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MEDICARE RULES

What you need to know about SGR fix and ICD-10

The long-maligned SGR formula – which would've instituted a 21% cut for 2015 – has been replaced with a series of automatic positive 0.5% adjustments through 2018.

That's just the top item in the "Medicare Access and CHIP Reauthorization Act of 2015." After 2018, the automatic positive updates will stop and physician compensation will be adjusted by a new incentive program, called the Merit-Based Incentive Payment System (MIPS). This new program is designed to consolidate the Medicare program's existing pay-for-performance initiatives.

One of the biggest initiatives is a new modifier known as the value-based modifier (VBM), which the Affordable Care Act required CMS to begin implementing in 2015. The relationship between MIPS and the value-based modifier is complex, because MIPS doesn't replace the VBM or the meaningful use program or the Physician Quality Reporting System (PQRS).

Instead, MIPS will measure Part B providers in four performance categories to create an overall merit score from 0 to 100. This score can significantly impact a provider's Medicare reimbursement during a given payment year. **Note:** It's not clear exactly when CMS will begin collecting performance data to generate MIPS scores, but the first MIPS payment year will be 2019.

With just five months remaining before the Oct. 1 deadline for ICD-10 implementation, the possibility of another delay is practically nil, experts say. The SGR fix law represented the last, best opportunity for Congressional opponents of ICD-10 to modify the transition timeframe. The fact that the final bill included no ICD-10 delays despite a significant lobbying effort suggests that the industry has finally accepted the deadline.

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With so many providers already heavily invested in training, education, and planning for ICD-10, a last-minute delay would do more harm than good. Recently, lawmakers suggested that CMS take measures to make transition less painful as an alternative to shifting the deadline again. Two possible ways to make ICD-10 penalties less severe were suggested, but there seems to be no concrete way for CMS to institute them without essentially accepting both ICD-9 and ICD-10 codes after the deadline.

The ideas mentioned were:

1. **Creating a hardship exemption for ICD-10.** This was raised by Rep. Andy Harris, a Maryland Republican and an anesthesiologist. Providers who could show that ICD-10 would be too great a financial burden would be exempt from converting and could stick with ICD-9. Unfortunately, this concept hasn't been well received by CMS; the agency points out that having to maintain two coding systems long-term would result in a claims-processing nightmare.

2. **Delaying the penalty phase for ICD-10 by two years.** "The reasonable thing would be to delay the penalty phase for two years as people transition," said Sen. Bill Cassidy, R-Louisiana, during a HHS budget hearing on April 23. The problem is that "delaying penalties" basically equates to paying for claims that still use ICD-9 after Oct. 1, so it's not clear how CMS could make this workable.

The last few years of deadlines and delays have created enough pressure to spur many providers– especially large health systems and hospitals – to action, investing time and money to prepare for ICD-10. As more providers have paid to become ready, they have become less hostile to finally facing the music and seeing whether their preparations will hold up.

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PRACTICE MANAGEMENT

Tips for hiring a healthcare attorney

Choosing the right lawyer can make a big difference to the success of your practice. A good lawyer will help you do things other practices avoid because of a misunderstanding of the law, but will also keep you from doing things that "everyone is doing" when they are illegal. The best lawyers will do this without costing you an arm and a leg. Here are some thoughts about retaining counsel.

When hiring a lawyer for a specific problem, ask them to describe their experience with that problem. Just like medical professionals, lawyers specialize. You don't want someone like me writing your will, or handling your tax dispute. I have colleagues who do that. Choose an expert. In a good sized-law firm, that expert should be able to connect you with experts in other areas. If one person claims that they can "do it all" for you, be skeptical. The fact of the matter is that there are so many areas of law, it isn't very realistic for one person to know them all. Even within the narrow specialty of health law, the incredible volume of regulation makes it inconceivable that one person can know it all well.

Ask who the lawyer represents. Many health lawyers primarily represent large health systems, while others represent physician groups. Many local lawyers will work with a health care client or two, but primarily represent other business. Ask the lawyer to describe their practice. How much of it focuses on health law, and who is their typical client?

Ask about risk tolerance, and know your own. The safest thing for a lawyer to say is "no, that's illegal" or "you will lose this appeal." Some lawyers, perhaps most, are risk adverse. That is not necessarily bad; staying out of jail is good. But you want to understand the perspective of the person giving you advice. Do they get a kick out of Russian roulette or do they think crossing the street is too risky? I try to tell people what the government's enforcement position is, and then explain whether I think the government is right. I rarely call the government for an opinion, and if I do, I still review the underlying law. There are other lawyers who rely almost entirely on what the government says. You have to decide which approach you want, and then know what approach your lawyer will take. While I will tell clients what I would do in a particular situation, that isn't the right test. You need to know the risks and decide how much risk you feel comfortable taking. You may opt to avoid any action that the government might criticize, but there might be some risks you are willing to take, particularly if your lawyer can explain that there is a strong legal argument available. The best lawyers will really help you asses the risk.

