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MEDICARE RULES



Proposed rule: Incident-to physician must actually supervise billed service

In an attempt to clear up confusion over which physician's identifier should be used to bill incident-to services, CMS proposes to make clear that the physician under whom the claim is billed must be the physician who provided the actual direct supervision of the billed service. The proposal is part of the 2016 Medicare Physician Fee Schedule proposed rule.

Which physician's identifier should be used to bill incident-to services has long been a source of confusion. In many instances, the physician who created the plan of care for the patient is not actually present in the office when the patient returns to see the non-physician practitioner (NPP).

Back in 2002, as noted in that year's fee schedule final rule, CMS stated that the physician billing for the incident-to service is effectively stating that he or she directly supervised the rendering of that service. The current regulation is worded more vaguely, and says that "the physician (or other practitioner) supervising the auxiliary personnel need not be the same physician (or other practitioner) upon whose professional service the incident-to service is based."

The proposal for 2016 would strike this language but make clear that, as with the 2002 clarification, when an incident-to service is being billed, the physician who has signed the claim is stipulating that he or she directly supervised the encounter for that date of service, meaning that he or she was in the office suite and available to provide immediate assistance as needed.

You would not be required to bill an incident-to service under the identifier of the physician who created the plan of care for the patient, unless that physician was the one who directly supervised the incident to service.

(continued on pg. 2)

In reality, the CMS proposal is not a change to the current and longstanding interpretation of CMS's incident-to rules. It does, however, provide clearer guidance showing that it would be a violation of incident-to rules to bill a service under the identifier of a physician who is not in the office suite providing direct supervision at the time the service is rendered.

Practically speaking, this change means the practice must be able to validate, via its schedules, that the physician who bills the incident-to service was available to provide direct supervision on that date. Practices shouldn't just randomly select a physician to bill incident-to services under, or simply always bill such services under the identifier of the physician who last saw the patient or created the plan of care.

Because the physician is not required by Medicare policy to sign or date the encounter, there is no way to validate that incident-to services were rendered properly other than reviewing the practice schedules and interviewing the applicable providers.

CMS further clarifies in its proposal that the actual rendering provider of the incident-to service must not be excluded from the Medicare program at the time of the service. Remember, given the way that incident-to claims are currently submitted, CMS has no way of actually knowing whether identifiers on claims are referring to individuals who provided the services, or are actually identifiers of physicians who supervised those services.

There's a good chance that this proposed change will be finalized by CMS, given that it doesn't represent a fundamental change to incident-to, but is in fact a clarification of the way the agency currently interprets incident-to policy. Other elements of incident-to rules that have long confused physician practices, including the requirements that the NPP strictly follow the plan of care, not address new problems, and the requirement that the physician remain substantively involved in the patient's ongoing treatment, would not change as part of this proposal.

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HUMAN RESOURCES



Independent contractors or employees? What you need to know

This is the first of a two-part series on independent contractors, which are seeing increasingly frequent use at a wide variety of organizations.

Does your organization use independent contractors? More and more employers do, for lots of reasons. Technology now allows remote work, while workers want flexible schedules that offer better work-life balance. Independent contractors take advantage of both these trends.

The economy is also fueling the growth of independent contractors. They are appealing to cash-strapped employers for many reasons — no payroll taxes, no benefits, and no need to worry about pesky matters such as FMLA leave and wage and hour compliance. Finally, if the contractor is not working out, you can just terminate the contract without worrying about receiving a charge from the EEOC in the mail.

The problem is that a worker is not an independent contractor just because you have classified him or her that way, even if you have a written contract. The law determines who is and is not an independent contractor, and if your workers don't meet the legal definition used by whatever agency or court is looking at the issue, you may be charged with all the taxes, wages, and benefits you should have paid, possibly going back several years.

Unfortunately, there are as many tests to determine whether a worker qualifies as an independent contractor as there are government agencies that deal with workers, from the federal Internal Revenue Service and Department of Labor to your state unemployment office, state workers' compensation agency, state tax department, and state Department of Labor. Figuring out how to treat a worker so that agencies classify the worker as an independent contractor can be a complicated undertaking. In this first article, we'll look at how the IRS classifies independent contractors.

U.S. Internal Revenue Service (IRS)

The IRS formerly used what became known as the “Twenty Factor Test.” In a response to a need for simpler standards, the IRS consolidated the twenty factors into three main groups: behavioral control, financial control and type of relationship.

1. Behavioral control. Facts that show whether the business has a right to direct and control how the worker does the task for which the worker is hired include the type and degree of the following:

- **Instructions that the business gives to the worker.** An employee is generally subject to the business’s instructions about when, where, and how to work, including the following.
 - ◇ When and where to do the work.
 - ◇ What tools or equipment to use.
 - ◇ What workers to hire or to assist with the work.
 - ◇ Where to purchase supplies and services.
 - ◇ What work must be performed by a specified individual.
 - ◇ What order or sequence to follow.

