The risks and benefits of using E/M bell curve data

You might think you’re reducing your compliance risk by comparing your evaluation and management (E/M) coding against “bell curve” data – a collection of E/M utilization data divided by code level – but you’re better off ignoring them and coding based on E/M guidelines and your own audit results, experts say.

Practices are increasingly showing bell curve data to their physicians because the graphs are easy to understand, and because E/M services have been targeted with increasing intensity by payers of all stripes over the last decade. Most notably, the HHS Office of Inspector General (OIG) has released several reports since 2009 making the case for closer scrutiny of E/M coding.

“Audits are the number one thing you worry about,” says Joseph Mathews, practice administrator at Advanced Orthopaedics Sports Medicine in Houston. “When CMS asks for records, they’re (continued on pg. 3)
See what the auditors SEE ABOUT YOU

COMPLIANCE RISK ANALYZER®

Analyze critical risk areas
Replace probe audits
Assess risk accurately

Produce drill-down reports
Validate education efforts
Gain insight beyond raw data

To watch our video or register for a demo, visit us at www.complianceriskanalyzer.com or call (800) 635-4040 today.

www.doctors-management.com/cra

D O C T O R S®
M A N A G E M E N T
Leave the business of medicine to us
like the IRS, they’re looking to see every ‘i’ is dotted and ‘t’ is crossed.”

Mathews uses freely available Medicare E/M bell curve data from 2012 as a monthly point of comparison with his physicians. “I’m looking for patterns,” he says. “If their E/Ms are on the higher end, I tell the doctors to watch it and make sure their documentation is good. I’m not too worried if they’re on the lower end.”

Mathews augments this data review with an annual audit of randomly sampled claims by a professional external auditor who specializes in orthopaedic coding. “We never solely rely on the data, we have coding guidelines that we follow, but if doctors are falling way off the curve, that’s when we talk to them.”

Dangers of using older Medicare data

Mathews’ approach is typical of many practices, regardless of specialty, but there are two possible risks with using 2012 Medicare data, says Frank Cohen, Director of Analytics and Business Intelligence at DoctorsManagement.

“Using data that’s more than three years old is almost worthless,” he says. “You might as well just do a probe audit and make sure your docs are meeting E/M medical necessity and documentation requirements.”

While Medicare’s E/M data doesn’t change significantly year-to-year, it does shift significantly over three-year periods or longer, Cohen says.

Many practices view the Medicare bell curve as a pattern they want their providers’ coding to emulate, under the theory that if their providers fall within the curve, they are less likely to be audited. But this is a false belief because payers “are always going to have much better data, near-time claims data,” Cohen says. What’s more, payers will have data based on taxonomy codes that distinguish a spine surgeon from a general orthopaedic surgeon, and subspecialty differences can often manifest significantly different E/M patterns, Cohen says.

Finally, Medicare data is just that – Medicare-only data that doesn’t reflect utilization patterns for commercial payers, which will often feature younger patients with different levels of medical complexity and clinical issues than Medicare patients. By comparing your provider’s all-payer data against Medicare-only data, you are essentially comparing apples and oranges to begin with, Cohen points out.

Undercoding is an underrated problem

Another common belief is that if your physicians are coding lower than their peers, this isn’t a big problem because CMS doesn’t pursue underpayments as aggressively as they do overpayments. This is factually true, since Medicare’s recovery programs and contractors have identified (and recouped) far more overpayments than underpayments. But from a compliance standpoint, undercoded claims are just as much of a false claims issue as overcoded claims, Cohen says.

“All data that’s anomalous should be reviewed. CMS audits such as the [Comprehensive Error Rate Testing or CERT] program have shown that many claims are chronically underpaid,” Cohen says. “If you’re only looking at data that’s off-curve at the high end, I think you’re missing a huge revenue opportunity with lower-level codes.”

Emphasizing audits over bell curves

The compliance approach at OrthoIllinois in Rockford, Ill., emphasizes proactive, pre-bill audits, which are done twice per year per physician, says Judy Larson, CPC, billing manager. “As long as you’re auditing your providers randomly and you’re doing it frequently enough, if they are passing those audits, you don’t have to worry if their coding patterns are falling out of their bell curves,” she says.

The 30-physician practice, which also employs 22 physician assistants (PAs) and 40 physical therapists, had used Medicare bell curve data packaged by Cohen’s company for years, making sure to use the newest year’s data. Now OrthoIllinois uses third-party software that also repackages current-year Medicare data, but adds dashboards and reports, says Cassandra Duarte, MBA, the group’s director of business services.

