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The Business of Medicine

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Medicare news

CMS: Modifier 59 will see stricter documentation requirements in 2015

Modifier 59 is the most widely used and apparently the most "abused" modifier, according to CMS audit data. In response, the agency is taking action, releasing new coding requirements that will be effective Jan. 1, 2015. CMS believes that more precise coding options coupled with increased education and selective editing is needed to reduce the errors associated with overpayments.

Modifier 59 by CPT definition: "Distinct Procedural Service: Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day." The modifier is required to unbundle codes when two or more non-E/M services are bundled within the National Correct Coding Initiative (CCI) edits. It should only be applied in specific instances, such as when multiple services are billed for different encounters, different anatomical sites, and/or distinct services requiring separate work. The issue being addressed by CMS is the usage of modifier 59 in situations where none of the above apply. CMS has thus established four new subset modifiers to encourage providers to explain the exact intended use when reporting the modifier on a claim.

The four new subset modifiers are as follows:

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

(continued on pg. 2)

CMS will continue to recognize modifier 59, but notes that per CPT, "**the 59 modifier should not be used when a more descriptive modifier is available**." If you find claims being denied with the less specific 59 modifier after Jan. 1, this is likely an indicator that a more specific "X" modifier is required. CMS further states that "in many instances, **it may selectively require a more specific 'X' modifier for billing certain codes at high risk for incorrect billing.**" CPT code combinations requiring the "X" modifiers should be listed in the new CCI edits. Additionally, local Medicare Administrators (MACs) are not prohibited from requiring the use of selective modifiers in lieu of the general 59 modifier in spite of CCI edits, so all providers will need to verify their individual MAC requirements prior to the use of modifier 59 after Jan. 1. It is unclear at this time if other payers (i.e., commercial carriers or Medicaid) will adopt the new modifiers.

Providers must ensure documentation supporting the "X" modifier reported is sufficient to pass any Medicare claim review or audit. Documentation must include:

- Medical necessity for a different session on the same day by the same provider (XE)
- Documentation of a different site or organ system, separate incision or excision, separate lesion, or separate injury (XS)
- Medical necessity for a similar or related service performed during the same session by a different provider (XP)
- Documentation of a different procedure or surgery not overlapping the work components of the primary surgery (XU)

If you have questions or would like a review of your documentation, please contact the Coding & Documentation Audit Department at DoctorsManagement for assistance.

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Practice management

5 steps to add a physician to your practice

The decision to add a new physician to your practice can be complicated. There are financial and emotional decisions that need to be considered such as: Do we really need a new doctor? How do we find the right one? How are we going to pay for him or her? How will our entire team work to integrate this person into our practice?

We will briefly touch on each of the areas and give you some tools and information to enter this process with confidence.

1. Examine the metrics. Before we decide to just hire an additional physician for our practice, we must put in place metrics to determine the business need for doing so. Many practices *feel* they are busier than ever, but have you truly looked at your patient load over the last two years? Have you looked at it on a month-to-month basis, and then studied rolling trends to substantiate that your patient volume is actually up? Go back to your schedule for the last 12 months and see how many weeks you were at maximum capacity during that time. What is your total panel size? How many new patients are you seeing on a weekly basis? Have you looked at the impact of adding another medical assistant, vs. a mid-level provider, vs. a new physician? If you have done these things, are satisfied that the analysis supports adding a new physician, and you have the space, then you are ready to begin the recruitment process.

2. Recruiting a new physician. It is unlikely that your ideal candidate is finishing residency at the medical school in your city (if you even have a medical school nearby) or working down the street at another practice. It's possible, but not probable. Thus you will either need to work with a recruiting agency or get some assistance through the local hospital. The local hospital generally has relationships with recruiting firms and thus more experience working with them. In addition, the local hospital has a vested interest in helping you find the right fit for your practice so they will gain another provider referring patients for necessary services and procedures. **Tip:** The going rate for recruiting a physician these days is approximately $24,000. The hospital is likely to pick up this tab for the reason previously mentioned. They may also be willing to help with other associated costs that we'll cover in the next step.

3. Determining compensation. It's no secret that the compensation package necessary to entice a new physician to your practice will depend heavily on specialty. Your specialty might be able to absorb the salary and incremental expenses (malpractice insurance, new

employees, supplies, benefits, etc.) related to adding this new physician. If the math doesn't add up, you could inquire about a loan with your local bank. Or, you could see whether the local hospital (referred to above) would be willing to offer some form of salary guarantee and expense assistance. Clearly, the ideal situation would be that your practice can shoulder the expense, but this is no longer the norm. **Tip:** It could take six to nine months before the new physician is actually generating enough revenue to cover the cost of his or her employment, let alone begin recouping the expenses incurred from the start. So, to be conservative, assume that it takes 12 months to break even.

