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The Business of Medicine

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COMPLIANCE

OIG's 2015 Work Plan has few physician targets

The HHS Office of Inspector General (OIG) continues to have its hands full when it comes to inspecting all the different elements of health care, particularly as more provisions of the Affordable Care Act (ACA) continue to be implemented.

As a result, the recently released 2015 OIG Work Plan has little in the way of new investigations planned that specifically affect physician group practices. Don't think you can just forget about compliance in 2015, however. A number of old standby investigation topics continue to hold the OIG's interest.

Here are the new areas of investigation for 2015 with some potential impact on physicians:

- **Pioneer ACO.** OIG will look at CMS's ambitious Pioneer Accountable Care Organization (ACO) model, designed for advanced providers, to determine if there are appropriate internal controls over the program.
- **Medicaid payments after death.** The OIG will investigate whether providers are being paid for treatments for Medicaid beneficiaries in managed care programs that occur after the death of the patient.
- **Ineligible Medicaid MCO payments.** In a similar vein, the OIG plans to look at Medicaid managed care organizations to see if payments are being made on behalf of patients who are not eligible.

While that list is about as lean as it's been in years, practices must continue to be vigilant about some other key areas of OIG focus that have been on the Work Plan in years past:

- **Provider-based clinics.** The OIG will look to see if clinics that are classified as provider-based meet CMS criteria, as well as

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compare provider-based and free standing clinics. There is widespread concern that, as provider-based clinics are paid more, practices are increasingly shifting to this model when aligned with a hospital, with the primary driver being payment.

- **Ambulatory Surgery Center (ASC) payments.** The OIG will assess whether ASCs, often owned by physician groups, have a fair and reasonable payment system.
- **Imaging services.** Addressing long-standing concerns over whether imaging services are overpaid, OIG continues to scrutinize the payments for these services when compared to the expenses incurred by providers.
- **Ophthalmology coding.** OIG will review ophthalmology billing from 2012 to look for inappropriate or questionable billing.
- **Chiropractic billing.** Similarly, the OIG plans to see if Medicare is paying chiropractors for non-covered services or for questionable overall billing. Medicare typically covers only manual manipulation as a chiropractic service.
- **Place of service errors.** A mainstay the past few years, the OIG wants to make sure that physician practices code the correct place of service on claims. It's noteworthy because services pay more when done in the office setting, to cover practice expenses.

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

CODING

5 keys to critical care coding

Critical care is the most highly-compensated E/M service, but it's also the most highly scrutinized by payers. Under the relative value unit (RVU) formula used by Medicare to determine payments, critical care services are paid more than high-level inpatient hospital admissions (**99223**) and high-level emergency room services (**99285**). Their high value means critical care codes get a correspondingly high level of auditor attention, so you must understand what a properly billed critical care service looks like, including the documentation and time requirements.

CPT defines critical care in this way: "...direct delivery by a physician(s) or other qualified healthcare professional of medical care for a critically ill or critically injured patient. A critical illness acutely impairs one or more vital organ systems such that there is a high probability of imminent or life threatening deterioration of the patient's condition."

There are three components required when reporting critical care:

- There must be a critical illness or injury.
- There must be critical intervention involving "high complexity decision making to assess, manipulate and support vital organ system failure."
- The time must be documented and defined.

Now let's look at five key points that will help ensure your critical care services get billed correctly for full payment.

1. Document the life-saving interventions. Auditors will expect to see which interventions were performed to prevent life-threatening deterioration, as stated in the CPT definition of the service. The decision making for the encounter should be of the highest complexity, because they were needed to keep the patient from deteriorating further. The documentation should also include specifics of what was done to support the vital system functions or address organ failure such as assessing labs, additional testing, etc. It is important to note here that the provider should document clearly their thought process and interpretation of these tests if it is not evident by the patient's presentation that there is organ failure or a critical scenario playing out.