The amount of instruction needed varies among different jobs. Even if no instructions are given, sufficient behavioral control may exist if the employer **has the right** to control how the work results are achieved. A business may lack the knowledge to instruct some highly specialized professional; in other cases, the task may require little or no instruction. The key consideration is whether the business has retained the right to control the details of a worker’s performance or instead has given up that right.

- **Training that the business gives to the worker.** An employee may be trained to perform services in a particular manner. Independent contractors ordinarily use their own methods.

2. Financial control. Facts that show whether the business has a right to control the business aspects of the worker’s job include:

- **The extent to which the worker has unreimbursed business expenses.** Independent contractors are more likely to have unreimbursed expenses than are employees. Fixed ongoing costs that are incurred regardless

of whether work is currently being performed are especially important. However, employees may also incur unreimbursed expenses in connection with the services that they perform for their employer.

- **The extent of the worker’s investment.** An employee usually has no investment in the work other than his or her time. An independent contractor often has a significant investment in the facilities or tools he or she uses when performing services for someone else. However, a significant investment is not necessary for independent contractor status.
 - **The extent to which the worker makes his or her services available to the relevant market.** An independent contractor is generally free to seek out business opportunities. Independent contractors often advertise, maintain a visible business location, and are available to work in the relevant market.
 - **How the business pays the worker.** An employee is generally guaranteed a regular wage amount for an hour, week, or other period of time. This usually indicates that a worker is an employee, even when the wage or salary is supplemented by a commission. An independent contractor is often paid at a flat fee or on a time and materials basis for the job. However, it is common in some professions, such as law, to pay independent contractors hourly.
 - **The extent to which the worker can realize a profit or loss.** An independent contractor can make a profit or loss.
- 3. Type of relationship.** Facts that show the parties’ type of relationship include:
- **Written contracts describing the relationship the parties intend to create.** This is probably the least important of the criteria, since what really matters is the nature of the underlying work relationship, not what the parties choose to call it. However, in close cases, the written contract can make a difference.
 - **Whether or not the business provides the worker with employee-type benefits, such as insurance, a pension plan, vacation pay, or sick pay.** A true independent contractor will finance his or her own benefits out of the overhead profits of the enterprise.

- **The permanency of the relationship.** If you engage a worker with the expectation that the relationship will continue indefinitely, rather than for a specific project or period, this is generally considered evidence that your intent was to create an employer-employee relationship.
- **The extent to which services performed by the worker are a key aspect of the regular business of the company.** If a worker provides services that are a key aspect of your regular business activity, it is more likely that you will have the right to direct and control his or her activities. For example, if a law firm hires an attorney, it is likely that it will present the attorney's work as its own and would have the right to control or direct that work. This would indicate an employer-employee relationship.

In the next issue, we'll take a look at how the U.S. Department of Labor classifies independent contractors.

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COMPLIANCE



Scribes: How to get the documentation right

With the increasing demands of physician time and documentation surrounding the use of electronic health records (EHRs), many medical offices are now utilizing the services of a scribe to ensure timely documentation completion. This can be an efficient and cost-effective way to keep your practice running smoothly and caring for your patients while retaining the volume of appointments and an appropriate amount of time spent on each encounter. However, there are a few regulations to keep in mind.

It has been said that a medical office scribe functions as a “living tape recorder.” This is due to the fact that he or she is recording, in real time, the actions and words of the physician or non-physician practitioner (NPP) as they occur. The scribe only documents what the physician or NPP states that he or she should add to the record. The scribe may not

interact with the patient or perform any part of the service *while acting as a scribe*, and must be physically present in the room during the entire portion of the visit that he or she is acting as a scribe. The scribe will be “clicking” and typing exactly what the physician or NPP says or dictates to him or her (“real time”), as an extension of the physician's hand.

Documentation entries made by the scribe should be made from dictation by the physician or NPP and should “document clearly the level of service provided at that encounter.” CMS Evaluation and Management Guidelines must still be met and the key components required to be performed by the physician or NPP are the same.

