CMS unveiled the 2015 Physician Fee Schedule (PFS) Final Rule late on Halloween, but fortunately there were no frightening surprises. The final rule hews closely to the proposed rule, and this article summarizes the biggest provisions that will take effect on Jan. 1, 2015.

1. SGR and overall Medicare payment rate. Under the Sustainable Growth Rate (SGR) formula, CMS is required by law to reduce physician fee schedule rates by 21.2% from 2014 rates. This is accomplished by slashing the conversion factor dollar value by 21.2%. A law passed by Congress in 2014, called “The Protecting Access to Medicare Act of 2014,” will keep Medicare payments flat until March 31, 2015. At that time, Congress is likely to intervene as it has done repeatedly before, almost always by passing a law to increase the conversion factor by a small percentage, though typically only for the remainder of that calendar year. Note: The current conversion factor is $35.8013. On April 1, 2015, this value will drop to $28.2239 without Congressional intervention.

2. Chronic care management (CCM). These are non-face-to-face services for Medicare patients who have two or more significant chronic conditions. They will be recognized on Jan. 1 under CPT 99490 (chronic care management services, at least 20 minutes of clinical staff time directed by physician or other qualified health care professional) and will pay $40.39 once per month per patient fitting the criteria above. Tip: CCM services can be billed incident-to, but CMS is also reducing the supervision requirement for CCM services from direct to general supervision. “General” means the services are being performed under a physician’s overall direction and control, but the physician doesn’t have to be physically present during the services.

3. Screening and diagnostic digital mammography. CMS is creating new add-on codes for 3D mammograms in recognition of their higher resource use when compared to 2D mammography. CPT 77063, paying about $57, will be an add-on to existing 2D code G0202 (continued on pg. 2)
(screening mammography, direct digital image, bilateral, all views). New HCPCS code G0279, paying about $57, will be an add-on to existing 2D codes G0204 (diagnostic mammography, bilateral) and G0206 (diagnostic mammography, unilateral).

4. **Removal of patient cost sharing for anesthesia during screening colonoscopies.** When a physician performing a screening colonoscopy also performs the anesthesia, the Part B deductible and coinsurance are waived. However, when anesthesia is separately provided by an anesthesia professional, Medicare doesn’t waive either. This changes starting Jan. 1 thanks to the 2015 final rule. CMS is including separately provided anesthesia as part of the screening service so that the coinsurance and deductible don’t apply, making it easier for patients to get this preventive benefit.

5. **Payment reductions from revalued codes will get a transition year.** CMS is implementing a one-year delay between finalizing the payment reduction of misvalued codes and making the reduction effective. “Establishing payment in the final rule for misvalued codes often led to implementation of payment reductions before the public had the opportunity to comment,” CMS states in the 2015 final rule. **Note:** This change affects codes getting pay cuts under the misvalued codes initiative, and doesn’t mean that you’ll enjoy a one-year grace period on all payment reductions that may occur.

6. **Major telehealth expansion.** CMS is adding a slew of services to the list of services that can be provided as telehealth benefits. The new additions are below.
   - Annual wellness visits
   - Psychoanalysis
   - Psychotherapy
   - Prolonged E/M services

7. **0-day global periods coming in 2017.** CMS is finalizing its proposal to turn all codes with 10-day and 90-day global periods into 0-day global codes. This will begin in 2017 with all codes that currently have 10-day global periods. In 2018, codes with 90-day global periods will get the same treatment. This major change is coming as a result of findings by the HHS Office of Inspector General (OIG) that many surgical procedures are being used to bill for visits during the global period that aren’t being provided. Another concern is that post-surgical visits are being paid more than visits furnished and billed separately by other physicians, particularly primary care providers. CMS is likely to introduce new rules improving bundled payment for surgical services to coincide

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with the coming 0-day global change, the agency says in the 2015 final rule.

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**COMPLIANCE**

**How to properly amend or modify medical records**

Your payers expect that your medical documentation is created at the same time the services it describes were delivered. But given the everyday complexities physicians have to deal with, it’s inevitable that some addition or modification of the record will be needed at some point.

Modifications and addendums are allowed, but there are specific rules and guidelines that must be followed. A medical record is a legal document and therefore there is a right way to modify a record and certainly a wrong way as well. All modifications and addendums must follow these guidelines whether it is the provider or clinical staff, or even ancillary staff that are modifying their own entries. Modifications would be a correction to a medical record. Addendums may also be corrective in nature or may need to address info or findings not available at the time the original documentation was created. Addendums may be subject to a higher level of scrutiny in evaluation of the use and frequency of addendums by the provider.

