Vol. 4, Issue 2

The Business of Medicine

Leave the business of medicine to us

MEDICARE RULES

Q&A: CMS clarifies meaningful use hardship application process

You have until March 15 to submit your application for a hardship exemption from Medicare's EHR meaningful use payment penalties, and it's important to understand the recently revised application process.

Many practices were confused about having no obvious option on the hardship application form to choose if they were unable to attest in 2015 due to CMS actions. Others were confused about the numerous deadline dates for the hardship exemption, especially after Congress passed a bill that required CMS to expedite hardship applications.

Below is a list of clarifications obtained by *The Business of Medicine* from conversations with CMS officials. The hardship application form is in PDF format and available here.

Remember: The hardship application pertains to the 2015 meaningful use (MU) reporting period, which CMS will use to determine payment adjustments for 2017. If you are facing MU payment penalties for this year (you'll know because CMS will send you a letter), those penalties are based on the 2014 reporting period, and you can still try to appeal them by using a "reconsideration" form available here. All reconsiderations must be submitted to CMS by Feb. 29.

***The Business of Medicine*: What's the final deadline date for eligible providers (EPs)?** Previously CMS had indicated a deadline of July 1, 2016, for its case-by-case process of reviewing EP hardship applications. However in the law recently passed by Congress, CMS is given wider authority to grant exemptions, and to do so more quickly than "case-by-case," but with a deadline of March 15. Can you explain whether the July 1 date has any relevance now?

CMS: Applications for eligible professionals will be due on March 15, 2016 and April 1, 2016 for eligible hospitals and critical access hospitals.

(continued on pg. 2)

***The Business of Medicine*: Which hardship option should EPs choose if they were impacted by CMS rulemaking?** If an EP was affected by late CMS rulemaking that altered measures and reverted the reporting period from 365 days to a 90-day period for 2015, which hardship option should be chosen? Can CMS confirm that "2.2.d" is the correct option in these cases?

CMS: Yes, that is correct.

***The Business of Medicine*: How will CMS determine eligibility?** For EPs who choose 2.2.d, how will CMS decide whether to grant the hardship? Will the EP be required to produce information to support this?

CMS: We will review each application submitted and determine whether the provider has demonstrated that their circumstances poses a significant barrier to achieve meaningful use. CMS is not requiring an EP to provide any documentation.

***The Business of Medicine*: How long will it take for CMS to make a decision?** With a March 15 deadline, how long will CMS take to grant or deny an application, approximately? Is it a matter of days, weeks, or months?

CMS: We plan on reviewing and approving each application on a rolling basis. Determinations will be sent out within the next 30 to 90 days.

Hardship exemption won't be 'blanket'

Previously, the hardship exemption was being referred to as a "blanket" exemption because the Congressional action was intended to give CMS wider authority to grant exemptions, but the actual application form doesn't mention any such broad scope, says Bradley Coffey, government affairs manager for AAOE in Indianapolis, Ind. "CMS has made it clear to us that this is not a blanket exemption, it is not intended to give any provider the chance to get out of a year of meaningful use," he says. "It was written to give providers an exemption for specific hardships."

The form also contains an ominous legal disclaimer that reads "NOTICE: Anyone who misrepresents or falsifies essential information to receive payment from Federal funds requested by this application may upon conviction be subject to fine and imprisonment under applicable Federal laws."

If you didn't intend to attest to meaningful use in 2015, but try to claim an exemption, it's lying to a federal agency which comes with hefty penalties, Coffey says. "To be safe, you should claim the exemption only if you really do have an EHR system, and did intend to meet meaningful use."

— Grant Huang, CPC, CPMA (ghuang@drsmgmt.com). The author is Director of Content at DoctorsManagement.

ACCOUNTING

What Obama's new bipartisan tax law means for physicians

On December 18, 2015, President Obama signed the Protecting Americans from Tax Hikes (PATH) bill into law, a bipartisan agreement that extended many tax provisions either two or five years, and made several other provisions permanent. What does this mean? For the first time in many years, business owners are able to forecast and plan with some idea of what the tax affect may be for an extended horizon.

