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IN THIS ISSUE

All Medicare fees are par, office, national unless otherwise noted.

Practice management

5 tips to help your practice stay independent and succeed

The way health care is delivered is changing forever and if you expect to remain in independent practice, be ready to understand the changes, embrace them, and change the way you do business, experts tell *Part B News*.

A recent study from the AMA suggests that more than half of all physicians continue to practice independently, while 60% work in a group that is wholly owned by physicians. The study acknowledges that 29% of physicians work in a setting partially or wholly owned by a hospital, up from 16% five years ago.

*(see **independence**, p. 4)*

Enrollment

Never lose billing privileges again: 14 top enrollment questions answered

On October 14-16, DecisionHealth held its annual National Medicare Provider Enrollment Summit in Philadelphia. One of the highlights of the conference was the opportunity it gave attendees to meet our experts — David Zetter, president of Zetter Healthcare in Mechanicsburg, Pa., and Dennis Grindle, a partner in the consulting and accounting firm

*(see **enrollment**, p. 7)*

Yes, you can now legally take care of PECOS for your doctors — learn how!

CMS has released its long anticipated "surrogate" program, which lets anyone create an account to update physicians' Medicare enrollment information in the official PECOS database. Learn how this program will work and what doctors must still do to legally grant surrogate access with David Zetter, a nationally recognized Medicare enrollment expert. Join David for "Do it right: Gain PECOS surrogate access legally," on Nov. 14. Learn more at *www.decisionhealth.com/conferences/A2431/index.html*.

Coding

ICD-10 update: Some payers aren't ready, but you can do lots of testing alone

Since CMS announced there'd be no end-to-end ICD-10 testing for Medicare last summer (*PBN 7/1/13*), not much has changed — except we're a few months closer to the October 1, 2014 deadline, and not only CMS but many private payers are being less than cooperative. Experts tell us what steps you should take now to prepare yourself as best you can.

Will CMS help? Probably not

When CMS announced last summer that they would not facilitate ICD-10 testing, it raised a tremendous roadblock on Medicare providers' preparedness. Carolyn Hartley, president of Physicians EHR, a Cary, N.C.-based firm that helps practices implement EHRs, thinks that after the recent problems with the Obamacare website, the agency might just change its mind.

"Given the black hole [at healthcare.gov]," says Hartley, "I think HHS will take a hard look at ICD-10 testing [and their decision not to test end-to-end]. I don't think anyone can stand to have another major failure on their hands."

Stanley Nachimson, president of Nachimson Advisers in Reisterstown, Md., is less sure. While "it's not too late for CMS to change their decision," he says, "I couldn't predict. The last I heard, they were 'looking at' the issue." And Maxine Lewis, consultant with Medical Coding Reimbursement in Cincinnati, is downright negative: "This doesn't affect the public the way enrolling in insurance does," she says. "If anyone can do it [push for a change], it will have to be the medical societies" such as the AMA. But as the months pass, that seems less likely to happen, she adds.

With CMS out of the picture, you're left with private payers and partners to test with. But these comprise so much of your transactions, our experts say, that any effort you spend getting them right should pay off handsomely when the new system goes into effect.

First, check yourself

The part of the testing you should look at first is the one you have the most control over: Your own internal ICD-10 processes.

Naturally you should be training staff on ICD-10 codes, said Nachimson, but don't forget that it's not just a matter of getting the codes themselves right — ICD-10 also requires more extensive documentation than ICD-9 due to added requirements in laterality, location, etc. "Make sure you're capturing all the necessary documentation in your EHR," he says; work with your EHR vendor to make sure the system can handle it, and with your physicians to make sure they're taking proper notes.

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Tip: Don't rely on mapping programs to "translate" your ICD-9 to ICD-10 codes. "They don't take into account the specificity of your documentation and the situation," says Nachimson. "You have to select the ICD-10 codes yourself." Also, "make an inventory of systems and interfaces that contain diagnostic codes," says Hartley. "Most practices don't have any idea how many interfaces have to be tested. For example, some EHR companies are providing a crosswalk of ICD-9 to ICD-10 billing codes. I would put those codes through end-to end-testing with an outside group before agreeing to use them."