Better E/M benchmarking solutions?

DoctorsManagement currently offers a comprehensive E/M benchmarking solution designed by Cohen called Compliance Risk Analyzer (CRA) that combines Medicare data with commercial payer data based on his claims clearinghouse partners, but he suggests that smaller practices don’t have to invest in E/M benchmarking software.
“Our package is a minimum of $5,000 per year, and the data is worth it, but if your group is three physicians or smaller, it may not be worth it in terms of the effort needed to generate the report data we need to give you your results,” Cohen says.

He recommends using current-year Medicare claims data if you absolutely feel the need to benchmark. CMS data is typically released in July or August of each year, and many vendors package the data into spreadsheets or apps like CRA MD. The current CMS data year is 2014, with 2015 data expected late this summer.

If you don’t have access to CMS data, and you’re a smaller group, running regular random probe audits to review E/M code levels can be effective, if time-consuming. Cohen says, “I think it’s always a mistake to tell somebody to stay within the curves. That means you’re coding by presumption and not by guidelines.”

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

**HUMAN RESOURCES**

**As new overtime rule looms, here’s what you can do**

Proposed changes to the federal overtime rules have caused quite a stir since their announcement last summer by the U.S. Department of Labor (DOL). Now, the proposed overtime regulations are one step closer to becoming a reality. Once the rule is finalized, an estimated five million more workers (who are currently exempt) will become eligible for overtime. The DoL sent the final overtime rule to the White House’s Office of Management and Budget on March 14.

Let’s review the implications of the overtime rule. The Fair Labor Standards Act (FLSA) requires employees to be paid at least the federal minimum wage and overtime for any time worked in excess of 40 hours in a workweek. In addition, the FLSA has strict record-keeping requirements for employees to track hours worked. There are employees, however, that are “exempt” from the FLSA’s minimum wage, overtime and record-keeping requirements. Exemption depends upon three things:

- **Salary basis (how an employee is paid).** The first requirement for exemption is that the employee must be paid on a “salaried basis,” meaning the employee receives a fixed, guaranteed minimum amount for any workweek in which the employee performs work. Simply stated, there is no change in salary regardless of the hours worked.

- **Salary level (how much an employee is paid).** Besides being paid on a salary basis, to qualify for an exemption, the employee currently must be paid a minimum of $23,600 per year ($455 per week). There is also an exemption for “highly compensated employees” who earn $100,000 per year.

- **The jobs duties test (what kind of work does the employee do?).** An employee who meets the salary basis and salary level tests is exempt only if the employee also performs exempt job duties. There are three primary “white collar” exemptions: Executive, Administrative and Professional. Regardless of the job title, the employee must meet each job duty requirement under one of the exemption categories to satisfy this test. To qualify for exemption from overtime, all three of these tests

---

**EVERYTHING YOU NEED TO KNOW...™**

About Adult and Pediatric Critical Care

**CLICK HERE FOR MORE INFORMATION.**

The Business of Medicine, Vol. 4, Issue 4
must be satisfied. Paying salary alone is not enough. A salaried employee is not the same as an "exempt" employee, although the two phrases are often used interchangeably.

How did we get here?

On March 13, 2014, President Obama sent an executive memorandum directing Secretary of Labor Thomas Perez to “modernize and streamline” the overtime exemption regulations. Shortly thereafter, on June 30, 2015, the DoL published its proposed changes – more than doubling the $23,660 salary level to $50,440 (or $970 per week) and increasing the salary level for the highly compensated exemption from $100,000 to $122,148. Additionally, the DoL proposed automatically updating the salary level annually using a fixed percentile of wages or the Consumer Price Index.

Now the final rule is with the Office of Information and Regulatory Affairs (OIRA), the division of the OMB charged with reviewing agency regulations. OIRA has 90 days to review the rule, but it can take less time.

When will the final rule be effective?

After the OIRA review, the final rule is published in the Federal Register and employers will have a minimum of 60 days to comply. During those 60 days, the rule may be challenged under the Congressional Review Act (CRA), if successful, has the effect of nullifying the regulation. The challenge is then subject to a presidential veto, which would require a two-thirds congressional vote to override.

It is unlikely that the new overtime regulation would survive a CRA challenge, as there are not likely enough congressional votes to override a veto. However, there is a catch: if a rule is submitted to Congress during a certain period at the end of an administration, there is a renewed review period under the new administration. According to the Congressional Research Service, rules submitted to Congress after May 16 “will be subject to renewed review periods in 2017 by a new President and a new Congress.”

