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REVENUE CYCLE MANAGEMENT

ICD-10 payments steady, but tougher edits may loom

Practices have seen little to no payment disruptions due to the new ICD-10-CM diagnosis code set a full two months after the Oct. 1 implementation date, experts tell *The Business of Medicine*. "We know that claims are being paid, and we haven't heard of any major payment problems," says Robert Tennant, director of health information technology policy for the Medical Group Management Association (MGMA) in Washington.

It will take a full year for MGMA to develop a comprehensive snapshot of the financial impact of the ICD-10 transition, Tennant estimates, but the lack of any widespread issues suggests that all of the stakeholder groups were better prepared than expected. "Our concern was that the other parties [besides providers and payers] wouldn't be ready – claims clearinghouses, EHR vendors, billing companies, and so forth," he says. "So far the reverse of that seems to have happened."

CMS has also been bullish on the transition, announcing that the overall claims denial rate in October 2015 (10.1%) was nearly identical to the historical baseline (10%). "CMS has been carefully monitoring the transition and is pleased to report that claims are processing normally," the agency wrote in an Oct. 29 press release.

CMS: Isolated issues due to LCDs

Some Medicare contractors have denied ICD-10 claims after Oct. 1 due to problems with some front-end local coverage determination (LCD) edits that didn't allow ICD-10 codes to be used. CMS has ordered claims affected by these edits to be "suspended" until its contractors roll out system fixes.

"In most cases, claims inappropriately rejected or denied have been automatically reprocessed and no action is required by the provider," the agency stated in a fact sheet on the LCD edits issue. Medicare contractors (MACs) will have a permanent fix for their systems in place by Jan. 4, 2016.

(continued on pg. 2)

Payers are taking it easy on providers

While providers are still taking productivity hit because of the additional time required to choose ICD-10 codes and become familiar with them, the transition has been far less painful than feared, says Stanley Nachimson, a former Senior Technical Advisor for Health IT at CMS who is now CEO of Nachimson Advisors in Reisterstown, Md.

One reason for the relatively painless transition is that many payers are deliberately using diagnosis code edits that are approximately the same level of specificity as they were under ICD-9, Nachimson believes. "For the first year, it makes sense that they might allow more unspecified codes," he says. "They're certainly not interested in putting providers out of business, and we know it's costly to both payers and providers to deal with lots of denials."

The MGMA's Tennant agrees. "It would be counterproductive for them to have ICD-10 codes coming in for the right [code] family, but engage in full-scale rejections just because they can," he says. "That would result in a ton of phone calls, appeals, and adjudications."

Representatives from UnitedHealth and Humana, two of the nation's largest payers, explained at a recent MGMA conference that they had deliberately adopted "relaxed edits" on the front end to minimize the chances of claim rejections due to ICD-10 so long as providers used codes from a reasonable code family for the diagnosis. While this is similar to the CMS "grace period" policy, which is in place for the first year of ICD-10, UnitedHealth and Humana are applying these relaxed edits on a pre-payment basis while the CMS grace period applies to post-payment reviews, Tennant explains.

At some point, UnitedHealth and Humana will activate stricter edits, and the MGMA has requested that they announce any such changes to providers before implementing them. "We certainly hope they will engage in outreach beforehand," Tennant says.

Steps you can take to prepare for 'hard' edits

In the meantime, Tennant advises all practices to take a proactive approach before the payers take off the kid gloves.

1. **Identify your most-used codes.** Use your EHR, practice management system, or reach out to your claims clearinghouse and get a report of your top ICD-10 codes.
2. **Categorize your codes.** Break your top codes into three categories – paid without incident, rejected, or on hold pending additional information.
3. **Identify problems.** For the ICD-10 codes associated with rejected or delayed claims, are they coded in that right family? Could they be more specific? Are there payer-specific LCDs that require more detail for those codes?

These measures will help improve your ICD-10 coding and make both your administrative staff and clinicians more familiar with the ICD-10 diagnoses they'll use most commonly, Tennant says, but you shouldn't expect to get back to 100% for a long time. "We're not going to get to the productivity levels we had under ICD-9 anytime soon," he says. In Canada, which transitioned to ICD-10 from 2001 to 2004, providers reported needing anywhere from 18 months to two years to return to full productivity.