Twenty-two provisions were made permanent, four provisions were extended five years through 2019, and another 30 were extended two years through 2016. This law extends both business and individual provisions. This article will summarize the provisions most likely to affect physicians, both at a practice and individual level.

Three items were made permanent that will affect many physician practices:

- Increased Section 179 expensing;
- A 15-year depreciable life for improvement made to leaseholds; and,
- Five-year holding periods for built-in gain taxes when C-corporations convert to S-corporations.

Section 179 expenses

Section 179 expense is an election that can be used to expense tangible personal property in the year it is purchased instead of depreciating it over the course of its useful life. While the expense amount has increased since 2002 from $25,000 to a $500,000 limit, it has always

been treated as a temporary extender in any tax bill. Now, beginning January 1, 2015 forward, this is a permanent item. Business owners can elect to expense up to $500,000 of asset purchases if no more than $2,000,000 in assets were placed in service that year. In short, it is a huge win for small business owners like physician-owned practices.

Depreciation period

A second item that has been made permanent is the fifteen-year depreciation period for leasehold improvements. Former law required these to be depreciated over thirty-nine years. Improvements made to a leasehold in a buildings that is three years old or older and are not structural or enlargements of the building will qualify. As most physician owned practices do not own the building inside the legal entity, this allows for faster expensing of the cost of the leasehold improvements. However, a caveat to this is it does not apply if the lessor/lessee agreement is between related parties.

Gains taxes

Finally, the third item that has been made permanent is the holding period for the built-in gains tax when a C-corporation converts to an S-corporation. When a C-corp converts to an S-corp, a period exists for how long the S-corp must maintain ownership of the assets it owned at the time of conversion. If these assets are sold within that period for a gain, a tax of 35% (the C-corp tax rate) would be assessed on the gain. Previously, that holding period has been ten years. Prior law changes have shortened this to seven years and then five, but at the end of 2014, the law expired and the period reverted back to ten years. Under PATH, the holding period is now five years and permanent law. This is a huge win for practices that have converted to an S-corporation and own many pieces of equipment, or those practices that own the office space they use to operate.

Other provisions

Additionally, other provisions were not made permanent, but have been extended. One popular business deduction that fits into this category is bonus depreciation, which was extended through 2019. Property purchased that is new (i.e., cannot be used) has a depreciation life of less than 20 years, off-the-shelf computer software, and qualified leasehold improvements can all get bonus depreciation. Property placed in service in 2015, 2016, and 2017 may

Meet DoctorsManagement

Visit www.doctors-management.com for details today.

March 2-4	**Association of Dermatology Administrators and Managers Annual Meeting,** Washington, D.C. – DoctorsManagement booth #29
April 14	**Audit Risk Webinar (free, 1.5 CEUs included),** 2pm to 3pm ET – Frank Cohen
June 1-2	**Practice Management Institute Conference,** New Orleans, LA – Shannon DeConda
June 12	**AAOE Webinar, "Evaluation and Management Services and Always Selecting the Right Level,"** 11am to 12pm ET – Sean Weiss
Aug. 9	**Webinar, "Physician Auditing for the Facility Coder/Auditor,"** 1pm to 2pm ET – Shannon DeConda
Oct. 8-9	**American Billing Association National Conference,** Las Vegas, NV – Shannon DeConda
Oct. 11-12	**HCCA Clinical Practice Compliance Conference,** Philadelphia, PA – Frank Cohen
Oct. 13-14	**MGMA 2015 Annual Conference,** Nashville, TN – Frank Cohen
Nov. 4	**Practice Management Institute 2015 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

have bonus depreciation of 50%. Property placed in service in 2018 is allowed 40%, and property placed in service in 2019 is allowed 30%. Taxpayers are allowed to take both section 179 and bonus depreciation in the same year; it is no longer one or the other.

Several popular individual tax deductions were also extended including deductions and credits. Some items that were made permanent are the child tax credit, the deduction for teachers purchasing items for their classrooms, the deduction for state and local sales taxes, and the ability to have tax free transfers from an IRA to charity. Items that were extended two years through 2016 are forgiveness from debt relief on a principal residence, a deduction for mortgage insurance premiums, and the deduction for qualified tuition and related expenses. It should be noted that many of these provisions do face income limitations, and will be phased out or disallowed if income exceeds certain thresholds.