What does this mean? If OIRA releases the new overtime regulation after May 16, 2016, the new Administration will have the opportunity to overturn the regulation. The CRA has been successfully used only once to overturn a regulation, one that was finalized under President Clinton and overturned by the Bush administration. Given the unique carryover review provisions of the CRA, the rule is most likely to be released before the May 16th deadline. Therefore, if there is a 60-day OIRA review period, the rule will be published on May 13 (three days before the CRA deadline), and the earliest effective date will be July 12.

However, Republicans are still looking to block the controversial rule. “This mandate on employers will hurt the lowest-paid American workers the most, by reducing their opportunities for a promotion or a better job and making it all but impossible for workers to negotiate flexible schedules,” said Senate Labor Chairman Lamar Alexander (R-Tenn.), who is sponsoring the bill.

Steps to take now

As these are proposed regulations, they may be changed before becoming final and binding. However, good practices would dictate employers should prepare as if the proposed regulations will go into effect as written. Here are some initial steps to take right now:

1. Review current salaries, focusing on white-collar exempt employees earning between the old salary threshold and the new threshold.
2. Determine which salaries you can raise to retain exempt status and which you cannot based on your staffing budget.
3. Analyze how many hours exempt employees now work and what it would cost if their current salary

HR managers: Keep using expired I-9 forms for now

The current version of Form I-9, the most fundamental tool HR professionals use to determine if applicants are eligible to work in the U.S., expired March 31. Until further notice, though, employers should keep using the expired form until the recently proposed “smart” I-9 is implemented, according to U.S. Citizenship and Immigration Services (USCIS). Once the comment period for the proposed form ends on April 27, the USCIS may make further changes before sending the proposal to OMB, which will need to review and approve it. The form will eventually be available for download at www.uscis.gov.
is converted to an hourly wage and they continue to work the same number of hours.

4. Decide whether you will lower the hourly rate when you convert from exempt to hourly status so that total earnings remain the same.

5. Do not forget to consider employee moral, some employees may think of hourly pay as a demotion. This requires good communication with employees.

For more information, visit www.dol.gov/whd/overtime/nprm2015/factsheet.htm.

— Philip Dickey, MPH, PHR, SHRM-CP (pdickey@drsmgmt.com). The author is a Partner and Director of Human Resources at DoctorsManagement.

**MEDICARE RULES**

**CMS softens stance on 60-day ‘clock’ in final overpayments rule**

Recent changes to Medicare’s regulations on provider overpayments will give you more time to determine the extent of what you may owe the government, an analysis by *The Business of Medicine* shows.

**The final rule** softens many of the blows found in the proposed rule, most notably cutting the proposed lookback period from 10 years to six years, and clarifying the definition of “identifying” an overpayment to mean when a provider confirms an overpayment was made after conducting a “timely, good-faith investigation of credible information.” The lookback period refers to how much time can pass after an overpayment is made before the provider is no longer obligated to return the money.

Let’s take a look at the specific measures of the final rule, which took effect on March 14 and is not retroactive, according to language in the rule itself.

Sometimes called the “60-day rule,” the existing CMS regulation required any overpaid amount to be reported and returned within 60 days after the date on which the amount was identified, or the due date of a corresponding cost report (or similar report, if one applied). Failure to report the overpayment within the 60-day period could result in civil or criminal penalties under the False Claims Act.

1. **Lookback period set to six years from 10.** CMS is reducing the lookback period to six years, down from the 10 in the proposed rule. The lookback period essentially refers to how many years back a provider is responsible for returning any identified overpayments. For example, if an overpayment is identified that was originally received by the provider seven years ago, it falls outside the new six-year limit and thus doesn’t have to be disclosed and returned.

2. **More time thanks to clarifying when the 60-day clock starts.** The best-known aspect of the 60-day rule is that providers have 60 days to disclose and return overpayments once they’ve been identified. However, the key word is “identified,” which hasn’t been explicitly defined by CMS until this final rule. As a result, up until now, it could be interpreted to mean the first time your practice gets notified of overpayments, even if it’s via an anonymous phone call. In the final rule, CMS makes it clear that “identified” means that providers have exercised “reasonable diligence” in conducting a “timely, good-faith investigation” into overpayments.

3. **Up to six months before the clock starts.** The period of time for this reasonable, diligent investigation is “at most six months from receipt of credible information, absent extraordinary circumstances,” according to the final rule. This effectively means you have a total of about eight months (six months plus the established 60 days) from the time you realize you have some sort of overpayment, to returning it.

