

# The Business of Medicine

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#### COMPLIANCE



#### **What new RAC changes mean for providers**

In last month's *The Business of Medicine* newsletter, we gave you an overview of some sweeping changes being made to Medicare's Recovery Audit Contractor (RAC) program that are intended to address provider concerns about RAC demand letters placing an unreasonable burden on the provider community.

These new changes are intended to incentivize the RACs to be more selective in their reviews and give the provider community a better opportunity to engage with RACs during their review processes.

Don't let these changes lull you into a false sense of security; you'll still need to worry about receiving demand letters from the RACs. Even with these changes, RACs have plenty of incentives to find payment mistakes and claw money back from physician practices.

In fact, a case could be made that these changes may cause the RACs to work even harder at auditing practices that show a pattern of repaying RAC demands quickly or not contesting erroneous RAC demands.

Here are five steps physician practices can take to best position themselves for success under the new RAC policies:

**1. Regular internal and external self-audits.** The number of additional documentation requests (ADRs) that a RAC can make of a physician group is tied to the group's denial rate. The fewer denials a practice has, the fewer ADRs the RAC can make. Appealing denials from your Medicare Administrative Contractor (MAC), as well as internal and external self-audits coupled with provider training, will help your providers get it right the first time and lower RAC exposure.

**2. Look for quick feedback.** Under the new RAC contracts, the RACs are required to notify you of the results of a complex review within 30 days, twice as quickly as the current timeframe of 60 days.

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**3. Have your physicians engage with RAC medical director.** The RAC is required to have a physician medical director. Instead of using your staff, ask your physician who is under RAC review to engage with the RAC's medical director one-on-one to discuss results or findings.

**4. Use the discussion period to get insight into RAC findings.** The RAC must give practices a 30-day discussion period before any claim adjustment can take place. This discussion period is halted once the provider formally appeals the RAC findings. Use the discussion period to get as much insight as possible into why the RAC is denying payments, then base your formal appeal on that information.

**5. When in doubt, appeal the RAC findings.** If you know you're in the wrong, then repay the claim. But if you think you have any chance for success, your best bet is to appeal because of two important reasons. First, under the new RAC contracts, the RAC doesn't get its contingency payment until it's successful at the second level of appeal. Your appeal signals to the RAC that it won't get an easy, instant contingency fee by targeting your practice. Second, RACs face penalties when more than 10% of its repayment demands are overturned at the first level of appeal, so successful appeals will deter the RAC from targeting your practice.

**Remember:** One of the other changes RACs must make in 2015 is to expand their reviews by provider type. In 2013 more than 95% of RAC reviews targeted inpatient claims; now RACs are expected to review more Part B claims, which means practices will be under the gun than before.

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## ACCOUNTING



### Tax season: Get automobile deductions right

Automobiles are a necessary part of doing business for many people, both business owners and employees. However, the tax rules for automobile expenses and deductions are complex, so strategies on how to use them can be tricky. In this article, we'll go through the tax law of allowable deductions and discuss some unexpected issues that may arise.

### Standard vs. actual expenses

The IRS provides two ways to determine the auto deduction you may take on your tax return: the standard mileage rate and the actual expense method.

**Under the standard mileage rate method:** Take the number of miles driven for business purposes and then multiply by the rate (\$0.56 per mile in 2014 and \$0.575 per mile in 2015). In addition, parking fees and tolls incurred for business use may be deducted.

To use the standard mileage rate, the following rules must be met. You must:

- Not operate five or more cars at the same time, as in a fleet operation
- Have used only straight-line depreciation in calculating depreciation for the car
- Not have claimed a Section 179 deduction on the car
- Not have claimed special depreciation (bonus depreciation) on the car
- Not have claimed actual expenses on a car you lease
- Choose to use the standard mileage method in the first year the car is used for business purposes (you can choose between this and actual in later years)

If the car is leased, the standard mileage rate must be used for the entire lease period, including renewals. You can't alternate between methods.

**Under the actual expense method:** You must determine what it actually costs to operate the car for business use. Items such as gas, oil, repairs, tires, insurance, registration fees, licenses, depreciation/lease payments are all allowed as deductions for the percentage of business miles the car was used.

Expenses must be documented and substantiated by adequate records. In recent years, the IRS and Tax Courts have been very stringent regarding logs. In cases where no log was produced, all deductions were denied for either method.

### What qualifies as a business expense?

Business use generally means travel between two business destinations, one of which may include your regular place of business. Examples include:

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## CODING



### 6 tips to properly bill for teaching physicians

Services that involve residents and teaching physicians will always be crucial for teaching hospitals and similar facilities, but their complexity has made them a top audit target. "Physicians at Teaching Hospitals" (PATH) has regularly appeared on the annual Work Plan of the HHS Office of Inspector General (OIG).

