If you read my alert from August or the followup article on Audit Red Flags to Avoid, you are aware that CMS hired an accounting firm, Figliozzi & Company, to audit the compliance of eligible providers and eligible hospitals that had already received payment under the meaningful use (MU) program. According to a report from the GAO as many as 20% of eligible providers and 10% of eligible hospitals may be audited, on a post-payment basis to confirm that they actually met the requirements of the program.

I recently had the opportunity to interview a physician that is currently going through the audit process with Figliozzi & Company (an edited transcript of the interview can be found here). Although he wishes to remain anonymous, he was willing to report on his experience and provide redacted copies of the correspondence and requests that he has received from the auditors.

This physician, whom I will call Dr. Jones, is a primary practice physician in the Southwestern United States. His initial stage one reporting period was in 2011 and he attested in 2011. He implemented a certified EHR application, SoapWare, in 2008 so he was already an experienced EHR user when meaningful use rolled around. According to a report published by the CDC, only about 17% of physicians in 2008 had implemented an EHR with most of the functionality that would be required by certified EHR’s under meaningful use. So when
HITECH and meaningful use became law in 2009, it is not surprising that Dr. Jones would be among the first round of physicians to attest. As you may know, the initial reporting period for stage one was a 90 day period that had to occur during a calendar year. This 90 day period is the period in which you have to collect and use your EHR and exceed the thresholds established for meaningful use. And for those measures requiring a Yes/No attestation, you have to affirm that you met the measure.

First I want to lay out the facts and then do some analysis.

In the third quarter of 2012, Dr. Jones received an email from Figliozzi & Co. informing him that his “facility has been selected by CMS for a HITECH meaningful use audit.”[i] All the correspondence with Figliozzi has been via email, something that surprised Dr. Jones and me. The email contained a number of attachments which you can view here, here, here and here.

None of the original documents specified the period for which Dr. Jones was being audited. Figliozzi might have assumed it that it was obvious because Dr. Jones had only attested and received payment once, for his initial 90 day attestation in 2011. However, that reporting period was long out of Dr. Jones mind and, as it was nearing the end of 2012 and the end of his first full year reporting period, he assumed that the audit was related to his current reporting period, the full 2012 calendar year. In his own words, “…it wasn’t very clear. Because at the same time that we received this (the audit letter) we were getting ready to attest for 2012.” Clearly, this betrays a common knowledge deficit about the meaningful use audit program. The post-payment audit program is only for those that have already attested and received funding. The email from Figliozzi could have been clearer on that point.

Dr. Jones prepared some data for 2012 and sent it along to
Figliozzi and Company, and hoped that he was done.

He was not.

A few weeks later, Dr. Jones received a terse email from a different auditor within the company. An attachment to the email clarified that the audit was for the 2011 reporting period and requested additional information. Specifically, Dr. Jones needed to provide additional supporting evidence such as:

1. Proof of possession. In other words, Dr. Jones needed to provide evidence that he owned the software at the time of attestation and that it was of a certified version of the software. The types of documentation might include invoices, contracts, or licensing agreements but the documentation needed to specify dates and versions in order to be acceptable.

2. Provide documentation specifically related to the Core Yes/No measures:
   
   1. **Core # 2** – Drug Interaction checks – provide evidence that the capability was running during the entire reporting period or demonstrate that the capability cannot be disabled.
   
   2. **Core # 11** – Clinical Decision Support (CDS) – provide a schedule of alerts from the period or demonstrate that the capability cannot be disabled.
   
   3. **Core # 14** – Exchange of Clinical Information – Screenshots from the EHR demonstrating a test exchange of clinical data or an email confirming receipt of the exchanged data.
   
   4. **Core # 15** – Protect Electronic Health Information – a risk analysis report dated prior to the end of the reporting period.

3. In addition, Dr. Jones needed to provide proof that he had had met the two Yes/No Menu measures that he had selected:
   
   1. **Menu # 3** – Patient Lists – A list of
patients with a specific medical condition generated by the EHR.

2. **Menu # 10** – Syndromic Surveillance Data Submission – Screenshots from the period which document a submission of test syndromic surveillance data or a dated email/letter from an agency indicating receipt of such data.

Dr. Jones scrambled to put together the supporting documents and mailed them to Figilozzi and Co. within the required deadline. He is waiting to hear from them.

Here are a few thoughts about Dr. Jones experience and the things to consider prior to attesting.

