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CODING

Billing injections on the same day as an E/M service

Physicians often reflexively attach what they believe to be an appropriate E/M code to a claim on the same date the patient receives an injection. But increasingly, payers are being just as reflexive when it comes to denying the E/M service, saying that it's bundled into the injection.

What's the truth? While there are many instances when the E/M service is bundled into the injection service, there are probably just as many instances when these denials can and should be successfully appealed, based on additional treatments or services being rendered during the visit.

For purposes of this article, we'll focus on common musculoskeletal injections, such as those in the **20500-20612** code range. CPT guidelines do not allow these minor procedures to be billed on the same date of service as an E/M service unless the E/M service is for a significant, separately identifiable reason.

When there is a significant, separately identifiable E/M service provided, it can be billed with the appropriate E/M code, appended with modifier **25** (significant, separately identifiable evaluation and management service by the same physician or other qualified healthcare professional on the same day of the procedure or other service).

It is up to the payer to set the rules for when it is appropriate to use modifier 25 for the E/M service, in order to justify whether both the procedure and E/M code are separately payable for that encounter.

Medicare defines these injection codes as minor surgical procedures and assigns zero global days to these codes. This means that, according to Medicare's National Correct Coding Initiative (NCCI) edits, the typical pre- and post-service work associated with the injection are considered to be part of the payment for the injection itself. In this

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scenario, this work does not rise to the significant, separately identifiable level of service that would justify the use of modifier 25 on a separate E/M claim.

As further noted in Chapter 1 of Medicare's NCCI manual, "The decision to perform a minor surgical procedure is included in the payment for the minor surgical procedure and should not be reported separately as an E/M service. However, a significant and separately identifiable E/M service unrelated to the decision to perform the minor surgical procedure is separately reportable with modifier 25. The E/M service and minor surgical procedure do not require different diagnoses."

While the NCCI edits typically list established patient E/M services as bundled into these injection codes, the NCCI manual states that the same rules for minor procedures also apply to new patient encounters. Many private payers follow NCCI rules, but you will need to verify with each payer that you are following its specific rules for billing an E/M on the same date as an injection.

The most common instance where an E/M would not be separately payable is when the patient presents for a scheduled injection that arose from a prior E/M service.

Consider these two common examples where the E/M would likely not be supported for separate payment:

1. **Injection arises from earlier E/M visit.** A patient presents for an E/M service and the provider says that if the treatments don't work, then the patient should return for an injection. If the patient then returns for a separate visit for an injection, and the documentation reflects no additional medical decision making beyond the typical pre- and post-service work, then a separate E/M visit would likely not be supported.
2. **Visit is for a scheduled injection.** A patient is coming in for visits for a series of scheduled injections. In this case there isn't enough justification for a separate E/M service if the patient simply visits, has the affected area checked out, and receives the scheduled injection.

When you can support a separate E/M

Typically, you can justify a separate E/M visit in two ways. First – and this is the easiest way – if the patient has a separate injury or problem addressed by the provider and documented in the medical record, then the treatment of that issue supports a separate E/M service.

Some Medicare Administrative Contractors (MACs) make it clear that they allow a separate E/M service for the visit or encounter when the patient begins the series of injections and the documentation supports the E/M service billed.

The second option is more difficult, but it involves justifying the separate E/M service with documentation of a diagnostic process that results in the decision to administer an injection. Documentation of an evaluation of the problem area, or the use of X-ray services, can help support the case that the separate evaluation was necessary, and the result of the evaluation was the decision to move forward with an injection.

Separate treatment of the injury, such as medical decision making to write a prescription or advise lifestyle modifications, can also serve as proof that the encounter involved more than just the injection.

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

ACCOUNTING

A costly problem: Net investment income tax

Over the last two years, at tax time (or extension time), you may have looked at your completed return and noticed that the tax due seems higher than what you were expecting. After some digging, you notice that a box was checked on line 62 for taxes from Form 8960 and a tax was calculated. After finally finding this form near the end of your return, you see that it's entitled the "Net Investment Income Tax" and it appears that you are being taxed extra on your investment income. You think to yourself, "This can't be correct, can it?" The bad news is that, unfortunately, it often is.

The Net Investment Income (NII) Tax is a tax created as part of the Affordable Care Act (ACA) to help pay for the healthcare reforms enacted by the law. It took effect on Jan. 1, 2013, and it is a 3.8% surtax imposed on the lesser of net investment income or Modified Adjusted Gross

Income (MAGI) over a threshold amount. In most cases, the MAGI will be the same as Adjusted Gross Income (AGI). The threshold amounts are $250,000 if married filing jointly (MFJ), $125,000 if married filing separately (MFS), or $200,000 for all other taxpayers.

The income that counts toward NII includes interest, dividends, rents, royalties, non-qualified annuities, sales of property not actively used in a trade or business, and other passive income, including partnership, LLC, and S-corporation flow-through income.