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CODING

What you need to know about fracture codes in ICD-10

In the world of ICD-10-CM, details are everything, and this means you have to collect more information in order to select the proper diagnosis code. For orthopedics, fractures and other types of injuries are among the most common diagnoses – but they are also the most detail-intensive from an ICD-10 perspective. In this article, we'll take a look at the information required for ICD-10 coding in the orthopedic sphere, and how you can alter your workflow to adapt.

Fractures in ICD-10

Fracture care is an orthopedic mainstay and you'll need to collect quite a few data points to create a high-specificity ICD-10 code for a fracture. Let's take a look at what goes into an ICD-10-CM diagnosis for a fracture.

1. Specify lateral side in each and every case
2. Document type of fracture
    a. Open
    b. Closed
    c. Pathologic
    d. Stress/Fatigue
        - Displaced or nondisplaced
3. Specify the location of the fracture
    a. Head
    b. Shaft
    c. Distal
    d. Proximal
4. Document the pattern
    a. Transverse
    b. Oblique
    c. Segmental
5. Specify the encounter type
    a. Initial (use seventh digit "A")
    b. Subsequent (use seventh digit "D")
    c. Sequela (use seventh digit "S")
6. Document the status in the post-op period at time of subsequent encounters
    a. Routine healing
    b. Delayed healing
    c. Nonunion
    d. Malunion

Example: Patient comes in for initial treatment of a stress fracture of the hip, where the pattern is transverse-posterior. The correct code is **S32.461A** (displaced associated transverse-posterior fracture of right acetabulum, initial encounter for closed fracture).

Open fractures in ICD-10

There's an extra level of detail with open fractures in ICD-10. There's something called the Gustilo open fracture classification system, which categorizes open fractures into three types based on the cause of injury, extent of soft tissue damage, and amount of bone damage. The classes are I, II, and III, with class III further subdivided into A, B, or C.

The extensions available for these open fractures are:

- B, Initial encounter for open fracture type I or II
- C, Initial encounter for open fracture type IIIA, IIIB, or IIIC
- E, Subsequent encounter for open fracture type I or II with routine healing
- F, Subsequent encounter for open fracture type IIIA, IIIB, or IIIC with routine healing
- H, Subsequent encounter for open fracture type I or II with delayed healing

- J, Subsequent encounter for open fracture type IIIA, IIIB, or IIIC with delayed healing
- M, Subsequent encounter for open fracture type I or II with nonunion
- N, Subsequent encounter for open fracture type IIIA, IIIB, or IIIC with nonunion
- Q, Subsequent encounter for open fracture type I or II with malunion
- R, Subsequent encounter for open fracture type IIIA, IIIB, or IIIC with malunion

Tip: If a fracture isn't indicated as displaced or nondisplaced, you should default to coding it as displaced. If a fracture isn't indicated as open or closed, you should default to closed.

As your providers adjust to the post-ICD-10 world, you'll need to pay extra attention to the information they capture in their documentation. For a fracture, changing their habit to always recording the pattern in addition to laterality and type will be a huge time-saver. Similar adaptations will be necessary for all of your top diagnoses.

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ACCOUNTING

Physician compensation models and expenses

One of the most important decisions that a growing medical practice must make is how to compensate its providers. When a practice has only one provider, the compensation model is very simple. Revenue is received, expenses are paid, and any funds remaining are paid to the owner. However, when new providers (whether they are associates or partners) join the practice, the compensation model suddenly becomes more complex. There are many different ways for the income and expenses to be split and all of them have pros and cons. This article will discuss the "eat what you kill" (also known as the "eat what you treat") model. While there are many other ways to split the profits of a medical practice, this model has become the most popular in smaller, physician-owned practices.

Under the "eat what you kill" model, each provider is allocated 100% of his/her professional receipts. From that, expenses are taken and a bottom line amount is calculated. This bottom line becomes the compensation available to that provider. Separating the income is fairly simple with the caveat that Stark and other Medicare fraud and abuse laws must be observed. Because each provider is uniquely identified in the billing system of the practice, a report can be run each month showing each provider's professional collections. The ease and accuracy for calculating receipts is one of the major benefits of this method. On the other hand, splitting expenses can become difficult and requires some careful planning.

It is easy to understand that a physician who saw a patient should receive the money paid to the practice on behalf of that patient. It is less obvious how expenses should be split among physicians. When tracking expenses, it is important to remember that sometimes we will not know exactly who incurred the expenses, and other times it will be cost-prohibitive to calculate the precise amount incurred by each individual provider. Some view these approximations and proxy calculations as a downside of this model.