2. Make it clear the patient is critical. As auditors, we often see documentation that the patient is "awake, alert and smiling," yet the provider reports critical care for the encounter. Upon discussion with the provider, one explanation is that there were lab values indicating to the provider that the patient was critical. But if there's nothing in the documentation of the encounter to show this, the patient doesn't appear critical and the service can't be billed as critical care. The documentation must communicate any concerns and interpretations by the provider. There should be no ambiguity or discrepancy between the presentation of the patient according to the provider, and the billing they are reporting through the coding. **Tip:** Don't rely on location to determine whether a service constitutes critical care. Critical care

services are based on the elements outlined above and not the location where the service was performed. Patients can be in the intensive care unit and be stable, or critical patients may receive interventions during the encounter that are not of a critical nature. In such instances, reporting critical care codes would not be appropriate and subsequent hospital care codes should be reported (**99231-99233**).

3. Time is of the essence. Beyond the presentation of the patient and the interventions performed, there's also a time component that must be factored in. For **99291,** there must be 30-74 minutes of critical care time spent with any additional time reported with the add-on code **+99292** which is reported for each additional 30 minutes. The time that is reported is that which is spent solely on the patient, this time does not need to be continuous. This time is spent either at bedside, with the patient's family discussing history or treatment options and time spent reviewing reports, results and consulting with other providers. It is important that these discussions be documented, along with any activities that were necessary to treat the patient, to provide support for the use of critical care.

4. Watch out for uncommon situations. For critical care services that take less than the 30-minute minimum for 99291, the provider must default to another set of E/M codes, such as emergency services (99281-99285). When the critical care services last longer than 74 minutes, the add-on code 99292 may be reported. CPT has traditionally required that at least half of the time designated for the code be met in order to report that code. **Example:** If a provider performs less than 89 minutes of critical care (74 minutes for 99291 and 15 minutes for 99292), some carriers will disallow the add-on code for not meeting the minimum requirements. Check with your local carriers to find out their rules on reporting add-on codes for critical care.

5. Know what's included and when to unbundle. The critical care codes also include some minor procedures that can't be reported separately. These minor procedures are listed in the CPT manual under the header for critical care services and include such procedures such as gastric intubation (**43752** and **43753**), vascular access procedures (**36000, 36410, 36415, 36591** and **36600**), and more. Refer to CPT for the complete list. These procedures are often performed in a critical care situation and therefore have been built into the RVUs for critical care codes. When other procedures are performed that are not listed in CPT as bundled with critical care, these procedures can be separately billed. Examples include resuscitation (**92950**) and endotracheal intubation (**31500**).

Because of the high compensation for critical care codes, audits of these services are not uncommon. It is important to make sure the documentation supports the three areas of necessity, intervention and time in each instance where critical care is reported. Performing reviews periodically of critical care services will ensure that coders are educated on what to look for to support these codes in the documentation and that the provider is sufficiently articulating these services in their reports.

Tip: For a comprehensive guide to critical care that includes detailed discussions of adult and pediatric critical care services, check out *Everything You Need to Know... About Adult and Pediatric Critical Care*. This 211-page eBook includes CPT and CMS source documents, quick reference cards, and clinical scenarios to test your knowledge.

— Sara San Pedro, CPC, CPMA, CEMC, CCP-P (ssanpedro@drsmgmt.com). The author is a Senior Consultant and NAMAS Instructor at DoctorsManagement.

Is a new FLSA proposed rule coming?

Does the Department of Labor (DoL) plan to address the "white collar" overtime exemption regulations in the New Year? Currently, most workers covered under the FLSA must receive overtime pay amounting to at least 1.5 times their regular pay rate for hours worked in excess of 40 hours per week. However, regulations regarding exemptions from the Act's overtime requirement, particularly for executive, administrative, and professional employees (often referred to as "white collar" exemptions), have not kept up with rising wages and inflation. For this reason, President Obama has directed DoL to modernize those exemptions.

The FLSA proposed rule was originally forecast to be issued in late 2014, but it is now more likely to be the first quarter of 2015, according to the Office of Management and Budget's Office of Information and Regulatory Affairs (OIRA). However, when the DoL was asked about the time frame of the proposed rule, it would not confirm or deny it. It was reported that they were continuing to work diligently to develop an updated overtime rule that reflects the President's directive.

Be prepared

Once a proposed rule is issued, employers should start looking at classifications, as there are not likely to be many changes between the proposed and final rules. Employers may not have enough time after a final rule to make the changes needed to avoid the scrutiny of the DoL.