Example: Dr. and Mrs. Smith filed a joint return for the 2014 tax year. They had the following income items:

- W-2 wages – $500,000
- Interest income – $1,500
- Dividend income – $53,000
- Rental property income – $35,000

The Smiths' total AGI and MAGI for 2014 is $589,500. Total investment income for 2014 is $89,500. MAGI exceeds the MFJ threshold amount by $339,500. In this case, the lower of the two amounts is total investment income, or $89,500. This amount will be taxed by 3.8% for a tax of $3,401. **Remember:** The NII tax is a *surtax*, meaning it is *in addition* to the regular income tax.

Mitigating the new tax

There are exceptions to the rule for what is treated as investment income. We will discuss two exceptions in this article: self-rental income and S-corporation flow-through income when the shareholder materially participates in the business.

Self-rental income. Self-rental income is a regular occurrence inside the physician practice industry. Most physicians or physician groups separate their real estate holdings from the actual practice operations in a separate legal entity. The practice will then rent the space from the real estate holding company. The physicians who are owners in the real estate holding entity will receive a K-1 with their income and distributions. Without the exception for self-rental, the income from the real estate holding entity would be subject to the NII tax. However, because the entity is actually functioning in a self-rental situation, the income is not subject to the NII tax.

Let's illustrate this by taking the earlier example of the Smiths and making some different assumptions. Assume Dr. Smith is a physician who is an owner in his actual practice and also an owner in the real estate holding company that rents its space to the practice. All $35,000 of rental property income is the income from this rental agreement. In this situation, the rental income would be considered a self-rental and would not be subject to the NII tax. The AGI would remain $589,500 and would still exceed the threshold by $339,500. However, the NII would only be $54,500. Since the lower of the two is used, the 3.8% tax would be applied to the $54,500 for a total NII tax of $2,071. This is effectively a savings of $1,330 compared to the same scenario if self-rental didn't apply.

S-corporation flow-through income when the shareholder materially participates. Many physician groups are organized as S-corporations with the goal to minimize Social Security and Medicare taxes while the physicians materially participate in business operations. Normally, S-corporation flow-through income would be treated the same as any passive investment income,

and thus be subject to the NII tax. Thankfully, there is an exception for S-corporation flow through income *if there is material participation*. So for physicians in groups organized as S-corporations, the flow-through income isn't subject to the NII tax, just like their self-rental income. Additionally, the sale of an ownership interest of an S-corporation in which the shareholder materially participates is also exempt from the NII tax.

Barring major philosophical and political changes in Washington, the NII tax is likely here to stay. However, physicians in particular can offset some of its burden by using these exceptions with proper planning.

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PRACTICE MANAGEMENT

Practice management Strategies for selling your practice: Advertising

Second of a three part series. This series broadly covers the process of selling a medical practice.

In the first installment of this series, we covered the importance of learning the true value of your practice, engaging a healthcare attorney, and knowing what you are selling. We also touched on the importance of "house cleaning" – making your office as attractive to potential buyers as possible. Once those items have been completed, the next step is to get the word out and attract potential buyers.

But this step should be handled carefully and deliberately. This is not the time to go shouting from the rooftops that you are transitioning away from ownership and putting the practice up for sale. It's important to avoid generating fear among your staff, which could lead to turnover or even a mass exodus. You also want to avoid disrupting the flow of referrals to your practice or give your current patients any reason to begin searching for other physicians.

You should initially leverage local contacts and practices for leads on potential buyers. Often, the best candidate will be someone in the area who has a connection with the community or is otherwise acquainted with you or your practice. You or physicians you trust can ask peers if they can think of anyone interested in buying a well-established and successful practice in their specialty. If the answer is anything other than "no," your healthcare attorney can make the initial overtures and have the interested party enter into a Confidentiality and Non-Disclosure Agreement. By doing so, you minimize the chance of this news trickling out into the medical community's rumor mill, leading to the undesirable results mentioned earlier.

Your local, state, and national specialty medical societies are also important resources. If you are working with a healthcare consultant, the consultant should be able to draft an ad and handle any inquiries on your behalf without having to state your name or the name of your practice. This is another way to help protect your practice and its staff from gossip and questions. Typically, there are costs associated with placing ads through the medical societies.

A good consultant should also be able to contact local healthcare systems and hospital directly on your behalf. In many cases, an offer from a hospital system may not be as strong as one from an individual and it may be more difficult to negotiate with such a large entity.

It's important to have as much interest in your practice as possible to be able to leverage multiple offers against each other. For example, I was involved in a recent practice sale where we pitted two competing offers against each other to get the best possible deal for the selling physician. Afterwards, the physician thanked us for our guidance through the process, which involved some very tense periods of negotiation that may have seriously detracted from the physician's practice if she had been handling the process alone.