Modifications aren’t as relevant since we moved into the EHR era. When we think of modifications, we used to think of a single line, initial, and dating of the change (which would still be applicable to those who are still handwriting and dictating their documentation). EHR changes should be tracked and notated, and if the EHR lacks the ability to include and track such notations, then an addendum should be used instead.

Again, while addendums can be used for corrections, they are more typically used to insert additional information. **Example:** A patient was seen on Oct. 1 and a urine culture was performed. The results are reviewed on Oct. 6. The addendum would be created by the provider to include relevant findings and any plan of care additions or changes warranted by the interpretation of the findings.

**Warning:** Addendums shouldn’t be used to regularly modify the record to support documentation guidelines. Occasionally, if the provider fails to include certain elements, an addendum would be an acceptable way to put them back in.

Medicare’s Program Integrity Manual includes three principles for proper record keeping, including the creation of addendums and corrections to medical record:

1. Clearly and permanently identify any amendment, correction or delayed entry as such;
2. Clearly indicate the date and author of any amendment, correction or delayed entry; and,
3. Do not delete but instead clearly identify all original content.

These principles apply to both paper and EHR records.

When modifying a record, be sure to distinguish amendments and keep amended content separate from original content.

**Example:** Below is a recent audit of a handwritten chart including an addendum by the provider. The addendum fails to distinguish the new content from the original content.

There is no way to distinguish what’s new from what was originally in the record. In fact, it’s very difficult to see exactly what was added. The provider may have meant to correct something in the record, but by simply labeling this as “amended” without showing anything to be corrective in nature, a carrier review might reject the documentation.

With the use of electronic medical records, errors such as this example are not as common since paper charts are being phased out. However, these principles would still apply to electronic records as well. CMS has specifically added to the
The principles additionally include:

a. Distinctly identify an amendment, correction, or delayed entry, and

b. Provide a reliable means to clearly identify the original content, the modified content, and the date and authorship of such modification of the record.

These principles don’t add much to the existing three mentioned above, because they still require the distinct separation of added vs. original content. Note: CMS doesn’t say that “click tracking” is an acceptable distinction. Many EHR vendors/sales reps fall back on “click tracking” capabilities for meeting gray areas in their product, but it hasn’t been explicitly recognized by CMS for amending records. Again, to make it indisputable, the note must have separate comments and headings indicating the addendum.

Regardless of the type of medical records a practice uses, educate all your staff on these principles and craft a policy specific to the type of record you use. Include any type of special addendum/modification tools offered by your EHR, specific reasons to justify creating addendums/modifications, and the timeliness of any such amendments.

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ACCOUNTING

Year-end tax planning for 2014: Changes you need to know

This is the first of a two-part series relating to year-end tax planning for businesses and individuals. In this article, we’ll discuss recent changes in tax law that may affect you and/or your business in 2014. In next issue’s article, we’ll provide ideas for how to mitigate those changes and potentially lower your tax burden for 2014.

Beginning in 2013, several changes to the tax law dramatically affected high income earners and especially those earners who are business owners:

• Marginal tax rate increase. Through December 31, 2012, the highest federal income tax rate was 35%. Beginning in 2013, that rate jumped to 39.6% (that’s an increase of almost 13%). While this rate only applies to income in excess of $457,600, it can be a significant amount for higher income earning taxpayers. For example, a taxpayer earning $750,000 per year would (based on this change) pay ~$13,500 more in 2014 than in 2012.

• Net investment income tax and additional Medicare tax. Until 2013, self-employed individuals paid Medicare tax at a rate of 2.9% on earned income and 0% on investment income. Beginning in 2013 and continuing into 2014, high income earners now pay an additional Medicare tax of 0.9% (for a total of 3.8%) on earned income and a new net investment income tax of 3.8% on investment income. Example: If you earn over $250,000, you will most likely pay 3.8% Medicare tax on those earnings.

• Increased capital gains rate. Capital gains are the amounts made from selling capital assets. For most taxpayers, this income is created from the sale of stock or ownership in a business. Example: If you bought stock in 2012 for $100 and sold it in 2014 for $200, the gain would be $100. For many years, gains on assets held longer than a year would be taxed at a maximum of 15%. Beginning in 2013 and continuing into 2014, that tax is 20%. Also, the new net investment income tax may apply, resulting in an actual tax rate of 23.8%. In short, the tax jumped from 15% to 23.8%, an increase of approximately 59%.