Among the other interfaces Hartley says you should check:

- Computerized Provider Order Entry (CPOE) to labs, with results posted back into the EHR;
- Imaging and pathology interfaces;
- Practice management and EHR systems;
- Medical device interfaces such as glucose meters that populate content into the EHR;
- Clearinghouses, payers, data analyzers, repricing companies, etc.

Call partners now

External testing will be a great challenge. For one thing, many payers aren't yet ready to test with you. In fact, says Nachimson, they may not be ready until after the deadline.

"To test with a provider, they have to be ready to accept transactions, and many are not," he says. Also, he's heard that many health plans will not test with all of their providers; they'll just test with a sample. Some say they'll only test with high-volume providers; others say their intent is to test with anyone who wants it, but "most health plans have not started their external testing," says Nachimson.

Nonetheless, it's incumbent on you to contact all your partners, including your clearinghouses, and see how soon you can run a test.

"Don't assume health plans will contact you [about ICD-10 readiness]," says Nachimson. "They should work with you, but you have to be assertive and pro-active."

Find a peer group

If you're not getting enough cooperation from payers, Nachimson suggests, go to peer groups for help: Local, national, and other organizations such as clearinghouse user groups and specialty groups.

"Say you're an orthopedist," says Nachimson. "You haven't been to be able to work with payers, but you talk to the society and find some of the orthopedists have." You can learn from them where the problem spots are: For example, "Maybe when they send to Plan A, it's good, but Plan B needs extra documentation for certain types of claims," he says.

"Some people tend not to get involved in professional groups, but the ICD-10 situation is so different, it's incumbent on people to become active," says Nachimson.

Get help

Inevitably you'll need help getting ready. There are armies of consultants specializing in ICD-10, and health IT companies like Optum, Atrilogy, Medical Mastermind and others that offer ICD-10 consulting services that include testing.

Tip: Make sure you get a report, not a yes-or-no. Hartley says testers may push through some transactions, but not give you details on what does and doesn't work. "We've never done ICD-10 in this country. There's got to be something that doesn't work!" she says.

"For example: Did testing verify that you are able to attach a suspected diagnosis to a CBC panel lab order, then receive results electronically in the EHR? Also, will the codes in transition also be recognized by your payers? … you'll need a report in a human, readable format that says what's wrong and needs to be fixed."

A major testing option is the National Testing Platform (NTP), owned by the Lott QA Group and found at *http://nationaltestingprogram.com*. Enrollments starts at $2,000 for practices, but that includes the consulting services of Lott.

"Providers use their own medical records that have already been paid in ICD-9," says Juliet A. Santos, Lott's executive vice-president for strategy & business development, and they're used for test case validation with partners.

NTP also evaluates your ICD-10 coding and documentation to "determine if your staff needs more education or training," Santos says.

This still isn't complete end-to-end testing — rather, "it allows you to begin testing your most important processes while waiting for full interoperability testing with your vendors," says Santos. But it's a start. — *Roy Edroso (redroso@decisionhealth.com)*

Part B News briefs

NGS launches mass claims adjustments for incorrectly rejected Part B claims

Providers governed by CMS Medicare administrative contractor (MAC) National Government Services can expect a series of claims adjustments for falsely rejected claims in the coming weeks.

A system error caused NGS to incorrectly deny Part B claims in Jurisdiction 6 — Illinois, Minnesota and Wisconsin, formerly covered under Wisconsin Physicians Service (WPS) — listing any of almost 200 procedure codes (*see list below*). Affected claims have a date of service of Sept. 7 or earlier, NGS says in a news release.

The error, which was "fully resolved" Nov. 5, resulted from a mismatch of WPS codes with NGS' type of service codes. NGS began doling out adjustments in early October. *— Lauren C. Williams (lwilliams@decisionhealth.com)*