4. Working with your local hospital. Let's focus on the particulars of the income guarantee and expense assistance through the hospital. If this is an option there is a major advantage and a major disadvantage. The major advantage is the practice will not have to come out of pocket for any salary or related incremental expenses for at least a year (these agreements are usually one or two years). The major disadvantage is the practice can be on the hook for the amount of money the hospital has provided minus the production (medical collections) the new physician has produced during the term of the agreement. We'll define what "on the hook" means shortly. **Example**: The combined salary guarantee and expenses paid by the hospital during the year were $300,000 and the physician produced $200,000 in medical collections. So, the loan or promissory note agreed to be paid back to the hospital is $100,000. The new physician and an officer of the practice will have their name on the dotted line of this document. The term paid back need not apply if the physician continues to practice during the loan forgiveness period. The loan forgiveness period can vary, but usually lasts two years after the term of the income guarantee and expense assistance ends. If, during the two-year forgiveness period, the physician decides to leave for any reason, the hospital will seek to recover the amount of the promissory note or at least the prorated amount. They will go after the physician first, but if they are unable to do so (physician leaves the country, for example) they will seek remuneration from your practice. Regardless of the way you decide to fund the additional physician, you can see how vital it is to take the time and use the means necessary to choose the right person.

5. Integrating a new physician. Now that we have our physician hired, we have to get them as productive as possible. The most important aspect of this phase is the

credentialing process. If a physician is leaving one private practice to join another across town, then credentialing is fairly simple. However if the physician is going from a hospital to a private practice, he or she will need to be un-delegated. Make sure that your new physician is not still delegated to the hospital. Three other common mistakes we see in the credentialing process are below.

a. Not starting early enough, which results in a physician showing up to work, but unable to bill for services provided because the credentialing process isn't finished yet.

b. Just because a physician is credentialed doesn't mean he or she is contracted with any given payer. Be sure to check the physician's status with your payers.

c. Applications that aren't 100% complete or 100% accurate, resulting in delays. Often, you have 30 days to complete these applications and delays may force you to restart the entire process.

A happy practice is generally a successful practice, and to create a successful practice you must continue to grow. A key component of growth is adding physicians, so start the recruitment process sooner rather than later. It always takes time to find the right fit emotionally and financially.

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Compliance

With fall in full swing, follow best practices for vaccine storage

Why is vaccine storage so important? Failure to store vaccines properly can significantly reduce the effectiveness of the vaccines, resulting in reduced immunity among the recipients as well as the loss of thousands of dollars in materials.

Proper handling and storage begins with the manufacturer and continues through transportation to the provider, storage at the provider's office, on to the actual preparation and administration. For the purpose of this article we will focus on storage at the provider's office.

When immunization vials are received at the provider's office, they should be in date, cold and undamaged.

Upon receipt, check containers for expiration dates and signs of damage or inappropriate temperatures. Make sure that the quantity will probably be used within the expiration date.

Compliance: Storage temperatures for vaccines

Store in freezer (from -58°F and 5°F or -50°C and -15°C)	Store in refrigerator (from 35°F and 46°F or 2°C and 8°C)
VAR*	MMR*†
HZV*	HepA, HepB, Hep A-Hep B
MMRV*	Hib*, Hib-HepB
MMR*†	Human papillomavirus (HPV2 and HPV4*) Influenza (LAIV and IIV*)
	IPV
	Meningococcal-Containing (Hib-MenCY* MCV4* and MPSV4) Pneumococcal (PCV13 and PPSV23) Rotavirus* (RV1 and RV5)
	Diphtheria toxoid-, Tetanus toxoid-,and Pertussis-Containing vaccines: DT, DTaP, DTaP-HepB-IPV, DTaP-IPV, DTaP-IPV/Hib, Tdap, Td, TT

**Protect from light (Varivax, ProQuad, M-M-R II, Hiberix, Gardasil, Fluarix, FluLaval, MenHibrix, Menveo, Rotarix, and RotaTeq.*
†Unreconsituted lyophilized MMR may be frozen or refrigerated.

Vaccines should be received with some sort of barrier (bubble wrap or Styrofoam pellets, for example) between the vaccine and the coolant. Diluents for varicella-containing vaccines should be in a separate compartment.

Verify that the shipment was received within recommended transport times: 48 hours for most vaccines; 3 days for varicella.