Tips and recommendations for ensuring compliance with Government regulations surrounding documentation guidelines, as well as, the use of EHRs:

- Keep EHR meaningful use regulations in mind when choosing personnel who will be acting as a scribe. Certain licensing and credentialing regulations apply when meeting meaningful use.
- The best practice is to ensure that scribe personnel only add entries in the EHR under their own login and password.
- Documentation should ensure transparency regarding the contribution of each individual during the encounter. The below is a suggested way to accomplish this:
 - ◊ The scribe notes: “Written by XXX, acting as a scribe for Dr. YYY.”
 - ◊ The physician or NPP documents: “This note accurately reflects the work and decisions made by me.” Any supplemental information should also be made by the physician or NPP and be electronically signed by the physician or NPP.
 - ◊ This can be achieved effectively via the use of text templates or other similar EHR tool.
- If a nurse or medical assistant performs the review of systems, past, family, social history and records vitals and then begins to act as a scribe for the remainder of the encounter he or she should remain in the room during the entire encounter to record “real time” (under his or her own login/password) the words and instructions of the physician or NPP, having no interaction with the patient while scribing.

- All office staff involved in the use of scribes should be educated on the workflow and guidelines before performing services.

With the above guidelines, tips and recommendations, the successful use of a scribe may increase productivity and workflow in the office, as well as alleviate frustration with EHR use for some physicians, while maintaining quality patient care.

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PRACTICE MANAGEMENT



Why patient engagement matters

This is the first of a two-part series on how to improve your practice with better patient engagement. In this article, we'll explain why patient engagement is an important but often underappreciated aspect of practice management.

We all know that it's less expensive to keep a patient than it is to generate a new patient, so it seems obvious that this should be an area of focus for any vibrant practice. The revolving door of "patients in and patients out" doesn't make a lot of sense, but that's exactly what is happening in a lot of cases.

Marketing dollars are expended to bring in new patients, but little is done to make sure they stay after that first experience. One of the terms that is sometimes used to describe this situation is "one and done." If this is something you deal with in your practice, you might want to explore some options to make a difference.

What studies show

A few years ago, Ted Kaptchuk, a professor at Harvard Medical School, conducted a study on the effect of "caring and communication" with regard to patient outcomes. Using a group of gastroenterological patients who all presented with the same symptoms, he set up a randomized controlled trial. The two groups in the study received identical treatment, but the method of delivery was different. In the

control group, little time was spent with the patients and there wasn't a lot of interaction. The second group received the same medical treatment but the visits were longer, with the caregiver exhibiting a high degree of interest and empathy. You may be surprised at the results, which went way beyond the placebo effect. The second group, in fact, had "measurably" improved outcomes. An increased level of caring equated to an increased level of healing. Surprised? Well, you shouldn't be. What you do "for" your patients is as important as what you do "to" them.

Last July, the NORC Center for Public Affairs Research at the University of Chicago published a report on their findings with regard to patient opinions of caregivers. They asked 1,000 study participants their opinion regarding what makes a "high quality" doctor. It's important to note that they weren't asking what made them like their doctor, or what made them want to keep going back to the same medical office; the question was with regard to qualities that make a "high quality" doctor.

Your first thought might be that things like training, expertise, and experience would be at the top of the list.

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Well, that wasn't the case. It's interesting to note that "communication" was the factor most cited. In fact it was as much as 40% more important to the study participants than the second factor - accurate diagnosis. The logical conclusion is that patients would prefer that you misdiagnose them over not communicating with them. While that may bring a smile to your face, it is in fact what the study showed. Of all the responses, 63% had to do with communication and caring, while only 25% had to do with training, education, and expertise.

Patients want to be heard and they want to know that their practitioner really cares about them. What can we learn from these studies? It should be obvious that you need to listen to, and communicate with, your patients. Some of it is face-to-face communication, but there are a number of ways you can maintain a dialog with them when they aren't even in your office. Will your patients notice, and will it make a difference to them? Look at the following example and draw your own conclusion.

Example: Jackie is a mother in Texas with a 5-year-old daughter who has a number of medical challenges that keep her in and out of hospitals and doctor's offices on a weekly basis. Recently Jackie shared the following quote on Facebook and gave permission for me to share it. Her sentiments are very reflective of many of your own patients. Here's what she said: "Every so often, you reach out to your child's physician's office and someone actually listens to you, cares what you have to say, addresses your concerns, and actively works to solve your issue. It's sad that I'm so impressed when this happens, but, when it does ... I want to send that person flowers and chocolate, and a day at the spa. That's how important it is, and how much it means to me."

I don't know if it can be said better than that. Effective communication really does make a difference. If you're doing it well, why would your patients ever consider going anywhere else?

In the next and final installment of this series, we'll look at how modern technology affects patient engagement and provide concrete tips and guidance on how to improve your interactions with your patients.

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CODING



Orthopedics: Billing rotator cuff repairs with shoulder debridement

Bundled services and when they can be unbundled is an area of coding that seems to be in constant flux. In this article, we'll take a look at an ortho-specific scenario involving rotator cuff repairs and shoulder debridement performed in the same encounter.