If your plan includes staying with the practice for a period of time after the sale, you can also offer the practice to younger physicians coming out of fellowship. Usually this will require a longer transition period for you, as it may be necessary for you to spend a year or more with the buyer to introduce him or her to the practice, the patients, and assist in some final training.

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Compliance: Should you use automatic level of service wizards?

Yogi Berra often gets credit for the saying "It's tough to make predictions, especially about the future." Actually, it was Niels Bohr, a brilliant physicist who received the Nobel Prize in 1922, who is responsible for this quote, but more power to Yogi for getting the credit. In healthcare compliance, this saying might go something like this: "It's tough to code, especially E/M codes." You can credit Frank Cohen for this one.

E/M codes are strictly bound to a set of complex and sometimes confusing criteria found within one of two sets of guidelines. There is the 1995 guidelines, which were really introduced in 1994 and the 1997 guidelines, which were really introduced in 1996. Either (or both) are made of a series of tables, lists and grids that must be followed in order to determine the correct code.

This is particularly true for, say, office and hospital encounters. For both of these, there are three key components; history, physical exam and medical decision-making and which code you chose depends upon a very complex and combinatorial matrix of grids, which convert these into key components. In fact, I once did an informal calculation of the complexity of coming up with the proper E/M code and I figured that a provider (or coder) has to go through some 1,600 decision points before assigning the code. And even then, if you believe several good scholarly studies that have been done on the subject, 42% of those that reviewed the chart would disagree with the other 58%, who also reviewed the same chart, at least within on code level. God bless coders.

I don't know how you do it, but I'm glad it's you and not me. I'll stick to simple areas, like applied statistics and predictive analytics. It may not sound easy, but at least I am bound to a set of rules that are relatively axiomatic rather than elastic.

There's the history lesson on E/M codes; at least that's all I really care about. The point is, it's tough to code, especially for E/M codes. As such, human beings have forever been searching for an easier and more consistent method to code correctly. I guess we should forget about scrapping the incredibly poor method of guidelines we use now because, well, nobody seems to talk about that much. Instead, the industry has created a niche market of 'cheat sheets' and even though I am not a coder, I have seen hundreds, if not thousands of these over the past 20 years. Go to any medical conference and probably half the vendors are giving them away for free. They are either little cards (or big cards) or one-sheets that have, in their own way, found a method to create grids to simplify the process. Great. Works for me.

Now comes along technology, because if a little is good then a lot is better, right? Right? Wrong, actually. But there are those that see it as the silver bullet to the E/M coding problem. As it goes, there are EMR systems out there that purport to be able to select the most correct and appropriate E/M code based on the information the provider enters into the program. The question is, does it work and even more important, if it does work, how well does it work? This, my friends, can be a compliance nightmare. I have worked with many organizations that have faced this dilemma; shoot or don't shoot. Should they employ the automatic level of service wizard or not? My experience has been that, without knowing whether there is a negative or positive impact; meaning whether the wizard would create a greater risk through an increase in coding error, it is best not to use these automated systems. Now, I didn't say you should use them; I said that, without some evidence that they don't increase risk, you shouldn't use them. And this is where statistics comes into play.

I have designed and run several experiments for clients to determine whether the wizard would prove to be a benefit or a hazard and this is a summary of how it would work. There are two parts to these types of studies. One looks at visible risk and the other at inherent risk. For the former,

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Compliance (cont. from pg. 5)

it can be as simple as trending the average level of code within each category before and after the wizard is turned on within the system. The goal is assess whether a change in utilization patterns will pose a visible risk; that is, will it look different enough to draw attention?

Even if the coding is correct and without error, the auditor doesn't know that unless and until s/he reviews your charts. This is about being the squeaky wheel and at the outset, if there is a large positive shift, puts you on notice that your risk for a review may increase. But this is not a reason to scrap the wizard. That comes in the second part.

The goal in the second part of the study is to test the system for error frequency, not to conduct a statistically valid analysis of error by provider. The purpose is to *test* risk, not to create it. To begin, we need to establish some baseline error rate. To do this, I take a random sample of, say, office and hospital visit codes from some group of providers within the practice. It can be all providers or it can be some providers. If some, then you are getting into more complex sampling methods, but since this isn't really a statistically valid study, do your best to pick a random group of providers. How large should the sample size be? That depends on how precise you want your measurement to be.

Example: If you estimate a starting error rate of 20% and you want to be accurate within plus or minus 5%, you will need a minimum of 528 units. If you're willing to accept an error rate of plus or minus 10%, then you can go with a minimum of 137 units. In any case, you take this sample and sterilize it, meaning that you don't want to know the names of the providers since the purpose is not to conduct a qualitative analysis by provider but rather a quantitative analysis for the group.