4. **Overpayment amount must be quantified.** Another addition to existing regulation from the final rule is the stipulation that the exact amount of the overpayment must be found prior to the overpayment being “identified.” This addition, coupled with the longer time afforded by the “reasonable diligence” clarification, helps protect providers from returning an overpayment, only to be accused of withholding other overpayments that weren’t found by the time the original 60-day clock had expired.

**Note:** The other key term that’s become important in the final rule is “credible information,” because CMS states that once you have credible information, you as the provider
organization become obligated to investigate it and exercise “reasonable diligence” in doing so. The agency has in the past offered a few scenarios that would constitute “credible information,” including:

- The practice finds instances of overcoding or incorrect coding that resulted in more payment than the proper coding would have.
- Overpayments were found during an audit, whether an internal audit, external third-party audit (i.e. by hired consultants), or a federal payer or contractor audit.
- The practice notices a major increase in Medicare payments without any obvious cause.

This is just a partial list, and doesn’t include obvious examples of credible information such as a whistleblower telling your practice about deliberate or accidental overcoding, for example. Tellingly, CMS was asked in the comments to the proposed rule whether finding “a single overpaid claim” should be considered credible information that should kick off first the six-month reasonable diligence clock and then the official 60-day clock.

The answer is essentially yes. “After finding a single overpaid claim, we believe it is appropriate to inquire further to determine whether there are more overpayments on the same issue before reporting and returning the single overpaid claim,” CMS writes in the final rule. “To the extent this concern is based on a question about when the 60-day clock begins to run, the final rule clarifies that identification occurs once the person has or should have through the exercise of reasonable diligence, determined that the person received an overpayment and quantified the amount of the overpayment.”

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

### PRACTICE MANAGEMENT

#### The growing importance of hospice care

Hospice is becoming increasingly important as baby boomers age and more patients require end-of-life care. However, many physicians and patients are unfamiliar with the benefits and processes of hospice care. Let’s take a look at the benefits of hospice care.

So what does hospice do? Hospice takes care of terminally ill patients that are diagnosed with six months or less to live by providing physical, emotional, social, and spiritual needs of dying patients and their families. Hospice organizations provide the following disciplines for patients: practitioner care, nursing care, CNA care, social worker service, volunteer services, and even chaplains. Hospice provides end-of-life care to keep patients comfortable through the last six months of life. Hospice organizations provide this care through several different types of care, which are as follows:

- Routine home care (RHC) – Hospice care is provided in the patient’s residence (home, nursing home, or assisted living). All hospice disciplines make visits to the patient’s place of residence to provide end of life care.
- Hospice general inpatient care (GIP) – General inpatient care can be provided to patients who are

---

**Meet DoctorsManagement**

Visit [www.doctors-management.com](http://www.doctors-management.com) for details today.

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
<th>Location</th>
<th>Presenter</th>
</tr>
</thead>
<tbody>
<tr>
<td>June 1-2</td>
<td>Practice Management Institute Conference</td>
<td>New Orleans, LA</td>
<td>Shannon DeConda</td>
</tr>
<tr>
<td>June 10</td>
<td>AAOE Webinar, “Audit Threats - What You Don’t Know Will Sting,”</td>
<td></td>
<td>Sean Weiss</td>
</tr>
<tr>
<td>June 12</td>
<td>AAOE Webinar, “Evaluation and Management Services and Always Selecting the Right Level,” 11 am to 12 pm ET</td>
<td>Sean Weiss</td>
<td></td>
</tr>
<tr>
<td>Aug. 9</td>
<td>Webinar, “Physician Auditing for the Facility Coder/Auditor,”</td>
<td></td>
<td>Shannon DeConda</td>
</tr>
<tr>
<td>Oct. 18</td>
<td>AHIMA 2016 Convention &amp; Exhibit</td>
<td>Baltimore, MD</td>
<td>Shannon DeConda</td>
</tr>
</tbody>
</table>

2016 © DoctorsManagement
having a hard time getting symptoms related to the terminal illness, or pain, under control. This type of care is performed in an inpatient facility and is used for short-term care in order to get the patient’s symptoms under control.

- Continuous home care (CHC) – Continuous home care is provided during a time of crisis. The regulatory definition of continuous home care is meant to include nursing care, covered on a continuous basis for as much as 24 hours a day, to achieve palliation and management of acute medical symptoms. This can include hospice aide service, but the care must be predominantly nursing care.