• Phase-out of exemptions and itemized deductions. On individual tax returns, two major factors that reduce taxable income are personal exemptions (currently $3,950 per taxpayer, spouse, or dependent) and itemized deductions (mortgage interest, charity, etc.). Beginning in 2013 and continuing into 2014, both of these are limited for taxpayers with incomes exceeding $305,050. For very high income earners, the personal exemption will be reduced to $0 and the itemized deductions will be reduced so low that the standard deduction of $12,400 will be used. The phasing out of these two factors are essentially a hidden tax increase.

• Expired Section 179 and bonus depreciation. To encourage spending, Congress had previously allowed the
immediate expensing of fixed assets (e.g., furniture, equipment, etc.) via two provisions: bonus depreciation and Section 179 expensing. Without these provisions, most assets would be written off (expensed) over five, seven years or even longer. This allowed for very large deductions in the years leading up to 2014. **Example:** If a practice bought $500,000 worth of equipment in 2013, they could expense the entire amount and reduce their taxable income on the entire $500,000 that year. In 2014, that deduction will only be about $100,000.

This is because Section 179 has been limited to only $25,000 and bonus depreciation has been completely removed. While the full $500,000 is eventually expensed (over the next five or more years), there are significant advantages to getting this deduction in the initial year. **Note:** There is much debate over whether or not Congress will vote to restore these deductions for 2014. This may occur after the November elections or even as late as January 2015. Passing laws this late in the year makes it extremely difficult for businesses to plan their tax strategy.

**Health Insurance Requirement.** The Affordable Care Act now requires most individuals to carry health insurance. Those that were not covered in 2014 may face fines of up to 1% of income.

In the next issue, we’ll provide ideas for reducing your 2014 tax burden. If you have any questions, please feel free to contact us at 800-635-4040.

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specifically by adding urine, vomit, feces, saliva and sweat to the list. Inanimate objects such as counter tops and floors may also become contaminated with these bodily fluids. Ebola can survive for several days in such fluids at room temperature, but on dry surfaces Ebola can only survive for several hours, according to the Centers for Disease Control and Prevention (CDC).

Initial symptoms may begin about 8-14 days after exposure and include a fever in excess of 101.5, fatigue, muscle pain, headache, and sore throat. As the disease progresses, the patient may exhibit nausea, vomiting, fever, rash, decreased liver/kidney function, and finally internal or external bleeding.

Thorough hand hygiene is imperative. Anyone who comes into contact with infected patients or contaminated items must wash their hands immediately, scrubbing all surfaces with soap and water for 15-20 seconds. Alcohol-based hand rubs may be used, if no visible soiling is present. This also includes scrubbing for up to 30 seconds using a product that is at least 62% alcohol. Alcohol-based products are flammable and must not be stored or used near flames.

The CDC now recommends “no skin exposed” when providing care for Ebola patients. This includes the following personal protective equipment (PPE) items that are donned and doffed in a specific order with the assistance of a trained supervisor who uses a checklist to ensure proper procedures are followed. The PPE items are:

- Booties that come up to calf level
- Gown that fastens in the back and falls to calf level
- Inner gloves with cuffs under gown cuffs
- Outer gloves with extended cuffs that cover the gown cuffs
- Fit-tested N95 respirator
- Surgical hood, down to the shoulders
- Full face shield

Thorough environmental disinfection must be performed after the patient leaves. The practice should use a professional product with claims for norovirus and poliovirus. None will have any labeling claims for Ebola at this time. Ebola has been found still infective after five days in dried blood.
2. Triage

Staff members responsible for triaging or screening patients should use a specific questionnaire to determine if patients presenting with certain, non-specific symptoms could be infected with Ebola. See pg. 9 for a sample questionnaire that can be used to quickly screen patients.

3. Transport

If, after reviewing the results of a patient questionnaire, the provider concludes that the patient is unlikely to have been exposed, remind the patient to self-monitor for 21 days and report back if any symptoms develop.

If the conclusion is that the patient may have been exposed, the practice should take the following steps immediately:

- Immediately isolate the patient and don recommended PPE items (see list, pg. 6), adding a fluid-resistant apron if the patient is currently experiencing diarrhea or vomiting.
- Call 911 and have the patient transported by ambulance to the nearest hospital prepared to handle Ebola cases.
- Implement environmental decontamination procedures.
- Report the potential Ebola case to the state health department.

Tip: You should research which hospitals in the area will accept potential Ebola cases and how those hospitals will respond. Hospitals may require members of your practice to be quarantined for up to 21 days.