In summary, this law is very friendly and beneficial for taxpayers. Please contact the DoctorsManagement accounting team to make sure you are taking advantage of these opportunities to the fullest extent possible.

— Nick Meals, CPA, CVA (nmeals@drsmgmt.com). The author is a Management Consultant at DoctorsManagement.

PRACTICE MANAGEMENT

CureMD™
Practice without boundaries

5 things to look for from your EHR vendor

Electronic health records (EHRs) are here to stay, even as many EHR vendors are starting up, shutting down, or offering new products. EHRs have gotten a mixed reception from providers and practices, with many complaints lingering long after implementation.

Compare this to the generally high satisfaction ratings of billing and revenue cycle management (RCM) systems, which have been around for longer than EHRs, and you'll see that there is a different design philosophy for these types of products.

With Medicare's meaningful use program facing a major transformation, even as CMS prepares to implement Stage 3, let's take a look at the qualities that a good EHR vendor and product should have, that most RCM and practice management software vendors already have.

If your current vendor doesn't have them, it may be time to consider a change, with an eye toward a future that is guaranteed to see increased adoption of health information technology.

1. A tendency to eliminate pain points and not add more. One of the biggest issues raised against EHR systems is that they impede workflow. Physicians must spend an inordinate amount of time performing tasks that they found simple on paper. Rather than help reduce the amount of steps for a task, EHR systems add more. Looking at RCM systems, they are designed to make providers' lives as easy as possible. Every function exists because there was a demand for it. Practices that do not like those functions can usually ignore them without the system getting upset or refusing to save changes made. A good EHR should try to emulate this approach by having different levels of specificity for physicians and their staff. They should allow for more fields to be left blank and

still have a valid record that saves changes. In fact, good EHR system allow an option to hide these fields until the physician asks for them. For example, clinical conditions that have no lateral diagnosis shouldn't even ask for one. Naturally, the trend towards excess specificity can be attributed to the ICD-10 transition, but EHR systems are still guilty of asking for too much information and requiring too many clicks to perform simple actions.

2. An implementation process that follows actual provider workflow. One of the biggest sources of EHR complaints is the fact that, to implement them, many physicians must rebuild their workflow process from scratch. EHR systems are demanding details before the patient is even fully admitted, requiring staff to ask more personal questions than before, some of which the patient is not capable of answering. The end goal is that patients will receive more outcome-focused treatment as a result of their condition being outlined earlier, but not everyone has symptoms that comply with this "expediency." Instead, workflow is disrupted and frustrated, making providers yearn for the days when they could do it their own way. A good EHR vendor should actively solicit feedback from providers to create more intuitive workflow structures for their systems. Better yet, they should allow physicians and staff to have options for modifying workflow that don't get in the way of critical functions. When EHRs are configured to work within existing processes, they can become a boon rather than a burden.

3. An ability to talk with many other systems. There's a huge gap in the usability of RCM systems compared to EHRs, which can make EHRs feel dated. Your EHR system can often feel isolated because it's difficult to communicate with your other systems like coding, billing or patient intake. This problem stems from the fact that EHR software development is still in its infancy, whereas RCM software evolved from enterprise-level financial software that was scaled down and made more user-friendly. EHRs must go through the same transition and learn to play nice with the other systems. Look for a vendor that talks about interoperability and prioritizes this function.

4. A flexible platform that lets providers use many devices. Even in 2016, many EHR systems aren't compatible with mobile devices, or won't work with certain Internet browsers on computers. When vendors force users out of their comfort zone into their systems' preferred environment, they generate friction and reduce productivity. While EHRs have become more compatible, they aren't up to par with other systems like RCM or content-management systems like WordPress. Look for

New DoctorsManagement clients	
Client	**Services provided**
Mohs surgery specialists, FL	Valuation consulting
Internal medicine group, GA	Practice management
Oral and maxillofacial group, PA	Practice assessment, ongoing management
Pediatric group, GA	Practice assessment
Urgent care group, FL	Analytics and reports
Pain management practice, AR	Analytics and reports
Multispecialty group, OH	Analytics and reports
Cardiology group	Post-audit extrapolation
Heart and vascular group, NC	Credentialing services
Lifestyle medicine practice, NY	Medicare and Medicaid enrollment
Dermatology practice, OH	CLIA services
Medical imaging group, FL	HIPAA audit
ENT group, FL	HIPAA services
6,735 new providers added to Compliance Risk Analyzer (CRA) program	

an EHR vendor with products that give your providers the freedom to use mobile devices such as phones and tablets so they aren't tied to workstations and can get more face-time in close proximity to patients.