You can and should ask how much something will cost. When you do, *don't focus on hourly rates.* A low hourly rate is meaningless when the lawyer works many hours, while a high rate isn't a problem when the lawyer is efficient. Ask for a total cost. Then find out if it is an estimate, or a guarantee. One administrator expressed pleasant surprise at receiving a bill for $850 for an email explaining how the group could share an MRI with another practice. The administrator explained that she had received a ten page memo exploring the question from their "regular" lawyer, along with a bill for $10,000. She found that letter difficult to read, and believed it said that it would not be possible to share the MRI. The administrator assumed that since my hourly rate was much higher than that of the other lawyer, the bill would be at least as high. She was shocked that the bill was actually more than 90% lower.

Don't be afraid to hire someone who is far away. Technology, including Skype and email, make it very easy to work with counsel at the other end of the country. It is quite easy to perform compliance training for a group 1,500 miles away using online software. You may think "don't I need to hire only lawyers licensed in this state?" For some things, that matters, but that list is pretty small. To appear in a state or federal court, you need a local license, or you must receive a waiver. But for many of the things lawyers do, you don't require any law degree. If you find an out of state lawyer you like, use them. In situations where it is necessary, that lawyer can always consult with a lawyer licensed in the state.

It is completely acceptable to treat your lawyer like a buffet. You can use some lawyers for some issues and others for other issues. You can use a great deal of legal services at some times and not at others. A good lawyer will recognize this, and even encourage it. They may even tell you "I won't spend the money looking at this."

Finally, if you aren't happy with something, speak up. A good lawyer will try to keep you happy. Don't be shy. If the advice was too slow or too expensive, speak up. That strategy can be particularly effective when you are friendly about it. A good lawyer is instrumental in helping you make wise choices. It is worth the time to choose wisely when selecting him or her.

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REVENUE CYCLE MANAGEMENT

Creating an effective revenue cycle process

Your practice's revenue cycle is affected by many different variables – so many that practices often struggle to manage them all. When the revenue cycle is inefficient, even when providers perform well, your cash flow can suffer, your A/R can get out of control, your write-offs can become excessive, and so on.

So, what are the areas where practices should focus their attentions? The first is ensuring you have the right people in the right positions. This starts at the top. Unfortunately

physicians as a collective group are not great business people. If they were, you would not be reading this article by me, but rather by a physician. Take a slow and methodical hiring approach to ensure you end up with people who possess the skills to perform at the level your practice requires. You have to approach revenue cycle management (RCM) with a high level of sophistication due to the number of moving parts. Make sure your managers are capable and competent to do a thorough job to avoid costly mistakes. You may have to pay more to get the help you need, but a mismanaged revenue cycle is what forces practices to sell, merge or file for bankruptcy.

Practices should focus on areas of vulnerability, and one of the biggest is front-end tasks. They may seem mundane, but the largest number of mistakes come during the patient registration and insurance verification process. Next up is coding and billing, which requires a tremendous amount of oversight. Your coders and billers are highly skilled professionals, critical to the success of the practice not just from a compliance standpoint but also from a revenue standpoint. Ensure payment posting and insurance follow-up happens consistently and that there are measures in place to capture charge-entry errors before the claims go out the door. Make sure you track denials or other issues tied to claims filing so you can resolve problems quickly. Untracked problems can linger for months or longer, growing larger and harder to fix.

Our large group clients always ask whether to centralize their revenue cycle operation or keep it decentralized (allowing each practice or location to manage their own coding and billing functions). There is no simple answer to this question. However, we are fans of centralizing the areas that have the greatest impact on the group's revenue. If there's a logical reason to keep it decentralized, such as vastly different patient demographics or services provided, then go with your instincts, but make sure you have strong reasons for your decision. Much of your decision-making will be based on the current size of the group, the growth trajectory and other items directly tied to the revenue cycle. Don't be afraid to be a pioneer or find a hybrid process if you believe that will make your group successful.

One of the biggest issues we've found in groups is tension between the high producer(s) and those at the bottom. Make your revenue cycle process transparent and build strong quality controls to mitigate financial loss or damage to the group. Make sure if an issue arises, it is discussed and strategies for corrective action are put into place before the issue metastasizes.

Finally, RCM can't be discussed without addressing compliance. Most practices don't have an effective compliance program in place. There is nothing worse than going into an organization and asking them about the compliance program in place, only to be handed a dusty binder with a 10-year-old date of implementation and no updates since then. Often we will ask clients why something is being done a certain way and the answer is "Because we have always done it that way." Our next question is "Do you know what you are doing is wrong?" All too often then answer is either "yes" or "what do you want me to do about it." If this sounds like your practice, then you have major gaps in your process and RCM is the least of your worries.

