevance for physician practices.

- 1. Physicians who refer/order Medicare services and supplies (*new*).** Physicians and non-physician practitioners (NPPs) must be properly enrolled in Medicare and legally eligible (that is, not on any federal exclusion list) to refer/order services, supplies and durable medical equipment. This has been an OIG target in previous years, but it seems to be a problem once more. Any provider who is having credentialing issues with Medicare's

Provider Enrollment, Chain and Ownership System (PECOS) may be considered ineligible to order/refer until their issues are corrected, and now they'll also be subject to OIG review.

- 2. Reasonableness of physician home visits (*new*).** CMS has paid approximately \$559 million for physician home visits since 2013, and the OIG believes many of these payments were not adequately supported. Physicians must document the medical necessity of a home visit instead of an office or outpatient visit. The OIG will be cracking down on E/M codes billed for home visits.
- 3. Reasonableness of prolonged services (*new*).** The OIG wants to see whether payments for prolonged E/M services were reasonable and met Medicare requirements. Prolonged services are used when E/M services take far longer than typical, at least 30 minutes over the CPT-specified time threshold for the most applicable E/M code. "The necessity of prolonged services are considered to be rare and unusual," the OIG writes in its work plan. Thus your documentation for prolonged services (CPT **99354-99357**) needs to demonstrate medical necessity for the extra time, along with time documentation.
- 4. Quality oversight of ASCs (*new*).** The OIG will review how Medicare has been providing oversight of ASCs, specifically state survey agencies that certify ASCs. In some cases more than five years have occurred between certification surveys in some states.
- 5. Non-covered anesthesia services (*new*).** The OIG will review Part B claims for anesthesia services to determine whether they were billed for a patient who actually received a related Medicare service.
- 6. Payments for personally performed anesthesia services.** Anesthesia services performed by anesthesiologists will be reviewed. This isn't a new issue, but a financially significant one because use of modifier "AA" indicates the anesthesiologist personally performed the service and thus full payment is made. Modifier "QK" denotes medically directed anesthesia and reduces payment by 50% of the "AA" modifier amount.

**7. Orthotic braces (*new*).** This item affects suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) more than orthopaedists, however orthotic braces are a common item. The OIG has evidence that some patients are receiving multiple braces or braces without seeing a physician, or braces without any documentation to support the need for braces. This item will include a carrier-specific review of any carriers that have local coverage determinations (LCDs) requiring more specific documentation for the need of braces.

**8. Part B payments for chiropractic services.** Medicare only covers one chiropractic service, which manual manipulation for subluxation of the spine. The OIG will take a look at Part B payments to chiropractors after previous audits found excessive payment to chiropractors as well as "unallowable" payments in which services other than manipulation were reimbursed. This is a very restrictive coverage guideline because Part B pays only for manipulation if the documentation shows the patient has a neuromusculoskeletal condition for which manipulation is the preferred treatment. Chiropractic maintenance is not considered to be reasonable or necessary and is not covered.

**9. Medical device credits for replaced devices.** This item will primarily affect providers who perform implantation of medical devices in the inpatient or outpatient setting, as well as hospitals. OIG has found that Medicare has made improper payments for inpatient and outpatient claims for replacement medical devices. These are devices that are implanted in patients to replace existing devices due to defects, recalls, or other problems. Replacement of implanted devices pays less than implanting the devices, and violation of this rule appears to be costing the government money.

Remember, while the OIG Work Plan is a good indicator of the agency's top areas of focus, it is absolutely not comprehensive and the OIG is free to review any other issue that it deems necessary to combat fraud, waste and abuse.

— Grant Huang, CPC, CPMA ([ghuang@drsmgmt.com](mailto:ghuang@drsmgmt.com)). The author is Director of Content at DoctorsManagement.