What's expected to change

While we can only make an educated guess at this point, it makes sense to keep an eye on two specific items:

The minimum salary. Many on Capitol Hill are predicting the DoL will more than double the minimum salary an employee must be paid in order to be exempt from overtime pay, taking it from $455 to nearly $1,000 per week. It was reported that the Economic Policy Institute, funded by the DoL, recommended a salary level of $970 per week or $50,440 per year. This is a very significant increase, which they justify by indexing for inflation the 1975 short test salary of $250 per week.

The duties test. Heavy modifications are expected for the FLSA's "white collar" duties test, which is used to determine if someone is performing an executive, administrative or professional role that would (along with exceeding the minimum salary threshold) exempt an employee from receiving overtime compensation.

When asked, some employers believe they know where the exemptions are headed; that is, they believe that the impact will be to tighten significantly the parameters of who may or may not be considered exempt from overtime.

What's not expected to change

The proposed regulations probably will not provide any real safe harbor for ethical employers who want to remedy a wage or hour violation committed under a good-faith belief that they were complying with the law.

A simple compensation test for exempt status is not likely. For example, if you earn at least a certain dollar amount, regardless of whether it is by salary, commission or any other means, you are exempt from the statutory overtime requirement.

Running out of time

The longer the DoL waits to issue its proposed rule, the closer it may come to not completing it during President Obama's administration. Completion of the proposed rule in the first quarter of 2015 should leave the DoL enough time. However, during the last major overhaul of the FLSA regulations in 2004, it took 17 months from the issuance of the proposed rule to the effective date.

If the proposed rule is issued beyond March 2015, "time will be tight" on issuing the regulation far enough ahead of the elections and it will likely become an election issue.

While sufficient time exists, Congress can complicate this task. They can impede the process, and the DoL may have to decide whether it is willing to compromise some of its objectives in order to achieve its ultimate goal.

What will all of this mean for employers?

Whether the proposed rule seeks to raise the income threshold or tighten the duties requirements (or both), any such move will likely have a substantial impact on

employers. Regardless of the content of new regulations, change is coming. The change will require reassessment of all FLSA exemption classifications to ensure compliance. Even before the regulations are proposed, you can start planning how you will ensure compliance when new regulations are effective.

— Philip L. Dickey, MPH, PHR (pdickey@drsmgmt.com). The author is HR Services Director and a Partner at DoctorsManagement.

PRACTICE MANAGEMENT

What your practice needs to do about exclusion screening

Your practice is required by the HHS Office of Inspector General (OIG) and State Medicaid programs to screen all of your employees, vendors, and contractors on a monthly basis to ensure that none have been excluded from either the Medicare or Medicaid programs.

Practices that fail to meet this requirement risk Civil Monetary Penalties (CMPs) and overpayments because Federal and State regulations prohibit payment for any item or service that was provided, directly or indirectly, by an excluded person.

Enforcement cases involving the employment of excluded persons are increasing dramatically, and it is significant to note that Data Analysis Projects by both the Office of Audit Services and the Office of Evaluation and Inspections have been identified in recent large settlements. In light of the potential consequences and the government's increasing enforcement efforts, it is critical that practices gain a basic understanding of the issues relating to OIG Exclusion Screening and State Exclusion Screening and how they can be addressed.

What is an exclusion?

HHS has the authority to deny persons and entities the right to provide services to federal healthcare programs, and it has delegated this authority to the OIG. When it is determined that a person or entity should be barred by the OIG, that person or entity is added to the OIG List of Excluded Individuals and Entities (commonly abbreviated "LEIE") and they become "excluded."

Exclusions can be either **mandatory** or **permissive**, but both have the effect of barring participation in all federal healthcare programs until the government agrees to reinstatement.

- **Mandatory** exclusions last a minimum of 5 years and generally involve felony convictions for defrauding health care programs, felony drug offenses, and convictions for patient abuse or neglect.
- **Permissive** exclusions implicate a wider range of conduct and most often involve misdemeanor health care fraud, misdemeanor drug offenses and licensing issues.