In order to be eligible for funding, an eligible provider must meet all the core measures and five (out of ten) menu measures. Most of the measures are reported directly out of the EHR but a few are not. These tend to be the measures that present the most problems with documenting compliance. They have the common characteristic that they are Yes/No measures and the affirmation needed cannot be auto-generated from data in the EHR. Based on a specific EHR, you might be able to document compliance using reports or the audit system of the EHR. For example, many EHR’s should be able to document and retain the creation of alerts for Core # 11, the CDS measure. This should also be true of Core # 2, the drug interaction check measure and Menu # 3, the Patient List measure.[ii]

Core # 14, Exchange Clinical Information and Menu # 10, should be readily provable if you successfully sent data to the receiving parties and received an email or letter affirming receipt. However, the standards explicitly allows that the test does not have to be successful. If it is not successful, it is crucial that providers take screenshots of the entire process of the tests as they are conducting them. Interestingly, both of the measures have exclusions, one of
which likely applied to Dr. Jones situation. If you claim an exclusion on any measure, be sure to thoroughly document the reason for the exclusion with supporting evidence.

That leaves Core Requirement # 15 which is of course, a focus of Health Security Solutions practice. So here are some thoughts on meeting this requirement:

- As we have reported before, the standard states that the risk analysis must be conducted during the reporting period (or prior to the initial 90 day reporting period).
- Organizations do NOT have to outsource this requirement but it will make sense for many organizations to do so. Typical physician practices have neither the expertise nor the resources to conduct a risk analysis.
- The audit specifies that they would expect to see a “report” documenting that a risk analysis was completed.
- The exact process for conducting and reporting a risk analysis is not defined in the regulations. So what will be acceptable to an auditor? Your best bet is one that complies with NIST Guidelines, specifically Special Publication 800-30. Appendix K of that document provides an outline of what should be included in a report. Page 29 lists the specific broad tasks associated with risk analysis[iii]:

One last thought. For many practices, the MU requirements seems overwhelming. This is especially true of the risk analysis requirement. Smaller practices are not flush with cash and even more bereft of resources. This is one reason we developed and introduced our Risk Analysis in a Box Lite service line, designed specifically for small providers. Please call us if we can be of service to you.

In future post, I hope to provide more reflections, ideas and advice on the MU audit program by seeking guidance from credible experts and others invested in seeing it, and its
benefactors, succeed. I will also keep readers updated on the status of Dr. Jones.

Steve

Steve Spearman, Founder and Chief Security Officer for Health Security Solutions, has been in the healthcare industry since 1991. After spending more than a decade observing health care providers struggle with the HIPAA Security and Privacy regulations, he founded Health Security Solutions in the summer of 2010 to help organizations minimize and mitigate the financial, legal, and compliance risks associated with running health care organizations.

Steve alongside his team of security experts, have helped healthcare providers qualify for millions of dollars worth of stimulus funding through a wide range of HIPAA consulting services and solutions, including his very own risk assessment method, Risk Analysis in A Box.

To learn more about Steve, Health Security Solutions, and the services they provide please visit www.healthsecuritysolutions.com.

[i] I wonder if the use of the word “facility” implies that all physicians at a single practice would be audited at the same time. Dr. Jones is a solo practitioner so we can’t know from his example.

[ii] I intend to contact an expert in the field related to the
capabilities and certification requirements of certified EHR’s and will report on that in a later alert.

[iii] Risk Analysis Tasks according to NIST 800-30.

- Identify threat sources that are relevant to organizations
- Identify threat events that could be produced by those sources;
- Identify vulnerabilities within organizations that could be exploited by threat sources through specific threat events and the predisposing conditions that could affect successful exploitation;
- Determine the likelihood that the identified threat sources would initiate specific threat events and the likelihood that the threat events would be successful;
- Determine the adverse impacts to organizational operations and assets, individuals, other organizations, and the Nation resulting from the exploitation of vulnerabilities by threat sources (through specific threat events); and
- Determine information security risks as a combination of likelihood of threat exploitation of vulnerabilities and the impact of such exploitation, including any uncertainties associated with the risk determinations.

Physicians are Leaving Hospital Employment and Starting New Practices on
Their Own Terms

In our consulting practice we are seeing physicians fleeing hospital employment just when many people are predicting the death of the private medical practice. We affectionately call these physicians our “Single Shingles” and they are approaching private practice much differently. These physicians often bring their spouses into the practice as their business partners, and we teach them how to manage the practice.

Here are some practice models that solo physicians are considering for their Single Shingles.

The Retainer-Based Practice

Although the retainer-based practice has many other names, calling it retainer medicine seems to be the most generic way to describe direct care, or care that patients pay for directly without the intervention of a third-party payer source. There are as many variations of retainer-based practices as there are name variations, but the three main types are listed below.