Full list of procedure codes and ranges NGS incorrectly rejected

- 75894-75896; 75945-75946; 75952-75953; and 75960-75968 (Transcatheter Procedures)
- 76536-76770 and 76816-76965 (Diagnostic Ultrasound)
- 77052-77057 (Breast, Mammography)
- Psychiatric Services codes within the 90000 range
- 91122 (Gastroenterology)
- 92025 (Special Ophthalmological Services)
- 92082-92083; 92255-92250; and 92275-92286 (Ophthalmology)
- 92541-92546; 92567; 92585; and 92587-92588 (Special Otorhinolaryngologic Services)
- 93270-93272 (Cardiovascular Monitoring Services)
- 93303-93351 (Echocardiography)
- 93609-93660 (Intracardiac Electrophysiological Procedures/Studies)
- 93880-93890 (Cerebrovascular Arterial Studies)
- 95907-95941 (Neurology and Neuromuscular Procedures)
- 96567 (Photodynamic Therapy)
- 95930 and 95937 (Neurology and Neuromuscular Procedures)
- G0202 (Screening Mammography)
- Q0091 (Screening Papanicolaou smear)

Congress

House, Senate leaders make new SGR proposals, invite comments

Members of both houses of Congress released details of a new plan to do away with the sustainable growth rate (SGR) and the annual "doc fix" that goes with it. Physicians will probably not be pleased, but at least it's a slight improvement on the previous plan.

The Senate Finance Committee issues a press release on October 30 saying Senate and House leaders "have collaborated closely to develop a framework to solicit input to begin the committee process for a full repeal of the flawed formula."

Last summer House members proposed a plan that would have given doctors five years of 0.5% "inflation adjustments" to fee schedule payments if they transitioned to a pay-for-performance model, and a fat pay cut if they did not. The new plan, which is supported by Democratic and Republican Congressional leaders, would freeze physician payments over ten years, but would also "encourage participation in alternative payment models (APM)" by letting physicians who adopted them "earn performance-based incentive payments through a compulsory budget-neutral program," though the operational details are at present vague.

While admiring that the new plan "reflects some level of bipartisan spirit," Christine Cohn, a health care attorney with the Buchalter Nemer law firm in Los Angeles, finds both the original House plan and the new one "deeply flawed… Each would introduce 'alternative payment models,' which don't exist yet. Both would impose significant additional reporting obligations on physician practices, with penalty provisions for those who don't adequately report the specified data." *— Roy Edroso (redroso@decisionhealth.com)*

independence

(continued from p. 1)

The key to thriving as an independent practice is not to become frustrated or angry about declining reimbursements or new regulations because that will only distract you from making changes, says Ken Hertz, a senior MGMA consultant based in Alexandria,

(continued on p. 6)

Benchmark of the Week

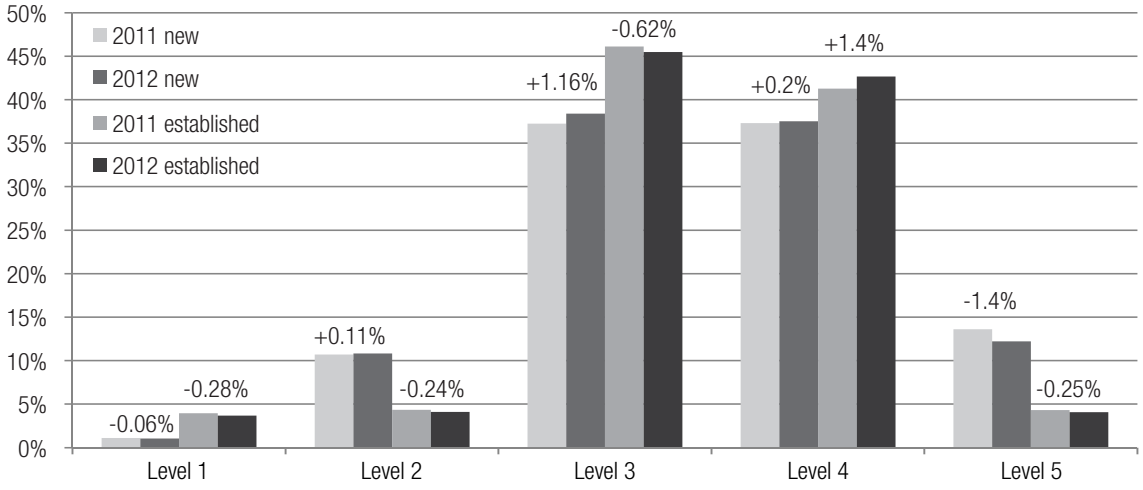
E/M level selection, primary care vs. specialists, 2011 vs. 2012

It looks like level 4 E/M services are all the rage these days, as E/M coding patterns for Medicare show a major shift away from other levels in favor of level 4 codes, both on the new and established sides. The data is similar to trends established last year by *Part B News* (*PBN 11/5/13*), when CMS claims data for 2011 became available. This benchmark uses the latest 2012 data.