5. A robust support service for training and troubleshooting. EHR systems are still relatively new, so both your providers and staff will need many hours of training before they become comfortable using them and maximizing their efficiency. Many EHR vendors simply seem to accept that any EHR transition is going to be tough, and leave their customers to sink or swim. The reality is that their customers need hand-holding, and many usability issues are due to bad design by non-clinicians rather than user error. Look for EHR vendors who provide a high level of hands-on support in the form of live representatives, free online training, and fast technical support when problems arise. Just like any business, the more proactive a vendor is about responding to problems, the better their customer satisfaction.

EHRs have room to grow and learn from RCM

As mentioned earlier, EHR systems have many conceptual and design differences from RCM systems, but they can still learn from each other. Currently, a lack of effective, forward-thinking EHR vendors, along with providers' understandable reluctance to switch systems and suffer through implementation again, even when they're unhappy with what they have, is a source of ongoing frustration from providers.

As EHRs mature, look for a few market disrupters to set a new, much higher standard for how EHRs work within providers' processes instead of the other way round. There will be an EHR parallel to iPhones – a product that made smartphones accessible to mainstream consumers. Until then, all providers can do is make customization requests of their vendors, or simply jump ship and find a vendor that embodies the five desirable traits above.

— Danial Schwartz is a content strategist who sheds light on various engaging and informative topics related to the health IT industry. He is passionate about topics such as Affordable Care Act, EHR, revenue cycle management, and privacy and security of patient health data. He can be contacted at https://twitter.com/dschwartz20.

REVENUE CYCLE MANAGEMENT

Boosting practice income with office-based surgery

As practice reimbursement continues to decline, many physicians are considering alternative solutions to increase revenue streams. While many surgical procedures were once performed solely in a hospital outpatient facility or ambulatory surgical center setting, advances in equipment and techniques have made it possible to perform complex procedures in the office setting. This scenario benefits all the stakeholders: patients, physicians, and payers.

Office-based surgery centers vs. ASCs

Office-based surgery is any surgical procedure performed by a licensed physician in the office setting. It differs from ambulatory surgery centers (ASCs) in that it's legally considered an extension of the physician's office and therefore doesn't require Article 28 certification.

Place of service code 11 ("non-facility") is used and global billing applies, which means higher reimbursement because payment is combined for professional and technical components of procedures.

Case study: Vascular surgery

Vascular specialists have seen a steady decline in their professional fees every year for the past decade. Given the scope of the decline, it wouldn't be feasible for many vascular specialists to derive their revenue solely from hospital-based services.

For example, in 2016, Medicare's national physician payment amount for CPT **37227** (revascularization, endovascular, open or percutaneous, femoral/popliteal artery(s), unilateral; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed) is **$786 in the hospital setting** vs. **$15,151 in the office setting (global payment).**

Since almost all peripheral diagnostic and interventional procedures involving angioplasty, stent, atherectomy, and thrombectomy can now be performed be in the physician office, this could be an attractive option to capture more revenue, as well as boost productivity, all while enhancing the overall patient care experience.

Again, vascular surgery is just one example. Many other specialties could potentially benefit from adding office-based surgery, including:

- Anesthesiology
- Dermatology
- ENT
- Interventional cardiology and/or radiology
- Gynecology
- Pain management
- Plastics
- Urology

Quality care rendered at the lowest cost setting obviously helps improve effectiveness for the entire system. Additionally, office procedures offer improved convenience, comfort and access to patients.

Logistics for office-based surgery

From a consumer standpoint, the main issue is whether the office is an appropriate setting for the type of surgery proposed. Is the staff trained? Is the equipment appropriate? As we see more types of surgery migrate to the office setting, it's important to ensure that procedures are done safely by qualified staff and that all patient experiences in the office setting, good and bad, are reported.