In this article, we'll take a look at six common issues that result in improper billing, which is a recipe for overpayment demands when the inevitable audit hits.

Reviewing your billing isn't just important to optimize revenue; remember that the federal government has a veritable alphabet soup of audit entities looking at perennial targets like PATH: Medicare contractors to Recovery Audit Contractors (RACs) and the newer Zone Program Integrity Contractors (ZPICs), just to name a few.

Here are six items to watch out for when dealing with residents and teaching physicians:

**1. Get supervision right.** You probably know that residents must be supervised by teaching physicians when they perform services. But supervision isn't as simple as it seems. Teaching physicians are required to be physically present and supervise the resident's "performance of the critical or key portion" of the service. This must be documented in the record (see #2 below).

**2. Fully document physician's involvement.** The teaching physician should document his or her involvement in the service, either in writing or by dictation. The explanation of involvement should be specific and show that the physician participated in managing the patient. A resident may not document the physician's involvement; the physician must document his or her involvement.

**3. Avoid time-saving shorthand.** Short and commonly used statements such as "agree with above,"

"rounded, reviewed, agree," or "discussed with resident, agree" are all insufficient for documentation purposes, according to CMS. A good example of a satisfactory statement would be: "I performed a history and physical exam of the patient and discussed her management with the resident. I reviewed the resident's note and agree with the documented findings and plan of care."

**4. Make sure to use modifier GC.** This may seem simple, but failing to use the teaching physician modifier is actually a fairly common mistake. You must append modifier GC (service has been performed in part by a resident under direction of teaching physician) to all codes that represent services with resident involvement. This modifier applies to E/M services as well as surgeries and other procedures. For anesthesia services, the teaching anesthesiologist should append modifier GC as well.

**5. Modifier GE may apply in some cases.** CMS allows residents to perform certain lower and mid-level E/M services without a teaching physician, under what is known as the "primary care exception." Codes **99201-99203** and **99211-99213**, along with three preventive services (**G0438, G0439, and G0402**) can be billed by a resident if **modifier GE** (service performed by resident without presence of teaching physician under primary care exception) is appended. **Note:** This exception must be attested to in writing in order for Medicare to pay for the codes above. The attestation must state that the E/M services are furnished in the outpatient department of a hospital or other ambulatory care facility. Residents who use modifier GE must have completed at least six months of their residency program.

Keep in mind that the primary care exception is complex and not something you can casually comply with. You can find the full requirements for this attestation in the Medicare Claims Processing Manual, chap. 12, section 100.1.1C. Here is a link to the online version of this manual: [www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf](http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf).

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- Traveling from one job to another
- Traveling from one client to another
- Traveling from your office or business location in order to perform business tasks
- Traveling from home to a temporary work site that is not the regular place of business
- Traveling outside of an area in which you normally work to a temporary work site, provided you do not have a regular place of business.

It's also important to remember that commuting expenses are never business expenses, regardless of any activities that may take place during the commute.

### The cons of having the business own automobiles

There are also some potential drawbacks to businesses owning the cars. I'll mention a couple here.

The first is the liability associated with the business being the owner. It's helpful to remember that if there is an accident involving cars owned by the business, the business will be liable for any related injuries and lawsuit awards that happen. If the car is held inside the business, it's important to have a good insurance policy in place to protect the business' assets, and such policies can be quite expensive. While individual owners would be shielded by being an LLC or being incorporated, the assets inside the business would be at risk.

A second drawback is specific to S-corporations. For various reasons, eventually the individual owner of the car may want to take his or her car out of the S-corporation. The owner usually does this as a distribution, which produces taxable income for the owner. The car is deemed to be distributed at fair market value at the time of the distribution. Since the car has been subject to depreciation, it's likely that the fair market value (FMV) of the car is greater than the tax value of the car.

**Example:** Mr. Smith is the sole owner (100%) of Acme Corp., an S-corporation. In 2010, he contributed a car worth \$20,000 to Acme Corp. and has used it 100% for business purposes. In 2015, Mr. Smith decides to take the

car out of the business and give to his son as his first car. During these five years, the car has accumulated \$16,235 of depreciation, so the net tax value of the car is \$3,765. Assuming the car has an FMV of \$7,000 at the time the owner takes it out, the result is the owner having a taxable income of \$3,235 from this action.

Other factors to consider are multiple owners for the S-corporation, in which case the gain on the distribution would be allocated equally among all owners and corresponding pro rata distributions would have to be made across the board to all owners. Additionally, if the distribution of the car creates a tax loss, the shareholder is not allowed to claim it.

As with anything else, there are pros and cons of having your business own automobiles. You should carefully consider your personal and business needs before taking any action.