Perform research and understand the risks you are taking on with failing to comply with standards set forth by CMS and other payers. If you cannot build a compliance plan or write effective policies, work with someone who can. Ultimately, the real secret to successful RCM is using common sense, documenting and tracking problems, and discussing issues with staff before they grow out of control.

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HUMAN RESOURCES

Top do's and don'ts for the I-9 form

Don't get careless when it comes to properly maintaining the employment eligibility verification form, better known as the I-9.

Form I-9 was created to help control illegal immigration by helping to "prove" an employee's identity and eligibility to work in the United States. Employers are required to complete and retain an I-9 for each employee hired after Nov. 6, 1986.

Over the past few years, the U.S. Immigration and Customs Enforcement (ICE) office has initiated paperwork audits looking at I-9s on a greater scale than in previous years. Recent times have seen ICE bring a greater number of cases against employers under the criminal code, rather than civil law. The agency says the new focus is on employers, rather than employees, targeting what they believe is the root cause of illegal immigration.

Poor documentation can cost you $1,000 per worker in penalties, and knowingly hiring an illegal immigrant can result in a $10,000-per worker fine. To avoid potential legal trouble, follow these Form I-9 do's and don'ts:

1. Do use a current form. Several versions of the Form I-9 have been issued since the form was first introduced in 1987. To determine whether you are using the correct version of Form I-9, look at the revision date printed on the bottom left corner of the form – and NOT the expiration date printed at the top of the form. Currently, only the form with this revision date should be used: "Rev. 03/08/13 N."
2. Do require all new hires to complete and sign Section 1 on their first day of work.
3. Do make sure the information on the form is clear and can be read.
4. Do make certain the start date in Section 2 matches the date in payroll records.
5. Do review employee documents to make sure they're on the new version of the I-9's list of acceptable documents and that they appear genuine.
6. Don't ask new hires for any particular documents or for more documents than the I-9 requires. The employee chooses the documents, not you.
7. Don't use abbreviations unless they are widely known and understood.
8. Do establish a consistent procedure for completing I-9s and educate your hiring managers on that procedure.
9. Do make and retain copies of all I-9 documentation provided. Only a few states make this mandatory, but it's a good idea.
10. Don't forget to keep a tickler file to follow up on expiring documents that limit the employee's authorization to work. You don't have to re-verify identity documents, such as a driver's license.
11. Do keep I-9s and copies of documents for three years after the employee's hire date or one year after his or her termination, whichever comes later.
12. Don't put the I-9 in an employee's personnel file. To protect against discrimination claims, keep it and supporting documentation in a separate file.
13. Don't ask an applicant to complete an I-9 prior to making a job offer. Un-hired applicants can use I-9 information to allege that you discriminated against them.

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COMPLIANCE

Modifier 25: Dismissing myths and instilling compliance

I've been auditing for twenty years and there is no doubt in my mind that modifier 25 is the one that applies most often. Proper use of this modifier is necessary to ensure proper payment while maintaining compliance. For many years, modifier 25 has been misunderstood and mis-used, resulting in overpayments. If you or your providers tend to report an E/M service every time a decision is made to perform a minor procedure (e.g. injection or biopsy) on the same date, don't stop reading here. Before we can fully appreciate the proper use of modifier 25, we must first understand its actual definition and intended use. CPT defines modifier 25 as follows:

"It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service

to be reported. The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date. This circumstance may be reported by adding modifier **25** to the appropriate level of E/M service. **Note:** This modifier is not used to report an E/M service that resulted in a decision to perform surgery. See modifier **57**. For significant, separately identifiable non-E/M services, see modifier **59**."

Not only do *all* minor surgical procedures inherently include pre-service work, but the National Correct Coding Initiative (NCCI) specifically precludes a provider from routinely reporting E/M codes with minor surgical procedures on the same date of service. According to current NCCI edit policies, "Modifier 25 may be appended to E/M services reported with minor surgical procedures (global period of 000 or 010 days) or procedures not covered by global surgery rules (global indicator of XXX). Since minor surgical procedures and XXX procedures include pre-procedure, intra-procedure, and post-procedure work inherent in the procedure, the provider should not report an E/M service for this work. Furthermore, Medicare Global Surgery rules prevent the reporting of a separate E/M service for the work associated with the decision to perform a minor surgical procedure whether the patient is a new or established patient."