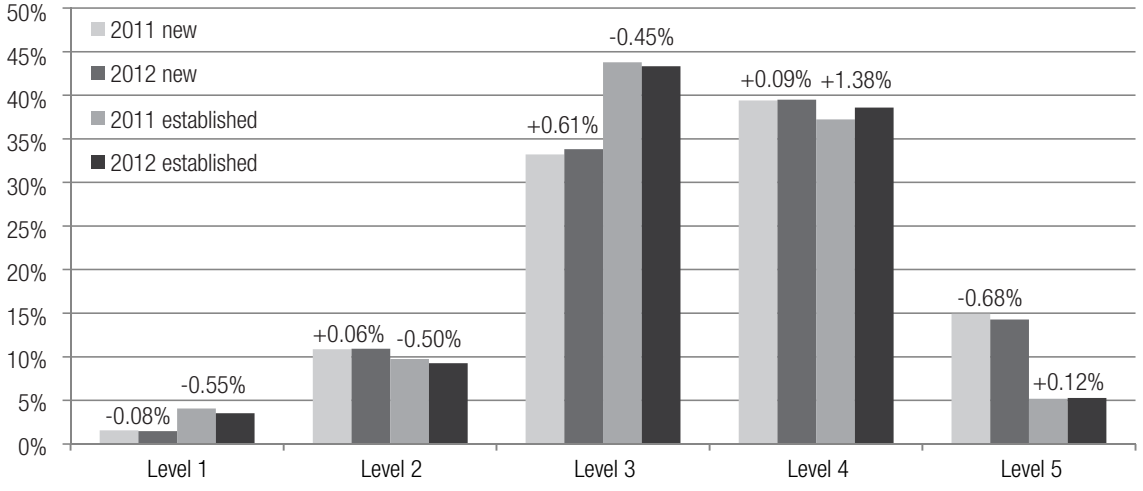
Each bar in the charts below represents the percentage of utilization reached by each E/M code level, for both new and established patients in 2011 and 2012. Data for the "primary care" category comes from family practice, general practice and internal medicine. "Specialists" include combined data for 11 specialties that bill the most E/Ms to Medicare: cardiology, dermatology, gastroenterology, hematology and oncology, nephrology, neurology, ophthalmology, orthopedic surgery, pulmonary disease, rheumatology and urology.

Most significant are the big increases to level 3 and level 4 E/M utilization for both new and established by primary care providers in 2012, as a jump of more than 1 percentage point represents millions of claims and hundreds of millions in dollars. By contrast, level 3 utilization has stayed flat for specialists, and the increase to level 4 utilization comes only on the established patient side for specialists. We also see a sharp drop in level 5 new patient visits billed by primary care (-1.4%) and a smaller but still significant drop for specialists (-0.68%). This could reflect the ramp-up in auditing of high-level E/M services that began in 2012 and has continued to intensify over the last 18 months.

Primary care E/M selection pattern, 2011 vs. 2012



Specialists E/M selection pattern, 2011 vs. 2012



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La. Instead, learn as much as you can, be it from books, articles, webinars or networking, to help you understand the current rules governing health care practices, Hertz says.

When it's your practice's goal to not join the ranks of the hospital-owned, here are 5 ways to fight to retain your independence:

1. Review staffing: Your goal is not to look for people to cut, but to make sure everyone on your team is working efficiently and avoiding duplication of effort, says Beth Dille, physician practice manager for Fisher-Titus Medical Center in Norwalk, Ohio. Dille goes into practices once they're acquired by Fisher-Titus and staffing is usually among the first places she looks.

Example: One practice recently acquired by Fisher-Titus had one physician seeing 20 patients a day, supported by two clinicians and three front-desk people, compared to an established Fisher-Titus owned doctor seeing 32 patients a day supported by a total staff of two people, Dille says. The less efficient practice was doing things such as having multiple people check charts before filing claims when it didn't need to be done that often.