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### PRACTICE MANAGEMENT



### Strategies for selling your practice

*First of a three-part series.* This first article will guide you through the process of preparing to sell your practice using a recent client as a real-life example. The next two articles will discuss the negotiation process, choosing the right offer, and how to triumphantly make it to the finish line on closing day.

Eventually, all good things must come to an end. So it is in life, so it is with a physician's practice. With proper management, skill, and a little luck, you (as the physician) will be the one deciding how, when, and why your practice comes to an end.

However, physicians looking to sell and retire (or move on to other things) often don't realize the scope of the process that awaits them. Selling a practice isn't like a selling a house – it's exponentially more complex.

Physicians often have a specific number in mind when they decide to sell. Unfortunately, that number rarely winds up anywhere near the true value. Many factors, tangible and intangible, comprise the total worth of a practice: equipment, supplies, longevity of the staff, location, accessibility, reputation, and most importantly, the list of patients (and their charts).

## Get an accurate valuation

The first and most important decision is selecting the right person to perform an accurate valuation of the practice. While any accountant can review your books and give you a number, you need someone with experience, who knows how to account for all the items listed above. Be prepared to answer a lot of questions and provide inventory numbers.

**Tip:** Speaking of inventory, this is often a good time to involve a consultant, who can evaluate your practice in other areas as well. Just like selling a home, a little “curb appeal” and cleaning up can go a long way. Some consulting companies, including DoctorsManagement, can combine a practice assessment with a practice valuation and charge one flat fee.

**Tip:** Depending on who you choose, you may need to have them sign a non-disclosure agreement and a business associate agreement to protect confidential information and patient privacy. Don’t skimp when selecting your valuation expert – getting the true worth of your practice and pricing it accordingly is usually the most important step in successful sales.

## Lawyer up from the start

Next, include a health care attorney in your planning from the very beginning. A good attorney can walk you through the entire process, field multiple offers, handle negotiations, and draft legal documents while you continue to focus on your practice and your patients. A good attorney can also tell you whether state-specific licensing is required for your valuation expert and any consultants involved in your sale. If state law requires it, your attorney should be the one doing the research and making sure you are fully protected.

## Office space considerations

Finally, know what you are selling. If your practice leases your office space, have your attorney review the

lease. You need to know how far in advance to notify your landlord that you don’t intend to renew the lease in your name. If you plan on having the purchaser take over the lease, you need to know whether this is allowed under your specific lease terms. Failure to notify the landlord of a change in ownership may be a breach of the lease, which could result in financial penalties. If you own your space, you need to decide whether to sell the practice but rent the space, or sell both. If you rent the space, you will rely again on your attorney to draft a lease that adequately protects you and your real property investment.

**Example:** A recent DoctorsManagement client from New York City took her time and did her homework, including taking a complete equipment and supply inventory, before selling her practice. She had multiple offers and DoctorsManagement helped her negotiate the best possible outcome. In addition, because she owned the building, we were able to draft a lease which will quickly pay off her remaining mortgage and provide her with a nice monthly income over an



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extended period of time. While she'd be the first to admit that the process was not without stress and emotion, she would also say she's very glad she invested in a team to walk with her every step of the way and deal with the business side of things so she could continue being a doctor throughout the process.

Once you finish the steps above, you still need to create a marketing plan and attract offers. In the next part of this series, we'll focus on how, when, and where to advertise your practice.

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## MEDICARE RULES



### What you need to know about the value-based modifier

The Affordable Care Act requires CMS to begin applying a new modifier known as the “value-based modifier” in 2015, part of its ongoing effort to move away from fee-for-service towards pay-for-performance.

For 2015, the modifier **will only apply to physicians who are in a group of 100 or more** participating providers, but this program will ramp up quickly over the next few years, so it's important you understand how it will affect you.

The value modifier will use both cost and quality data to differentiate payment to a physician or group of physicians under the Medicare fee schedule. The quality of care will be compared against the cost of that care over a performance period to determine payment.

For your 2015 payments, if you are in a group of 100 or more physicians, CMS will use CY 2013 as the performance period for the value modifier that will be applied. Remember that CMS defines a “group” of physicians as a single Taxpayer Identification Number (TIN) that has the Medicare billing rights for two or more individual eligible professionals (EPs). The EPs will be identified based on their National Provider Identifiers (NPIs).

### Relationship to PQRS program

CMS is implementing the value modifier based on participation in the Physician Quality Reporting System (PQRS). Groups with 100 or more EPs must participate in PQRS by registering for the PQRS as a group and reporting at least one measure, or choosing the administrative claims option to avoid a payment reduction of 1% from the value modifier adjustment. If the group elects “quality-tiering,” then the value modifier could result in an upward, downward, or no payment adjustment based on performance. **Note:** If your group didn't opt for the administrative claims option by Oct. 15, 2013, that ship has sailed and you'll be subject to the 1% cut.