Categorizing expenses

When allocating expenses among the providers, we usually recommend using a combination of three categories for expenses, although it varies by practice. The first category contains expenses shared equally. This would normally include administrative staff, accounting, and rent. Because the providers are essentially sharing these expenses close to equally, the expense is divided evenly among them. For example, if we have a practice with three owners, then each owner would be allocated 33% of the wages for the office manager.

The next category contains expenses split pro rata. These are expenses that are not used equally and may include medical supplies, billing staff and nursing staff. When splitting these expenses, we want to use a variable that would approximate who incurred the expense. Most of our practices choose to do this based on collections but others use number of patients or half-days worked. It depends on the practice which is the best method. For example, if a provider is collecting 45% of the revenue for a practice, he/she would be allocated 45% of the billing expenses. This is an approximation for ease of understanding and accounting. While we *could* track the exact number of patients billed or have the billing staff clock in for each physician, these measures may be costly and reduce

efficiencies practice-wide. We generally try to avoid making a system less efficient simply for cost accounting purposes.

The third category is direct expenses. This category consists of expenses that can be easily traced to an individual provider and that the practice would probably not incur without that provider. The simplest examples are malpractice insurance and continuing education. If that provider did not work for the practice, these expenses for him/her would not exist. Therefore, we allocate that cost to the provider.

At the end of the month, a provider is allocated his/her collections, then the equally shared expenses are split equally, the pro rata expenses are split based on collections (or some other variable), and finally the direct expenses are allocated. Once this is done, each provider will have a bottom line number and that will be the compensation due to them. As your practice grows, it is important to meet with your advisors to find a compensation model that fits the needs of your specialty and the providers in your group.

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COMPLIANCE

Two major Stark changes you need to know about in 2016

CMS is relaxing some of the burdens associated with the "Stark Law," also known as the physician self-referral law. Several new exceptions are being created and CMS is also clarifying some of the longstanding provisions. The first will allow hospitals, federally qualified health centers and rural health clinics to pay physicians who employ NPPs.The 2016 final rule also creates a new exception for timeshare arrangements where hospitals or physician organizations share support staff, office space, equipment, supplies, and other items with physicians.

These changes are being implemented on Jan. 1, 2016, as part of the Medicare Physician Fee Schedule final rule for 2016.

Let's take a detailed look at the two major changes to Stark Law that you should be aware of.

1. Compensation for NPPs. CMS is adding a new exception to the Stark Law for compensating non-physician practitioners (NPPs). Hospitals, federally qualified health centers (FQHCs), and rural health clinics (RHCs) may compensate physicians for employing NPPs in the geographic service area of the hospital, health center, or clinic. Prior to this exception, Stark allowed hospitals and other organizations to pay physicians to relocate to their service area, but not NPPs to relocate. CMS is making this change due to the demand for NPPs not just in primary care, but for surgical specialties such as orthopaedics as well.

- Six types of NPPs are included under the new exception: physician assistants, nurse practitioners, clinical nurse specialists, certified nurse midwives, clinical social workers, and clinical psychologists.
- To qualify for this exception, at least 75% of the NPP's services must be primary care and/or mental health in nature.
- The compensation arrangement with the physician must meet existing Stark provisions, such as having to be in writing and signed by the hospital (or FQHC or RHC), physician, and NPP. The compensation agreement can't be based on on the physician or NPP's referral of patients to the hospital, FQHC, or RHC,

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April 17-20	**2016 HCCA 20th Annual Compliance Institute,** Las Vegas, NV – Staff TBD
June 9-12	**2016 American Academy of Orthopaedic Executives Annual Conference,** San Francisco, CA – Shannon DeConda

and the amount of actual monies involved can't be determined by the volume of referrals to the hospital, FQHC, or RHC. A record of the arrangement must be maintained for at least six years and be available to CMS during that time.

2. Timeshare arrangements. This is a new exception for "timeshare" arrangements, where a visiting physician pays a hospital or physician organization for the right to use office space, equipment, and personnel periodically. Such timeshare arranges are already being used in rural or underserved areas where there just isn't enough patient demand for specialists to support a single full-time practice. The timeshare arrangement exception is not the same as leasing agreements, which are already covered by an existing Stark exception, CMS writes in the PFS final rule. These existing lease arrangements remain unchanged in 2016, and the timeshare arrangement is simply a new option for providers and hospital groups.