Example: A cross-trained staff will also help a small practice remain lean, says Donna Beaulieu, assistant director of revenue cycle development for Emory Healthcare in Atlanta. A medical assistant with a CPC credential who is savvy with coding can improve your coding efficiency and revenue, she suggests. You can also save as much as .25 FTE with kiosks for patient check-in and an automated appointment reminder service, she adds.

2. Have a budget based on the best business model: It sounds like a given, but many small practices don't even have a budget that gives them visibility into expected revenues and expenses, Dille says. You need to know your numbers and not be surprised by results at the end of the month, she adds.

One way to budget is to take last year's numbers and add 3%-5%, or you can use a zero-based budget approach and start with a clean slate, Hertz says.

With the zero-based approach, you'll need to make smart assumptions about the business, including how the doctors will want to work, how the practice can make its biggest impact, the key leverage points for the practice and what it will take for the practice to be the best it can be, Hertz says. You're not making predictions — you're building your assumptions based on what you know and scenario planning, he adds.

You'll also have a better understanding of your overhead, from copier costs to staff and benefit costs, Dille points out. You can always find expenses to trim, she adds.

3. Look for ways to operate more efficiently: Physician groups will often make decisions based on the needs of the physicians or the staff instead of the patients. That needs to change, Hertz believes.

Example: A 12-doctor OB/GYN practice Hertz worked with didn't see patients after noon on Friday because the doctors liked having the afternoon off. But the practice still faced rent and utility costs during that time slot and had idle overhead as a result. While everybody likes to have Friday afternoons off, in this case it wasn't in the best interests of the business, Hertz believes.

Example: Physician groups — particularly pediatricians and internal medicine doctors — could benefit by having office hours either on Saturday mornings, during the lunch hour or after regular business hours on some weeknights, Hertz points out. These are things you can do to change the dynamics of your practice.

4. Take advantage of opportunities to earn more money: Don't stick your head in the sand when it comes to bonus payment opportunities — they're the future of health care, Hertz says.

Small practices often don't do a good job with programs such as the Physician Quality Reporting System, or the Healthcare Effectiveness Data and Information Set (HEDIS) for private payers, Dille says. You are leaving critical dollars on the table when you avoid these opportunities, she adds.

5. Provide great customer service: Your patients are focused more on the total experience of healthcare. Most negative patient feedback on a healthcare practice has nothing to do with the quality of the care provided — the average patient can't make that distinction, Hertz says. Instead, the experience is rated on factors such as friendliness of the check-in person, length of wait in the office — you need to shine in these areas to effectively compete, he adds.

In order to remain independent, it's not a time to be timid. It's a time for vision, thoughtfulness and commitment, Hertz believes. — *Scott Kraft (pbnfeedback@decisionhealth.com)*

But if you *do* want to sell…

If you're not up to the commitment needed to run a practice in today's environment, this could be the best time to sell, says Beth Dille, physician practice manager for Fisher-Titus Medical Center in Norwalk, Ohio.

Going to work for a hospital is different from a retirement plan and you can still get an attractive price in this market for selling, Dille believes.

Arthritis Associates of Mississippi in Jackson is in the process of winding down operations because the physicians, approaching 60 years old, felt it was a better opportunity to work in a hospital-owned setting rather than tackle what they saw as looming cash flow issues, says administrator Joan Senteney.

The costs to transition to ICD-10, the sequester, costs associated with Recovery Audit Contractor (RAC) audits and pay cuts from the practice's biggest payer were among the factors that drove the decision, Senteney adds. — *Scott Kraft (pbnfeedback@decisionhealth.com)*

enrollment

(continued from p. 1)

Seim Johnson, LLP in Omaha, Neb. — and ask the kind of enrollment questions that aren't usually addressed in PECOS and NPPES Q&As.

Some of the questions that Zetter and Grindle fielded, and their answers, appear below.

1. I recently enrolled, and have just added a new practice location. How much time do I have to add it in PECOS?

Grindle: By regulation, this varies based on the provider/supplier type. CMS requires practice location changes for physicians, nonphysician practitioners, physician and nonphysician practitioner organizations, IDTFs and DMEPOS suppliers to be reported within 30 calendar days from the date the change occurs. For all other providers and suppliers, the practice location changes are to be reported within 90 calendar days.