Again, for 2015 your group is only subject to the value modifier if it has 100 or more EPs. CMS automatically determines whether your group meets this standard with a two-step process. First the Provider Enrollment, Chain, and Ownership System (PECOS) is queried to find groups of physicians that had 100 or more EPs as of Oct. 15, 2013. The result is a potential list of groups that the value modifier applies to.

Second, CMS performs a claims analysis for services furnished during CY 2013 and through February 28, 2014. Any group on the list that doesn't have claims from 100 or more EPs billed under the group's TIN during this period is removed from the list subject to the value modifier.

### Quality tiering

The term “quality tiering” is one you'll hear a lot in future years, as it will become an increasingly significant factor in determining value-based modifier payment. Quality tiering is the analysis used to determine the type of adjustment (upward, downward, or neutral) and the amount of the adjustment based on the group's performance on quality and cost measures. Quality tiering determines if a group practice's performance is statistically better, the same, or worse than the national mean.

As mentioned above, for the 2015 value modifier, group practices with 100 or more EPs could voluntarily choose to participate in quality tiering under the value modifier. Those who did not choose quality tiering

would have a neutral value modifier, which would have no impact on their payments under the MPFS.

For the 2016 value modifier, quality tiering is mandatory for groups with 10 or more EPs. Physicians in groups of 10 to 99 EPs will be subject to an upward or neutral payment adjustment, while groups of physicians with 100 or more EPs will be subject to an upward, neutral, or downward payment adjustment.

Below is a breakdown by category for how Medicare determines the value modifier in CY 2015:

**Category 1:** The value modifier will be 0% unless the group chooses quality tiering. This category includes those groups of physicians that a.) have registered for PQRS as a group and reported at least one measure, or b.) have elected the PQRS administrative claims option as a group. For groups that do choose quality tiering, CMS will use the performance rates on the quality measures reported through PQRS to calculate their value modifier. If a group that elects quality tiering registers for the group practice reporting web interface or CMS-qualified registry and fails to meet the reporting criteria for the PQRS incentive payment, CMS will use the group's performance on the administrative claims option to calculate the value modifier.

**Category 2:** The value modifier will be -1%. This category includes groups that don't fall within either of the two subcategories of Category 1, including:

- Physicians in group practices of 100 or EPs who submit claims to Medicare under a single tax identification number (TIN) will be subject to the value modifier in 2015, based on their performance in calendar year 2013.
- Physicians in group practices of 10 or more EPs who participate in fee-for-service Medicare under a single TIN will be subject to the value modifier in 2016, based on their performance in CY 2014.
- For 2015 and 2016, the value modifier doesn't apply to groups of physicians in which any of the group practice's physicians participate in CMS's new payment model programs, including the Medicare Shared Savings Program, Pioneer ACOs, or the Comprehensive Primary Care Initiative.
- All physicians who participate in fee-for-service Medicare will be affected by the value modifier starting in 2017.

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If a group practice does not report quality measures via 2014 PQRS GPRO, CMS will calculate a group quality score if at least 50% of the EPs in the group report measures individually and meet the criteria to avoid the 2016 PQRS payment adjustment.

## Future planning

As the law currently stands, for the 2016 value modifier and beyond, quality tiering is a zero sum game for the government. If CMS applies a negative 1% adjustment to one or more TINs, they will apply an equal dollar amount toward upward adjustments to other TINs. The result is a system that's designed to incentivize being in the top 50% of your peers to

be safe. Most likely, those groups in the top 60% will experience minimal or no negative adjustments. Those in the bottom third among their peers will find the value modifier's payment adjustment to be financially painful as the highest adjustment tier in future years is negative 4%.

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Primary care group, TX	Practice start-up
Reproductive endocrinologist, FL	Feasibility study
Teaching hospital, Ohio	Comprehensive compliance risk assessment
Health system, FL	Pre-bill auditing
University health system, FL	Pre-bill auditing
Multi-specialty health system, NY	ICD-10 training
Medical center, NC	Web-based training
General surgery group, FL	Credentialing services
Plastic surgery group, TX	Credentialing services
Multi-specialty practice, IL	Credentialing services
Spine and pain management group, MD	Credentialing services
Family practice, NE	CLIA technical consulting
Family practice, ID	CLIA technical consulting
Pediatric dentistry practice, AL	OSHA training
Dermatology group, TN	HR consulting and employee handbook
Family practice, GA	HR consulting
Pediatric practice, FL	Employee handbook
6 new power buying clients (dental, ENT, family practice, dermatology and occupational health)	