Check the contents against the packing slip to be sure they match. When receiving lyophilized vaccines, check for the proper type and quantity of diluents. Make sure the diluents are also in date. If any discrepancies are found, contact the supervisor or vaccine coordinator immediately and isolate the suspect vials, labeling them "Do not use."

As with all materials, the package inserts for vaccines provide invaluable information, including the temperature range for storage - refer to them often as information may change. While it may be intuitive that temperatures above recommended storage temperatures can damage vaccines, temperatures that are too cold can also damage these materials. Most vaccines that are meant to be stored in the refrigerator lose all potency if frozen; few can be either refrigerated or frozen.

Refer to the table on pg. 4 for vaccine-specific details on storage temperatures and procedures.

The type of refrigerator/freezer is critical in maintaining proper storage temperatures for these very labile products. When selecting a unit, follow these guidelines:

- Choose stand-alone units rather than combination freezer/refrigerators. If a stand-along refrigerator is not available, place water bottles, not vaccines, on the top shelf. Do not use the freezer for vaccines.
- Avoid self-defrosting freezers, which may not reliably maintain the proper temperature.
- Never use dormitory-style or bar-style units for vaccine storage; temperatures vary too much. Storing vaccines purchased with public funds (example: Vaccines for Children) in this type unit is strictly prohibited.
- Consider purpose-built or pharmacy grade refrigerators or freezers. These are generally small enough for use in smaller offices.
- Make sure that the unit is large enough to hold a reasonable supply plus water bottles to help hold the proper temperature. See more on this issue below.

The next consideration is where to place the refrigerator and/or freezer. **Tip:** Storage equipment should have sufficient space around the unit (top, bottom, back and sides) to allow good air circulation. This general means four to six inches clearance between the back of the unit and the wall plus one to two inches off the floor after leveling. Nothing should block the cover of the motor,

which may be on the back or the side. Refer to the owner's manual for more specifications.

Use a reliable electrical outlet for your freezer. Place a sign "Do not unplug" near the plug and one "Do not turn off" near any switch, including the breaker.

How the unit is packed is also important.

- Never allow food or beverages to be stored with vaccines. This results in frequent opening of the door and consequential temperature fluctuation. Place a sign on the outside, "No food or beverages."
- If possible, do not store other medications or biologic products with vaccines. If there is no other choice, store them on separate shelves.
- Place water bottles in the refrigerator and frozen coolant packs in the freezer to stabilize temperatures. Label water bottles "Do NOT drink." Place them against the inside walls and in the door racks. If the unit has drawers at the bottom, remove them and place large water bottles there; vaccines must not be stored on the floor. Place freezer packs along the walls, back and bottom of the freezer and in the door rack. Leave spaces between all containers to allow for sufficient air flow. Do not pack items close together, and do not overload the door so that is does not properly close.
- Group similar types of vaccines together, with pediatric and adult versions of the same vaccine clearly marked.

Once inactivated, vaccines cannot be used and must be discarded. Visual observations (except for obvious damage, such as breakage, or clumping that does not go away when the vial is shaken) are not reliable, as many damaged vaccines look perfectly fine. This means that temperatures *must* be meticulously monitored.

Each unit should have a thermometer of the correct temperature range and should be monitored at least twice daily. Document each reading. If the reading is outside the acceptable range, adjust the thermostat and document the new temperature about an hour later. Repeat until the correct temperature is achieved. Document all corrective actions.

This process should be implemented after the unit is installed and water bottles/frozen coolants are added, first allowing sufficient time for the unit to reach the desired temperature. This may take up to three days. Make sure temperatures are stable before adding vaccines.

After the unit is stable at the correct temperature, add yet another sign: Do NOT adjust temperature controls. Contact (vaccine coordinator) if adjustment is needed. This will discourage too frequent adjustments, which could actually result in the *wrong* temperature. And remember that if you must use that combo unit, adjusting one thermostat can affect the other temperature as well. Do not turn off the freezer, even if it is not in use, because this, too, can affect the refrigerator temperature. **Tip:** If a storage unit malfunctions, call the manufacturer or an authorized service company.

Storage units, after stabilization, must be maintained according to the manufacturer's instructions. All coils and motors must be carefully cleaned monthly to prevent build-up of dust and dirt. It is best to temporarily store vaccines in another unit so that the unit can be unplugged for cleaning. The inside of the unit should also be cleaned with warm, soapy water and dried. Check the door seal and hinges while cleaning for gaps or damage.

Tip: Make sure the temperature is restored before returning vaccines to the unit.