2. Will revalidation information flow from PECOS to the Physician Compare website to correct inaccurate records?

Zetter: Some information from Medicare enrollment gets to Physician Compare, but this is probably only whether they participate with Medicare or not. There is other information in Physician Compare that PECOS does not have, such as hospital affiliations and residency programs.

3. How many specialties can you put under one provider in PECOS and NPPES?

Zetter: Quite a few for NPPES — I have never experienced maxing this section out. PECOS allows a specialty for an individual physician and a sub-specialty.

4. For referring/ordering providers, we have fellowships that can't bill government payers. Should these providers be enrolled as referring/ ordering providers?

Grindle: Yes, any eligible practitioner that can order and refer that otherwise will not be billing the Medicare program must enroll as an ordering/referring practitioner through the Form CMS-855O or its electronic equivalent in PECOS.

5. Since independent labs do not bill with rendering practitioners' NPIs, is there any reason to enroll the physicians working for the labs in PECOS?

Zetter: If a physician is submitting claims to Medicare or ordering/referring, then they should be enrolled with Medicare in PECOS.

6. If you use an 885-A to terminate an enrollment, do all practitioners who reassigned benefits automatically get unlinked?

Zetter: No. If you are deactivating PTANs or an enrollment, the reassignments are still active in all provider individual enrollments — you didn't terminate the reassignments, only the enrollment for the facility.

7. If a physician with dual affiliations is revalidated on the hospital side, does he also need to be revalidated on the private-practice side?

Zetter: Revalidation is based on an NPI and the PTANs associated with it. The revalidation letter will denote which NPI and PTANs are required to be revalidated. There may be another request for revalidation at a later date, depending on what CMS is requiring.

(Note: If a provider has other PTANs that are not listed on the revalidation letter, then they do not have to revalidate those PTANs at that time until they are notified.)

8. Can physician groups have subparts?

Zetter: A subpart would most likely result in a separate NPI. If you're going to utilize the NPI for billing purposes, then yes, a group can have a subpart — but why? What is the purpose of billing under a separate NPI? If it's just to be able to track revenue differently, you can do that with accounting rather than with an NPI.

9. Is there an additional fee to add additional practices to the enrollment of an existing supplier?

Grindle: Application fees apply when adding practice locations on a Form CMS-855A, Form CMS-855B (except when being completed for a physician and/or non-physician practitioner group), and Form CMS-855S or the electronic equivalent in PECOS.

CMS has an application fee matrix summary on their website at *www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/ApplicationFeeRequirementMatrix.pdf* that sets forth when application fees are due for each provider/supplier type and enrollment action.

10. In NPPES do you enter the taxonomy according to the practitioner's board certification or according to what he practices (e.g., certified for internal medicine, practicing as a hospitalist)?

Based on what type of medicine the physician is practicing.

11. To what level of specificity must location addresses be accurate (e.g. if you put "Ste 450" instead of "Suite 450" will you be rejected)?

Zetter: It doesn't matter — all locations are verified in NPPES and PECOS with the USPS and corrected.

12. What about *locum tenens*?

Zetter: There is no enrollment for locums — that's why they're locums. They work using the NPI of the temporarily absent physician with a Q6 modifier to denote that a locums is standing in. If another provider [from the practice] is just standing in for a doctor and that provider is enrolled, then there is no use for a Q6 modifier because the provider is enrolled with Medicare — you just bill using the provider's NPI as the rendering physician.

Also: You cannot use a locums for a physician that leaves because that physician will most likely be working someplace else, and you cannot use his/her NPI (with Q6 modifier) when they are billing for services elsewhere on the same day with their NPI.

Also, you have to terminate Medicare enrollment (reassignment) with the group on the effective date (per federal regulations, within 30 days) to have accurate enrollment information.

13. If you use a *locum tenens* provider and bill for his or her work, who is responsible for seeing that he or she has been properly enrolled?

Grindle: If the physician does not meet Medicare's *locum tenens* requirements, the entity that will be billing for the physician's service (accepting the reassignment of benefits from the physician) would be the entity responsible for enrolling the physician under the billing entity's group PTAN. — *Roy Edroso (redroso@decisionhealth.com)*

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