Retainer: Fee for Extra Services Model

It is not unusual for practices to implement a “fee for extra services” model for Medicare patients. Medicare reimbursement does not pay enough to keep the lights on. To help pay for
services to these patients, some practices turn to fee for extra services, which is allowed for services that Medicare never covers. The Office of the Inspector General (OIG), Department of Health and Human Services says this:

“Medicare participating providers can charge Medicare beneficiaries extra for services that are not covered by Medicare. In addition, participating providers may charge beneficiaries for any Medicare deductibles and coinsurance without violating the terms of their assignment agreements.”

The Fee for Extra Services Model for Medicare patients uses an annual membership fee or extra fees a la carte to cover the annual physical (see my article on “Why You Can’t Get An Annual Medicare Physical” here) and the practice may also cover longer appointments, 24/7 access to the provider and same day/next day appointments. A typical panel is 500 patients and the physician usually sees about 10 patients a day. Some practice may use this model for non-Medicare patients as well, and the fee may cover other custom services. In this model, the insurance is always filed on behalf of the patient.

Other forms of the fee for extra services model are the Concierge Model, where the annual membership fee is higher ($1500+ per year) and the physician may offer additional services such as house calls and personal scheduling of referrals and tests, and the Boutique Model, where the membership fee is even higher and additional services may include Botox, medical spa services and nutraceuticals.

Retainer: Fee for Care Model

The Fee for Care model is also called “direct access primary care,” and patients pay the practice directly to have primary care and urgent care covered. Patients pay an average of $70 per month and insurance for these services is not filed.
Retainer: Hybrid Model

This model is a mix of retainer-based care and traditional insurance-based care.

The Micropractice

The Micropractice is another name for the Ideal Medical Practice (IMP) which was pioneered by Gordon Moore, MD in 2003. The Micropractice is a solo physician working in a very slimmed-down, lean model. The physician works alone without staff and leases space in another practice, using one exam room. The physician answers the phone, patients book appointments online and there is a heavy reliance on technology. The patient panel is much smaller, but because the practice overhead is significantly lower, insurance and patient reimbursement goes much further.

The Virtual Practice or Telepractice

This model leverages the technologic advances that enable secure communication with patients via phone or video conference, and also can include remote physiologic monitoring. With the age-in-place movement gaining popularity, the virtual practice may be a great option for geriatrics. Psychiatry is also a good fit.

The House Call Practice

Medicare payments have increased for house calls, making this practice model more feasible than it has been in the past. This model is also supported by the interest in aging-in-
place. As payers put more emphasis on keeping patients out of hospitals, and with the recent creation of two new transition care codes (99495 and 99496) that reimburse physicians for helping patients transition home from a hospital stay, a house call practice may be the practice of the future.

Why You Can’t Get An Annual Medicare Physical

In 2011, the Centers for Medicare and Medicaid (CMS) unveiled a new benefit to address the need for annual care for seniors. It was widely hailed as a wonderful thing for Medicare patients who previously had no preventive care unless they paid out-of-pocket for a “complete physical.” What some people overlook is that the new Medicare benefit includes no actual physical examination of any kind.

The “physical” terminology is what trips most people up. The American Medical Association (AMA) owns Current Procedural Terminology (CPT) which is part of the Medicare’s Healthcare Common Procedure Coding System (HCPCS). Neither CPT nor HCPCS lists an “annual physical” or a “complete physical,” with the exception of the preventive visit codes which include an “age-
appropriate examination.” The traditional expectation for an annual physical is complete review of all physical systems with reporting of any issues, a complete head to toe physical examination, and any needed tests to confirm/promote wellness or to ascertain illness.

According to CPT/HCPCS, confirming/promoting wellness and ascertaining illness are not both parts of one code, but are addressed in two different types of codes – the well visit codes and the sick visit codes. The question on everyone’s mind is “What if you ascertain and address illness (a new problem) during a well visit?”

I don’t think there is a good answer to this question. There’s the right answer for billing, according to Medicare and there’s the right answer in the minds of most physicians I know, but there is not a single answer that works for billing and what patients want.

Because of this confusion, there is great frustration on the part of physicians and patients. If the office doesn’t understand what the patient wants, or the patient doesn’t understand their Medicare benefits, there is either a surprise in the exam room, or a surprise at the check-out desk, and no one enjoys that kind of surprise.

The only answer is to help patients understand what Medicare will and will not pay for and to try to match their benefits, their needs and what they are willing to pay for.

Here are the service choices defined by CMS/Medicare:

**NAME: Welcome to Medicare Visit**

**WHEN:** Available to all Medicare patients during the first 12 months of Medicare Part B eligibility
WHAT HAPPENS: Review of patient’s medical history, risk factors, functional abilities and referrals for education or counseling. Could include an EKG or referral for an EKG. Could include screening for an abdominal aortic aneurysm (AAA). Does not include a physical exam.