When a new patient is evaluated for a new problem, and the decision is made for minor surgery, if the medical decision making supports moderate or high complexity, we believe that modifier 25 may be reported to demonstrate that a "significant and separately identifiable" evaluation has been performed. When established patients with established problems are evaluated by the same provider, we believe that only the procedure should be reported and that the E/M service would be included as part of the "pre-service" work inherent to the procedure. The only exception would apply in cases when the provider is evaluating a "significant and separately identifiable" problem (e.g., distinct diagnosis) and moderate or high complexity of medical decision making is clearly demonstrated. Remember that Medicare defines the same provider as all of those of the same specialty who are practicing in the same group practice. There are plenty of misinterpretations for modifier 25. Below, you'll find some myths that apply to the improper use of the modifier -25:

- Modifier 25 is always applicable when seeing new patients and performing minor surgery.

- Modifier 25 always applies when the decision for minor surgery is made.
- If the procedure is performed for one diagnostic purpose and the E/M is performed for another, modifier 25 will always apply.

Below is a suggested series of guidelines to follow to ensure proper use of modifier 25. While there's always some level of subjectivity with E/M services, we are confident that our stance is defensible at any appeal level based on our understanding of modifier 25 and current NCCI edits. Feel free to use the language below in your practice. It is intended to be a standalone document and repeats some of the references cited above.

Proposed policy for using modifier 25 with an E/M

Modifier "25" should be appended to an E/M code when reported with a minor surgical procedure on the same date of service. Minor surgical procedures are those that carry 0 or 10 day global periods, per RBRVS. Appending modifier -25 to the E/M code indicates to the MAC carriers or fiscal intermediaries that as a result of the patient's condition, the provider performed a significant and separately identifiable E/M service above and beyond the typical pre-procedure work inclusive to the procedure itself.

"Modifier -25 may be appended to E/M services reported with minor surgical procedures (global period of 000 or 010 days) or procedures not covered by global surgery rules (global indicator of XXX). Since minor surgical procedures and XXX procedures include pre-procedure, intra-procedure, and post-procedure work inherent in the procedure, the provider should not report an E/M service for this work. Furthermore, Medicare Global Surgery rules prevent the reporting of a separate E/ M service for the work associated with the decision to perform a minor surgical procedure whether the patient is a new or established patient."

We have reviewed the current CMS guidelines and NCCI policies, including recent revisions stating that all minor procedures that carry 0 or 10 day global periods include E/M performed on the same day. As a result of these policies and our interpretation, we have implemented the following internal policy:

1. When a minor procedure (e.g. 0 or 10 day postoperative days) is performed for an established patient with an established problem, only the minor procedure code(s) will be submitted for that DOS.
2. When the minor procedure (e.g. 0 or 10 day postoperative days) is performed for an established patient with a new problem but that medical decision making score for this visit is straight-forward or low, only the minor procedure code will be submitted for that DOS. It is our opinion that a straight-forward or low medical decision making score does

not constitute a "significant and separately identifiable" E/M service.

3. When a minor procedure is performed for a new patient with a new medical problem and the medical decision making level for the visit is straight-forward or low, only the minor procedure code(s) will be submitted for that DOS. It is our opinion that a straight-forward or low decision medical decision making does not constitute a "significant and separately identifiable" E/M service.

   We realize this is subject to some interpretation but the NCCI bundling edits directly implicate established patient visits with minor procedures but it is possible that a low complexity of MDM along with detailed history and physical (supporting code 99203) can support modifier 25. This is determined on a case by case basis.

4. When a minor procedure (e.g. injection) is performed for a new patient or established patient with a new problem on the same date of service, and the medical decision making score is moderate or high, the modifier 25 will be appended to an E/M service (e.g., codes 99214, 99215, 99204, and 99205). It is our opinion that a moderate or high medical decision making complexity does constitute a "significant, separately identifiable E/M service."

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New DoctorsManagement clients

Client	Services provided
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Orthopedic group, NC	Analytics and compliance risk assessment
Family practice, OH	Analytics and compliance risk assessment
Gastroenterology group, VA	Analytics and compliance risk assessment
Hospital, TN	Analytics and compliance risk assessment
Cardiac surgery group, NV	Litigation review
Orthopedic group, CA	ICD-10 training and implementation
Healthcare consulting group, OH	ICD-10 training and implementation
Family practice, LA	Practice assessment and strategic planning
Solo provider, GA	Practice integration
Health clinic, TN	New provider credentialing/enrollment
ENT group, NC	New provider credentialing/enrollment
Solo provider, MO	Credentialing services
Solo provider, FL	Credentialing services
Federal agency, AZ	Coding training
Family medicine group, AZ	OSHA training for entire staff
Orthodontics group, TN	OSHA training for entire staff
Cardiology practice, TN	OSHA and HIPAA training
MGMA	Keynote speaker
MGMA	Breakout session speaker
4 new power buying clients (Behavioral health, podiatry, allergy/asthma)	