States also have the authority to exclude individuals and entities from participating in their own programs, such as Medicaid, and currently, 37 states maintain their own exclusion lists that are separate from the OIG's LEIE. Since each state is free to adopt its own exclusion criteria and states also often fail to report their exclusions to CMS or the OIG, it's not uncommon for an individual to end up on a state exclusion list, but not the LEIE.

What's the impact of being "excluded"?

Federal and State regulations prohibits payment for any item or service performed by an excluded person if it contributes in any way, either directly or indirectly, to a claim for reimbursement from any federal or state healthcare program.

For example, the OIG has expressed the view that an excluded person can't prepare a surgical tray or even input information into a computer. Even if an excluded person offers to volunteer, the prohibition can be interpreted to apply unless these volunteer activities are "wholly unrelated to federal health care programs," according to the OIG. Thus, a practice that hires an excluded person or does business with an excluded vendor or contractor could find that every billable service he or it contributes to is tainted and a potential overpayment. Most states have also adopted this rationale and apply it to their Medicaid claims.

In addition, CMPs are often used by the OIG as an enforcement tool when claims are made to a federal health care program for an item or service that was provided, or contributed to, by an excluded employee. The OIG has interpreted the relevant federal regulations to create a "knew or should have known" standard. This means that the entity either "knew" of the exclusion and still submitted the claim, or that the entity "should have known," but failed to properly screen the employee. Either way, penalties are appropriate, according to the OIG.

A final important consequence is found in Section 6501 of the Affordable Care Act (ACA) which requires "State Medicaid Agencies to terminate the participation of any individual or entity if such individual or entity is terminated under Medicare or any other State Medicaid plan." As such, any person terminated under any federal or

New DoctorsManagement clients

Client	Services provided
Pediatric psychiatry group, New York NY	Practice start-up
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Rehabilitation center, Queensbury NY	Audit training
Hospital, Dover NH	Provider audit
Physician practice, Knoxville TN	Individual tax services
Hospital system, Fort Wayne IN	Compliance analytics and benchmarking
Ongoing legal investigation	Post-audit extrapolation mitigation
Ongoing legal investigation	Audit sampling and analysis
Ongoing legal investigation	Contract review

state authority is subject to exclusion by all federal or state authorities.

Can't I just screen someone when hiring them?

The ability of individual practices to meet federal and state screening requirements is difficult and often limited despite OIG suggestions to the contrary. The current web-based LEIE interface allows only five employees to be screened at a time. You must also enter each name manually, and potential matches can only be verified individually by entering the Social Security Number

This might work for a provider who only has to screen a handful of employees or contractors, but how would this work out if a provider has 200 employees or more? The alternative OIG suggestion, to download the entire LEIE database and compare your employee list to it, is equally problematic. The LEIE currently contains almost 60,000 names and few providers have the ability to compare it with their own employee database in a reliable or economically viable way.

Again, the LEIE is federal only, and state exclusion lists must also be checked. These state lists come in a variety of formats (Word, Excel, or PDF) with different data fields (some have little more than a name and the excluding agency). Most states require, at a minimum, that providers screen their state exclusion list in addition to the LEIE, but many also have state-specific required screening, such as for lists of sex offenders, elder abuse lists, etc. Finally, practices need to be aware that a number of States include additional broad screening requirements in their Medicaid Provider Agreements that must be addressed on enrollment and re-enrollment.

Can I outsource exclusion screening?

There are vendors who can help practices that find the difficulty and costs of screening to be overwhelming. When comparing the various vendor options, practices should consider such factors as their background in healthcare, the full extent of the services provided, and the support they give.

— Paul Weidenfeld (pweidenfeld@lilesparker.com). The author is co-founder of Exclusion Screening, LLC and a healthcare attorney representing providers and practices nationwide.

REVENUE CYCLE

2015 RVUs: Epidural injections, ultrasound studies see big gains

You can expect to see payment boosts for a number of frequently billed epidural injection codes in 2015, according to our analysis of the 2015 Medicare Physician Fee Schedule, which contains the new relative value units (RVUs) being used for CPT codes. RVUs, and thus payments, are also going up for the technical component (TC) of several ultrasound exams.