Audit the charts and record the error rate. Let's say you get an error rate of 15%. Then you turn on the wizard. Train for the first 30 days, normalize for the next 30 days and then take another random sample (same number of units from same group of providers) from the next 30 days. Audit these and compare the results. If the error is the same or less, then the wizard doesn't introduce any additional risk. If the error rate is higher (in my case, I like to see it as statistically significantly higher), then forget the wizard, because it will introduce more error and likely increase your risk.

The point here is that, before you employ a new technology, test it to see what impact it will have on your organization. It is my experience that CMS is not a fan of automated level of service wizards so if you are bent on using it, at least make sure that, when the auditor comes knocking, you can at least say that you conducted a test and found that there were no statistically significant differences between using the wizard and not using the wizard. And a point of clarity here; the test itself can be significant without the review of the providers being significant. This is important because remember, the goal is not to identify individual charting and coding issues but rather to establish a benchmark for comparison and testing. And what about that 15% error? Well, fix it and that's one less thing to worry about.

— Frank Cohen (fcohen@drsmgmt.com). The author is Director of Analytics and Business Intelligence at DoctorsManagement.

Practice Management (cont. from pg. 4)

Your consultant should be able to contact fellowship directors at regional and national universities on your behalf to place ads and inquire about graduating fellows interested in relocating to your area.

Finally, it's extremely important that you and your consultant and attorney establish a realistic timeline for advertising your practice or recruiting a physician or health system to purchase your practice. Allow at least one year from start to finish, but be aware that the process often takes much longer. With proper planning and the right team in place, you can continue to see patients and leave the stress of recruiting, negotiating, and selling the practice to your consultant and healthcare attorney.

In our next and final installment, we will cover the actual contract and negotiation process, as well as how to transition out of practice after a successful sale.

— Jesse Overbay, JD (joverbay@drsmgmt.com). The author is a Management Consultant and Associate General Counsel at DoctorsManagement.

FINANCIAL MANAGEMENT

SAGE VIEW Finance & risk management are interconnected

I recently had a conversation with a finance officer at a mid-size company in which we discussed Enterprise Risk Management (ERM) and Captive Insurance Companies (CICs). This company is successful and growing with complex operations, hundreds of employees, over one hundred million dollars in annual revenue and millions of dollars of annual profit as well.

The officer I spoke to was clearly a strategic thinker who fully grasped the benefits that ERM with CICs could provide to his company. However, he was also convinced that his CFO would either not grasp ERM or simply choose to "stay in the box." He said two things that really stood out to me. First, he said "Our CEO hates insurance." Second, he said "We just don't focus on risk management ... We renew our insurance policies annually and try to spend as little as we can."

These comments likely reflect the sentiments of business owners and executives at many

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June 1-2	**MGMA New York –** Frank Cohen
June 4	**National Society of Fraud Investigators, Indianapolis, IN –** Shannon DeConda
June 22	**PAHCOM, Clearwater Beach, FL –** Frank Cohen
Aug. 14-15	**AAPC Hawaii Honolulu Chapter Annual Coding Conference –** Sean Weiss, Shannon DeConda
Sept. 13-14	**MGMA National Conference, Nashville TN –** Frank Cohen
Sept. 21	**Wisconsin Medical Society 2015 Symposium, Wisconsin Dells, WI –** Shannon DeConda
Sept. 24-25	**MGMA Colorado –** Frank Cohen
Oct. 8-9	**American Billing Association National Conference, Las Vegas, NV –** Shannon DeConda
Nov. 30-Dec. 3	**"Navigating the New Frontier," Optum 360 Essentials Conference, Las Vegas, NV**
Dec. 6-9	**NAMAS Annual Conference, Nashville, TN**

mature and growing companies. Clearly, his CEO views insurance as a "grudge purchase" – a necessary evil. Insurance is a cost to be borne and as a CEO, he would probably rather spend his time crafting strategies to grow the business. But this mindset is short-sighted, addressing risk and insurance in one-year increments.

For mature and growing companies, risk management ought not be seen simply as an afterthought or a tiresome part of the business to be completely delegated to an outside insurance broker. Business owners, executives and CFOs of successful businesses should consider making risk management a core financial strategy.

After all, all risk management is financial, and all financial aspects of a business are at risk. Risk and Finance are thoroughly intertwined.

Making risk management a core financial strategy requires a paradigm shift from viewing risk management as a cost center to viewing risk management as a profit center. Perhaps paradigm shift is an understatement? How is it possible to view risk management as a profit center? It's possible because business owners and executives can choose to own their own insurance company as part of an overall ERM strategy. This pivotal decision is a financial game changer.

As I ponder the comment, "Our CEO hates insurance," I can't help but think, "That is precisely why you need to own your own insurance company. Don't hate it, embrace it!"

— Ryan Manaker, SageView Advisory Group.

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