- The space, equipment, and personnel must be used "predominantly to furnish evaluation and management (E/M) services to patients" according to CMS. The equipment included in the timeshare may not include advanced imaging equipment, radiation therapy equipment, or clinical or pathology laboratory equipment (other than those used for CLIA-waived tests).
- Like the new NPP exception, a timeshare arrangement must also be in writing, signed by all parties, and list in detail the space, equipment, personnel and other items being shared.
- Again, in keeping with longstanding Stark provisions, the compensation for timeshare arrangements can't be based on the volume of referrals between the parties.

The PFS final rule also makes some clarifications to existing Stark language that will clarify some issues for hospitals and other large organizations, but don't alter the compliance landscape nearly as much as the two new exceptions discussed above. This includes a definition revision that affects the NPP exception.

CMS is revising the definition for "geographic area served by an FHQC or RHC" for the existing Stark physician recruitment exception (and also the newly created NPP recruitment exception). The revision defines the geographic area served by an FQHC or RHC as "the lowest number of contiguous or noncontiguous ZIP codes from which the FQHC or RHC draws at least 90% of its patients, as determined on an encounter basis." This is more specific than the current definition, which is the "area composed of the lowest number of contiguous ZIP codes from which the hospital draws at least 75% of its inpatients.

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PRACTICE MANAGEMENT

Physician perspective: Adding obesity care to your practice

If your independent medical practice is like many across the nation, you may be challenged by some common but difficult issues:

- Slowing or falling revenues
- Heavy caseloads of patients with preventable chronic conditions
- A sense you're falling short of helping all your patients get healthier

In 2009, I faced these problems. I needed to find an effective, credible way to increase revenue and improve my patients' health outcomes through the practice of clinically-proven, sound medical treatment.

To accomplish my goals, I focused on obesity medicine. As decades of research have demonstrated, obesity is a major contributor to, or root cause of, more than 59 chronic conditions. It affects close to 40% of adults with another 30% classified as overweight. However, many providers feel ill-equipped to effectively treat obesity as a disease and are often uncomfortable having discussions about the health risks associated with obesity. Yet your patients spend lots of money outside your practice on ineffective commercial weight loss options that fail 95% of the time.

Integrating obesity care into your practice

Many of my patients needed help losing weight, and it was clinically-proven that weight reduction has a direct positive impact on health. A modest 5% weight loss reduces the health risks associated with obesity.

I knew my patients would trust my treatment recommendations for weight management and obesity, but first I needed to find a program that would provide me with the training and knowledge necessary to increase my confidence in delivering obesity care, and one that had clinical proof of its efficacy.

After extensive research, I decided to integrate a medical weight loss program into my family practice in July 2010. It combined cash payments from patients with insurance coverage. In 2010, I became my first patient, losing 25 pounds, and I've maintained my new weight..

Fortunately, I had a built-in patient base for weight loss services, so I took some simple steps to start generating awareness of my new medical weight loss program:

1. Placed signage throughout the office.
2. Identified high-risk patients and scheduled screenings.
3. Discussed the program with patients during office visits.

Outcomes: Improved revenue, patient satisfaction

The results of my initial activity exceeded my expectations. I launched my weight loss program in August 2010 planning to see two to three weight loss patients per week. Due to overwhelming response, I needed to expand my plan to see two to three weight loss patients per day. In six months I had outgrown my space, found a larger office, and hired a nurse practitioner to help administer the program, which doubled my weight loss program's incremental monthly gross revenue from $10,000 to $20,000, while only practicing obesity medicine part time. Since my launch, insurance reimbursement for obesity counseling has been implemented at favorable levels, making care more accessible and revenue potential even higher.

Obesity screenings and counseling visits can generate double the typical visitation fee, and since its classified as preventive care, up to 26 visits can occur annually.

Most importantly, the results my patients achieve mirror a clinical study that was published in The American Journal of Medicine. My patients average 11% weight loss in 12 weeks, and those continuing with a maintenance plan, achieve15% at one year and maintain 12% at two years.

My experience integrating a medical weight loss program and in helping many providers do the same, has convinced me that physician-directed obesity treatment is a viable, scalable business opportunity.