Temperature monitoring is critical. Temperatures must be monitored at least twice daily: first thing in the morning and last thing before the clinic closes. Thermometers met be calibrated. New thermometers should have a Certificate of Traceability and Calibration Testing (or Report of Calibration). Calibration must be verified annually by an entity that is accredited by the International Laboratory Accreditation Cooperation (ILAC) Mutual Recognition Arrangement. Links for listings are available at cdc.gov. When the certificate expires, the practice has three options:

- Have the thermometers tested by an accredited laboratory.
- Purchase a replacement thermometer.
- Contact the immunization program for testing resources.

The CDC recommends using a digital thermometer with a detachable probe that is kept in a glycol-filled bottle, allowing the temperature to be downloaded without opening the door to remove the probe from the unit. The

probe should be located near the vaccines. Some Vaccines for Children (VFC) programs require a backup temperature probe, so read the requirements if you are a VFC provider.

Continuous monitoring thermometers are preferred. They can help determine how long a unit has been outside the specified range, recording all temperatures over time. Min/max thermometers will at least inform the reader about the lowest and highest temperatures that were reached. Many thermometers continuously log data and may be capable of a visual alarm (light changes color), an audible alarm within hearing distance of the unit itself or even sending alarms to cell phones, especially when the office is not manned. Digital data loggers are typically batter operated and come in many styles and prices.

Avoid fluid-filled biosafe thermometers, bi-metal stem thermometers, food thermometers and mercury thermometers. These may be difficult to read and may not be precise. Chart recorders may also be difficult to read and require frequent paper changes.

In addition to temperatures, expiration dates must be monitored and documented. When a multidose vial is first opened, mark it with that date. Label reconstituted vials with the date and time it was reconstituted. Adhere to the open vial date as closely as the manufacturer's original expiration date.

- Never use expired vaccines.
- Always use older items first. Checking expiration dates (manufacturer's and user-added ones) daily will help. Putting the older ones in front will facilitate this process.
- Always store vaccines and diluents in their original containers, including outer packaging. This helps managing the inventory and protects from exposure to light. Some diluents may be stored at room temperature, but this requires careful matching of diluent to vaccine.

Anytime vaccine storage is less than ideal, items are damaged, or expiration dates are exceeded, the affected items must be removed from the storage unit and marked "Do no use." Document all information available, including all temperatures, the length of time the vaccines may have been exposed to inappropriate temperatures, and corrective actions implemented. Contact your vaccine coordinator as well as your vaccine supplier and any publicly funded vaccine program. Do not discard vaccines unless instructed to do so by your immunization program or the manufacturer.

A good vaccine storage and handling requires effective staff training, appropriate transportation and storage equipment, and clearly written policies and procedures.

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Practice management

Department of Labor boosts fines on retirement plans

It was reported at the beginning of 2013 that the Department of Labor (DoL) hired roughly 700 new agents with the express goal of garnering $1 billion in new revenue. Instead, the final figures show that in 2012, the DoL collected almost $1.3 billion in fines, and this increased by 33% in 2013, resulting in nearly $1.7 billion in fines, according to Benefitspro.com.

These figures may seem far removed from everyday activities, but our experience talking with retirement plan sponsors suggests otherwise. Late last year we spoke with a plan sponsor fresh off an audit. She said very clearly that "the DoL is not looking for compliance ... they are looking for revenue."

If your plan is a non-ERISA plan, you're still not off the hook as a fiduciary. **Tip:** Although DoL rules may not apply, the Internal Revenue Code does, which means that noncompliance could ultimately result in a loss of tax-protected status for your plan.

Regardless of the type of plan, be wary of the two most common violations: failure to have and adhere to the proper plan documents, and failure to remit employee contributions in a timely manner. On a separate but related note, the most common lawsuit brought by employees against plan sponsors involves fees paid by the plan's participants.

If you are unsure that your retirement plan is running properly or paying reasonable fees for products and services received, we can help. Whether it is filing for a determination letter, benchmarking fees, or performing an internal audit, SageView Advisory Group can partner with you to open up the black box.

SageView is an independent SEC Registered Investment Advisory (RIA) firm that consults on $32 billion in assets and more than 560 company retirement plans. We offer a complete suite of services including retirement plan consulting, actuarial consulting, executive benefits, and wealth management. SageView services retirement plan sponsors throughout the United States. SageView advises on 401(k), 403(b), 457, defined benefit and deferred compensation plans. We have been partnering with plan sponsors since 1989. SageView has been recognized as a "Top 5 Plan Advisor" by Plan Adviser magazine for 2008 through 2014. SageView is also certified by the Center for Fiduciary Excellence (CEFEX) and by DALBAR for its 3(38) fiduciary processes.

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