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E/M services and the history of present illness

Evaluation and management (E/M) services are complex, but not because we choose to make them that way. They’re complex because determining the level of an E/M can be highly subjective, and often the same piece of documentation can give rise to competing opinions on the level of service supported. This month’s column focuses specifically on just one aspect of the E/M coding process: the History of Present Illness (HPI). Next to Medical Decision Making (MDM), this is the single most important aspect of an E/M service.

The HPI is by and large one of the most critical aspects of any progress note. We know it is made up of either elements (location, duration, context, timing, severity, modifying factors, and associated signs and symptoms) or for complete HPIs, the status of (three) chronic conditions. However, the most important part of the HPI is not what you document, but who actually documents it.

Each year, I spend approximately 48 weeks on the road, working in practices ranging from solo physicians up to integrated health systems with more than 2,000 providers—and I always find someone who is derelict in their duties as a provider (physician or non-physician provider). It is the physician and or other qualified provider’s responsibility to perform and document the HPI. This means ancillary staff such as MAs, RNs, LPNs, etc. can’t be used.

Countless times during remote audits or at on-site consulting engagements, my team and I uncover that individuals other than the physician or NPP have performed this aspect of an E/M service. In 1997, CMS (then known as the Health Care Financing Administration or HCFA) created guidelines for E/M services which clearly state that the physician or NPP must perform the HPI. Thus this has been true for the last 17 years and is still true today. As recently as this July, Wisconsin Physician Services (WPS), which is a Medicare Administrative Contractor (MAC), updated their online list of frequently asked questions with the following:

"Question 18: Who can perform the History of Present Illness (HPI) portion of the patient’s history?"

Answer 18: The history portion refers to the subjective information obtained by the physician or ancillary staff. Although ancillary staff can perform the other parts of the history, that staff cannot perform the HPI. Only the physician can perform the HPI.

"Question 19: If the nurse takes the HPI, can the physician then state, ‘HPI as above by the nurse’ or just ‘HPI as above in the documentation’?"

Answer 19: No. The physician billing the service must document the HPI.

This issue becomes an even bigger risk to practices using EHRs. It’s very easy for ancillary staff to perform the Chief Complaint (CC), which they are allowed to do, and then move seamlessly to the HPI, capturing the elements. But if you are using your certified EHR properly, the person making the HPI entry must electronically sign the note, attesting to the validity of the information. If your ancillary staff are doing the signing, during an audit the entire section would be rejected by the auditor, largely eliminating one of the key components of the E/M. For new patients or consults, this would either result in a level one service or turn it into an established patient visit. In the worst case, the auditor could deem the visit non-billable and demand a refund.

So what portion of the HPI can your ancillary staff perform? Based on the E/M guidelines from CMS, they can perform the Review of Systems (ROS) and the Past, Family or Social History (PFSH). That’s all!

How do you avoid making this costly error? Simple, make sure your ancillary staff know these rules when triaging a patient:

1. Document the Chief Complaint. The CC is a clear, concise statement for the reason of the encounter. It can be a symptom, sign a condition, or physician recommended return.
2. Document the Review of Systems, if applicable.
3. Document the PFSH (if applicable).

This will force the physician or NPP to perform the meat of the HPI, capturing relevant elements or documenting the status of chronic conditions. Follow this policy and you cut your chances of losing money over a high-risk but easy-to-fix issue.

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Ebola screening questionnaire

Have you traveled to a Sierra Leone, Liberia, Guinea, or any other area with widespread Ebola Virus Disease in the last 21 days?  ☐ Yes  ☐ No

If yes, please complete the items below:

Country: _____________________________ City: _____________________________
Date of arrival: ________________________ Date of departure: ________________________
Did you experience any illnesses while there?
________________________________________________________________________________________________
________________________________________________________________________________________________

Have you had contact with any individual who was suspected or confirmed with Ebola infection in the past 21 days?  ☐ Yes  ☐ No

Have you taken care of anyone with Ebola?  ☐ Yes  ☐ No

Have you attended funerals or had contact with bodies of anyone with Ebola?  ☐ Yes  ☐ No

Have you had contact with wild animals or “bush” meat?  ☐ Yes  ☐ No

Do you have any of the following symptoms? (Triage nurse may ask these questions)

• Fever > 100.4° F/38.0° C in the past 48 hours  ☐ Yes  ☐ No

• Headache  ☐ Yes  ☐ No

• Weakness  ☐ Yes  ☐ No

• Muscle pain  ☐ Yes  ☐ No

• Vomiting  ☐ Yes  ☐ No

• Diarrhea  ☐ Yes  ☐ No

• Abdominal pain  ☐ Yes  ☐ No

• Bruising  ☐ Yes  ☐ No

• Unusual or unexplained bleeding  ☐ Yes  ☐ No