- Inpatient respite care – Respite care is a type of care that is only necessary to relieve the family members or other individuals caring for the patient at home. This is a short-term type of care that can’t last any longer than five days per single billing period. The patient is normally moved to a nursing home during this time to provide the respite care. It is important to note that Medicare will pay for respite care in the nursing home as long as the nursing home is capable of providing 24-hour nursing care.

Misconceptions about hospice care

There are many misconceptions about hospice care but there are two main misconceptions that need to be addressed.

- Hospice is only provided within the last two days to two weeks of the patient’s life. In 2009, more than a quarter of all hospice care was given within the last three days or less of the patient’s life and 40% of those late referrals ended up in hospitalization or intensive care. Studies have shown that if a patient goes on hospice services when diagnosed with 6 months or less to live, then it not only improves the quality of the patient’s life, it also extends the patients’ life.

- Hospice only provides pain control. Hospice provides so much more than pain control. They provide comfort to patients and family members. Comfort can be defined in many different ways depending on the patient or the family member. Comfort for a family member may be making sure the patient expires within the home or that a nurse is present when the patient expires. Comfort for a patient may mean that every time a facility member visits the home, they bring a candy bar or a newspaper.

Looking at 2016 hospice changes

Hospice organizations have faced many challenging changes over the past five years and 2016 is not going to be any different. The following items will be changing in 2016:

- Routine home care will be paid at a higher rate for the first 60 days of the hospice episode of care (hospice election period separated by no more than a 60-day gap, according to Medicare Common Working File data). This payment rate will be $186.84 per day. From the period of 61 days and
after for routine home care, the hospice agency will receive less Medicare reimbursement. This payment rate will be $146.83 per day. Remember, if the hospice organization picks up a patient who previously had more than 60 days of hospice care, they can't bill the higher rate again. The patient has already exhausted the rate. If the patient had ten days of previous hospice care, then the new agency can bill for 50 days at the higher rate.

- New service intensity add-on payments (SIA) – This payment applies only to the last seven days of life when the patient is discharged to decease and applies only to routine home care level of care. Only visits made by a registered nurse or a medical social worker apply and it excludes LPN visits and MSW phone calls. The payments are equivalent to the CHC rate; it is paid in 15-minute increments, and it involves a combined time by an RN and MSW and is paid up to four total hours per day.

- Claims must report all diagnoses that are identified in the initial assessment even if it is not related to the patients' terminal diagnoses.

- New code: G0154 is no longer valid as of Jan. 1, 2016. G0299 will now be for RN services and G0300 will now be for LPN services.

Over the next five to ten years, hospice is going to play an even larger role in end-of-life care. A 2009 survey showed that only 42% of the elderly used hospice care or were even aware of it as an option for treatment. Most physicians don't understand hospice care and what hospice can provide for their patients. Hospice can play a very essential role in end-of-life care if the patient receives the care within a timely manner.

— James Goosie, MBA, CMPM (jgoosie@drsmgmt.com). The author is a Management Consultant and Director of Revenue Cycle Management at

<table>
<thead>
<tr>
<th>New DoctorsManagement clients</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Client</strong></td>
</tr>
<tr>
<td>Pediatric surgery group, CA</td>
</tr>
<tr>
<td>Multispecialty group, NY</td>
</tr>
<tr>
<td>Vascular surgery group, IL</td>
</tr>
<tr>
<td>Interventional vascular surgery group, FL</td>
</tr>
<tr>
<td>Urology practice, FL</td>
</tr>
<tr>
<td>Urgent care provider, CA</td>
</tr>
<tr>
<td>Urgent care practice, NC</td>
</tr>
<tr>
<td>Health system, IA</td>
</tr>
<tr>
<td>Rehab clinic, MD</td>
</tr>
<tr>
<td>Pediatric dentistry group, NC</td>
</tr>
<tr>
<td>Podiatry practice, TN</td>
</tr>
<tr>
<td>Dental practice, FL</td>
</tr>
<tr>
<td>Medical center, TN</td>
</tr>
<tr>
<td>Urgent care association</td>
</tr>
<tr>
<td>Medical lab group, GA</td>
</tr>
<tr>
<td>Pain management group, AR</td>
</tr>
<tr>
<td>3 new power buying clients (family practice, oral and maxillofacial surgery, dentistry)</td>
</tr>
<tr>
<td>255 new providers added to Compliance Risk Analyzer (CRA) program</td>
</tr>
</tbody>
</table>