The more we researched this specific scenario, the cloudier the answers became. We at DoctorsManagement have always followed CMS guidelines when providing coding and regulatory advice to our clients, but in this case, the best CMS guidance may be outdated and may not reflect what many Medicare carriers currently allow under their local edits and policies.

The scenario

When both arthroscopic and open procedures are performed for the same patient on the same date of service, codes for both services are billed with modifier 59 (distinct procedure) appended to the lower-RVU code. The question is whether or not this is allowed under CMS guidelines. According to National Correct Coding Initiative (NCCI) edits, subacromial decompression performed arthroscopically (+**29826**) is included in an open, **chronic** rotator cuff repair (**23412**). We have emphasized the word "chronic" only because a separate code exists for the repair of an "acute" rotator cuff repair (see CPT code **23410**).

There are also two separate codes that can be used for arthroscopic debridement of the shoulder: one for "limited" debridement (**29822**) and another for "extensive" debridement (**29823**). Depending on which of these debridement codes is most appropriate, the bundling edits differ. There are three billable shoulder compartments:

1. Glenohumeral joint
2. Subacromial space (SA space)
3. Acromioclavicular joint (AC joint)

One interpretation is that you can report 29823 if at least two of these "compartments" are addressed and debrided.

When subacromial decompression (+29826) is performed in addition to the open rotator cuff repair, the American Academy of Orthopaedic Surgeons (AAOS) and the American Medical Association recommend reporting 29822 or 29823 (limited or extensive debridement) instead of using the add-on code +29826.

This means we must answer two questions before we can address the original bundling question. First, which is the most appropriate debridement code (29822 or 29823)? Second, which open rotator cuff repair code (23410 or 23412) is most appropriate? Once these questions are answered, the coding situation becomes a bit clearer.

Let's start by taking a glance at the various reporting scenarios below for **open rotator cuff repair and arthroscopic debridement** with subacromial decompression.

- 23412 (repair of ruptured musculotendinous cuff (eg, rotator cuff) open; **chronic**) and +29826 (arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with coracoacromial ligament (ie, arch) release, when performed) are bundled. According to NCCI policy, Code +29826 is a component of Column 1 code 23412.

We feel, as many orthopedic coders do, that it's a bit outlandish for a code performed arthroscopically (+29826) to be inclusive to an open procedure (code 23412). However, we don't make the rules. While the NCCI edits do allow these to

be unbundled with a modifier, the more conservative position to disallow this is supported by CMS guidance.

According to the AAOS, if arthroscopic subacromial decompression is performed followed by an open or mini-open (eg, mini deltoid split) rotator cuff repair, the provider should report 23410 **or** 23412 along with +29826 with modifier 59. Refer to the following article for more information: www2.aaos.org/bulletin/apr04/code.htm. While this article was published in 2004, it's the most recent document from the AAOS on this topic. But because the AAOS doesn't determine payment policy, let's look at the CMS guidance. CMS has stated that +29826 should *not* be reported with open rotator cuff repair unless performed on the contralateral shoulder.

The CMS guidance we have dates back to 2008. A management firm contacted a CMS carrier medical director, who communicated with federal officials and received the following response:

"We discussed your letter with CMS (Centers for Medicare and Medicaid Services) which owns NCCI and makes all decisions about its contents. The edit has a modifier indicator of '1,' and your interpretation of its meaning is correct. For Medicare claims, the two procedures should not be reported with an NCCI-associated modifier if they are performed on the ipsilateral shoulder joint unless the two procedures are performed at separate patient encounters on the same date of service which is highly unlikely. If the two procedures

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are performed on contralateral shoulder joints, it would be appropriate to report both codes utilizing NCCI-associated modifiers. CMS and we hope that this information is helpful to you and your clients.”

Let’s review the facts as we have them. CMS stated in 2008 that +29826 is only billable with modifier 59 if performed on the *contralateral* shoulder or at different operative sessions on the same date. We at DoctorsManagement don’t necessarily concur with this rationale and suggest that readers who perform and bill for these services should attempt to obtain timelier and more payer-specific guidance regarding this scenario.

As we move forward, our auditors have been instructed to disallow subacromial decompression (+29826) when performed with open rotator cuff repair (23410 or 23412) when performed on the same date, the same surgical session and on the ipsilateral (same) shoulder. Some important reminders are as follows:

- When arthroscopic debridement is performed, the provider will be required to document the “extensive nature” of the debridement (e.g., two or more of the shoulder compartments)
- When open rotator cuff repair is performed, there are two different codes; 23410 and 23412 or acute and chronic repairs, respectively. When selecting 23412, the provider should use documentation to support the “chronic” nature of the rotator cuff pathology.

When and if we receive a definitive answer from CMS on this scenario, we’ll let you know in an issue of *Business of Medicine*. In the meantime, please feel free to check with your local carrier for specific coverage determinations.

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