Concluding thoughts

The need and support for provider-directed obesity care continues to grow. We are in the best position to make a difference – for our patients and for our own bottom lines.

- Obesity medicine is a high-growth area
- Policymakers support medical obesity care:
  - The Centers for Disease Control and Prevention (CDC) recognizes obesity as a national epidemic
  - CMS initiated favorable reimbursement for behavioral counseling

New DoctorsManagement clients	
Client	**Services provided**
Pain management group, NC	Managed care review and negotiations
Solo practitioner, FL	Practice start-up
Vascular group, IL	Compensation review
Internal medicine practice, TX	Practice start-up
Urgent care group	New provider enrollment
Integrative medicine group	New provider enrollment
Interventional vascular group, FL	New provider enrollment
Rheumatology and internal medicine group, GA	New provider enrollment
OB/GYN practice, AL	OSHA and HIPAA services
9,512 total providers enrolled in the Compliance Risk Analyzer (CRA) program	

- The United States Preventive Services Task Force (USPSTF) recommends annual obesity screening for adults and treatment for patients with 30+ body mass index (BMIs)
- The AMA recognizes obesity as a disease state
- The Affordable Care Act (ACA) includes obesity screening and ongoing treatment as preventive care.

- Return on investment happens swiftly, with the ability to double monthly gross revenue in months

Patients seek effective, long-term, safe approaches and will not be dissuaded by cost if they understand value to their overall health. Physician-directed weight loss, integrated into your practice as a comprehensive program, offers your providers the opportunity to practice sound preventive medicine, a goal of the ACA. If your patient population could benefit from weight loss – and most probably can, given the national statistics – you should consider this new business opportunity.

— Matthew Pinto, MD. The author is Medical Director for The Center for Medical Weight Loss and a board-certified family medicine physician.

MEDICARE RULES

Bundle up: CMS releases final rule for bundled joint replacements

CMS has finally released the final rule for its Comprehensive Care for Joint Replacement (CJR) program, a complex pay-for-performance experiment that will bundle lower extremity (hip and knee) joint replacements for five years in 67 areas nationwide starting April 1, 2016.

The final rule (click here to view PDF online) makes a few concessions to provider complaints, which centered around the fact that the program is mandatory, yet is being rushed into action, with fewer than six months between the release of the proposed rule and the proposed implementation date of Jan. 1, 2016. In its final rule, CMS pushed that date back to April 1 and also reduced the number of affected geographic areas from 75 to 67 (metropolitan service areas or MSAs).

The program is limited to five years, during which affected hospitals will continue to receive fee-for-service Medicare payments, CMS will calculate actual episode payments and compare them against CJR payment targets. If the actual costs were greater for a hospital, CMS will demand repayment from those hospitals. If the actual costs were less, CMS will make a "reconciliation payment" to the cost-saving hospitals based on the difference. Overall, CMS is projecting a cost savings of $343 million over the five years.

While the CJR program will end after the five years are up, if CMS achieves anything close to its projected savings without negatively impacting patient outcomes, the agency is likely to make the CJR model permanent and expand it.

When and how bundling is applied

The bundling will affect inpatients admitted to the hospitals located in the 67 selected areas. A lower extremity joint replacement (LEJR) episode of care would begin when a Medicare patient is admitted to a hospital being paid under the Inpatient Prospective Payment System (IPPS) and is discharged under the relevant diagnostic related group or DRG.

The LEJR episode would last for 90 days following discharge, and all Part A and Part B services related to the LEJR would be covered by the episode. In fact, hospitalizations and practically all services within the 90-day period would be covered by the bundled payment. The hospital that bills the relevant DRG assumes the financial risk and rewards. At the end of each year, CMS will compare the hospital's actual spending against target spending to determine whether the hospital gets a bonus payment or a recoupment demand.

Hedging against losses

The cost sharing won't take effect till the second year, thus participating hospitals will be protected from any negative costs in the first year, giving them time to make changes that reduce costs. As a further hedge against excessive negative financial impact, a stop-loss limit will be in effect from year 2 and beyond to protect hospitals. A matching stop-gain limit will also be in effect from year 2 forward to protect CMS. Patients can't choose to opt out of the CJR program unless they switch their care to another, non-participating hospital. You can view the 67 geographic areas being targeted in the proposed rule by visiting CMS' website on CJR here. Any hospital being paid under IPPS in the 67 MSAs will be subject to the CJR program.

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