Many states have implemented regulations to promote the safety and quality of surgical procedures performed in office settings. These state-specific criteria must be met by physicians who wish to offer office-based surgery. Some states follow AMA guidelines and require a physician's office to be accredited by a nationally recognized accreditation agency when performing surgical procedures requiring Level II anesthesia (moderate or "conscious" sedation) or higher. It is important to know your state's regulations regarding office-based surgical procedures.

For clinicians seeking ways to regain control of their busy schedules and strive to improve their service offering to patients, an office-based surgery suite can prove extremely beneficial. Providers can reclaim some of their bargaining power with payers and hospitals while exercising better control

of their workflow and improving their income and patient outcomes. If you are considering office-based surgery suites, DoctorsManagement can help simplify the process and reduce setup time and cost while ensuring high-quality patient care.

— Alycia Viscardi, RN, LHRM (aviscardi@drsmgmt.com). The author is a Senior Management Consultant at DoctorsManagement.

COMPLIANCE

Experts: Meaningful use isn't dying anytime soon

Recently, CMS officials announced that Medicare's EHR Meaningful Use (MU) program is going away. "In 2016, meaningful use, as it has existed, will now be effectively over and replaced with something better," CMS Acting Administrator Andy Slavitt wrote in a Twitter post heard around the healthcare industry.

But this seemingly bold pronouncement has practically no near-term implications for how your practice approaches meaningful use attestation and EHR usage, experts tell *The Business of Medicine*.

While the industry reacted strongly to Slavitt's Twitter comments, with many physicians cheering the perceived death of meaningful use, CMS posted a clarifying blog article weeks later that appeared to soften Slavitt's words.

In the blog post, CMS talks about a "transition from the staged meaningful use phase to the new program as it will look under MACRA," the acronym for the Medicare Access and CHIP Reauthorization Act of 2015, also known as the official Sustainable Growth Rate (SGR) repeal law.

In addition to the removal of SGR, MACRA creates a larger umbrella program called the Merit-Based Incentive Payment System (MIPS), which will encompass not just meaningful use, but also PQRS, Physician Compare, and more.

Initially, Slavitt's Twitter posts "caused a lot of panic among vendors and providers," says Stanley Nachimson, a former Senior Technical Advisor for Health IT at CMS who is now CEO of Nachimson Advisors in Reisterstown, Md. "Then CMS really walked that backwards to say they're not killing meaningful use, they know there's problems with it and they're going to try to address them."

In the meantime, don't expect Stage 3 of the MU program to simply disappear, Nachimson says. "CMS has already said that stage 3 of the MU program is still going to happen, although it's possible that changes could be made as part of this new process."

Look for the agency to release a proposed rule for MIPS at the end of March that will contain changes to the MU program. The proposed rule will offer details on CMS' approach and will also be an opportunity for people to use the comment period and give feedback, Nachimson says.

Meaningful use will have more meaning

The move by CMS is a response to provider complaints and criticisms of the MU program, which include workflow disruption and compliance risks, says Sean Weiss, partner and chief compliance officer with DoctorsManagement.

Providers who attest to meaningful use and earn an incentive payment can have their attestation audited, and be asked to return large amounts of incentive money, Weiss says. Also, the initial stage 1 rules were so convoluted that successful attestation was difficult, while first-generation EHRs were hard for providers to implement and disrupted their workflow.

Finally, physician coding and documentation has been negatively impacted "because many EHRs are configured to produce much beefier documentation than physicians would create on paper records," Weiss says. The result is more aggressive code selection and billing, which raises providers' audit liability.

All of these concerns have given many practices a reason to avoid EHR adoption and/or MU participation for as long as possible, Weiss says.

The good news is, CMS has been spurred into action, and providers can hope for MIPS to advance the program with more provider input.

"So the reports of the death of meaningful use were certainly premature, and we will be living with this program, as it evolves for a number of years," Nachimson says. "Don't throw away your EHR because you will still need it."

— Grant Huang, CPC, CPMA (ghuang@drsmgmt.com). The author is Director of Content at DoctorsManagement.