Some of the biggest increases are for epidural steroid injection codes 62310/62311 (without catheter) and 62318/62319 (with catheter), which see a total non-facility RVU increase of greater than 100%. This is actually the result of CMS deciding to reverse cuts for steroid injections that became effective in 2014 and were slated to be effective in 2015 prior to the final fee schedule release.

To put this in perspective, the non-facility reimbursement for 62311 (national locality) is $224.90 in 2015, up from $108.90 in 2014. Note: While interventional pain physicians can rejoice over this RVU change, keep in mind that CMS is bundling fluoroscopy into these codes, which reduces the net value of the positive change.

CMS is also increasing payments for the interpretation of a variety of ultrasound exams. Examples include Doppler flow testing (93990) and extremity studies (93930, 93931).

Fistula revision codes 36831 and 36832 are also major beneficiaries in 2015, with each seeing an RVU increase of more than 30%.

A sampling of the greatest positive and negative RVU changes from 2014-2015 can be seen in the table associated with this article *(pg. 8)*. For more information on RVU changes and products that can analyze how they affect your practice fee schedule and revenue outlook, please email ghuang@drsmgmt.com. Keep in mind that this article is not intended as a comprehensive analysis, but is merely a high-level review.

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

Sampling of greatest 2014-2015 RVU changes					
Code	Modifier	Description	Work RVU change	Total NF RVU change	Payment differential
36832		Av fistula revision open	28.21%	31.29%	$191.92
36831		Open thrombect av fistula	36.82%	36.54%	$176.08
62310		Inject spine cerv/thoracic	61.86%	121.68%	$133.51
62318		Inject spine w/cath crv/thrc	32.47%	110.29%	$121.71
62311		Inject spine lumbar/sacral	31.62%	107.57%	$116.00
62319		Inject spine w/cath lmb/scrl	24.67%	48.60%	$55.56
93314	26	Echo transesophageal	68.00%	65.68%	$39.57
93930		Upper extremity study	73.91%	-8.20%	$16.77
93990	26	Doppler flow testing	100.00%	97.22%	$12.84
93880		Extracranial bilat study	33.33%	6.72%	$12.15
93931	26	Upper extremity study	61.29%	61.36%	$9.63
93880	26	Extracranial bilat study	33.33%	31.76%	$9.60
92542	26	Positional nystagmus test	45.45%	42.86%	$7.48
93978	26	Vascular study	23.08%	21.74%	$6.73
76857	26	Us exam pelvic limited	31.58%	25.93%	$5.33
76940	26	Us guide tissue ablation	-77.50%	-77.44%	$1.23
76948	26	Echo guide ova aspiration	142.11%	142.86%	-$0.04
92542		Positional nystagmus test	45.45%	0.00%	-$0.05
76948		Echo guide ova aspiration	142.11%	86.02%	-$0.07
76857		Us exam pelvic limited	31.58%	-13.16%	-$6.90
93314		Echo transesophageal	68.00%	-3.94%	-$13.10
29520		Strapping of hip	-27.78%	-34.81%	-$16.90
93930	26	Upper extremity study	73.91%	72.31%	-$19.75
93313		Echo transesophageal	-46.32%	-46.22%	-$19.75
93976	26	Vascular study	-33.88%	-34.30%	-$20.86
29260		Strapping of elbow or wrist	-29.09%	-43.06%	-$22.26
29530		Strapping of knee	-31.58%	-44.06%	-$22.63
29200		Strapping of chest	-40.00%	-43.62%	-$22.99
93931		Upper extremity study	61.29%	-16.97%	-$26.76
29240		Strapping of shoulder	-45.07%	-49.07%	-$28.35
93990		Doppler flow testing	100.00%	-16.82%	-$32.91
93975	26	Vascular study	-35.56%	-35.83%	-$33.07
93978		Vascular study	23.08%	-14.38%	-$33.68
93976		Vascular study	-33.88%	-22.48%	-$48.31
93975		Vascular study	-35.56%	-20.89%	-$76.85
67042		Vit for macular hole	-27.03%	-26.28%	-$418.84

Source: DoctorsManagement analysis of Medicare 2014 and 2015 Physician Fee Schedule Final Rule