WHO PAYS: This visit has no deductible and no co-insurance, unless the patient has a screening EKG. The EKG does have the deductible and co-insurance applied.

NAME: Annual Wellness Visit

WHEN: Available 12 months after the Welcome to Medicare Visit and every 12 months thereafter

Does not include a physical exam.

WHAT HAPPENS: Review of your medical history, risk factors, functional abilities, a depression screening and a written screening schedule.

WHO PAYS WHAT: This visit has no deductible and no co-insurance.

NAME: Sick Visit (standard office visit)

WHEN: No restrictions on how often as long as there is a documented need for the visit.

WHAT HAPPENS: This is a regular office visit for an illness, injury or new problem or for monitoring of an existing problem. The three parts of a standard office visit are the HISTORY, the PHYSICAL EXAM, and the ASSESSMENT/PLAN.
WHO PAYS WHAT: This visit will apply to the deductible ($147 for 2013) if the patient’s deductible has not been met, and co-insurance will apply.

SPECIAL NOTE: Patients can have a wellness visit and a sick visit at the same appointment and will not owe anything for the wellness visit but will owe the deductible/co-insurance for the sick visit.

NAME: Preventive Visit (most like the old “annual physical”)

WHEN: Annually.

WHAT HAPPENS: This is a visit where the physician will review your medical history and perform an exam, order routine lab tests and talk to you about risk factor reduction.

WHO PAYS: Medicare does not pay for this service at all and the patient is responsible for 100% of the cost of the visit.

RAC Alert: How to Bill Medicare for Hospice Patients When You Are Not the Hospice Provider
What is Hospice?

Hospice care focuses on improving the quality of life for persons and their families faced with a life-limiting illness. The primary goals of hospice care are to provide comfort, relieve physical, emotional, and spiritual suffering, and promote the dignity of terminally ill persons. Hospice care neither prolongs nor hastens the dying process. As such, it is palliative not curative. Hospice care is a philosophy or approach to care rather than a place. Care may be provided in a person’s home, nursing home, hospital, or independent facility devoted to end-of-life care.

How is Medicare Hospice Care Paid?

When hospice coverage is elected, the beneficiary waives all rights to Medicare Part B payments for services that are related to the treatment and management of his/her terminal illness during any period his/her hospice benefit election is in force, except for professional services of an attending physician, which may include a nurse practitioner. If the attending physician, who may be a nurse practitioner, is an employee of the designated hospice, he or she may not receive compensation from the hospice for those services under Part B.
These physician professional services are billed to Medicare Part A by the hospice.

**What is the RAC Issue?**

Recovery Auditors recently reported a billing issue for physicians providing services unrelated to a Hospice terminal diagnosis provided during a Hospice period. Hospice claims are filed under Part A, while services not related to a Hospice diagnosis are filed under Part B. In these cases, unrelated care was billed **without** the accompanying GW modifier. **All services related to a Hospice terminal diagnosis are included in the Hospice payment and are not paid separately.**

For beneficiaries enrolled in Hospice, Medicare Administrative Contractors (MACs) and/or Medicare Carriers must deny any service furnished on or after January 1, 2002, that are submitted without either GV or GW modifier.

**GV Modifier** = Attending physician treating a patient with a Hospice related terminal diagnosis, but not employed or paid under arrangement by the patient’s hospice provider

**GW Modifier** = Service not related to the Hospice patient’s terminal condition

**Recovery Auditor Finding**

In this audit, the recovery auditors conducted an automated review of claims for physician services. A significant number were deemed to contain improper billing resulting in overpayment.

**Claim Example 1:** A patient is enrolled in Hospice and goes to a physician’s office for open treatment of a femoral fracture, with internal fixation or prosthetic replacement, CPT code 27236.
Finding: If the procedure is unrelated to the terminal diagnosis (Non-Hospice related), the physician’s bill should contain modifier GW. If this modifier is not appended, the procedure is related to the terminal diagnosis and should not be reimbursed under the part B benefit, instead paid under the hospice benefit.


Finding: The billing of code 45378 would be incorrect since the beneficiary was enrolled in hospice. There can be no separate reimbursement unless the service was unrelated to the terminal diagnosis, which has to be reflected by the proper modifier.

How to Capture Medicare Hospice Information

- Identify patients enrolled in Hospice, and document in your system the Hospice in which they are enrolled.
- If you have referred a patient to Hospice, flag their account in the computer so anyone performing coding or billing can investigate the use of appropriate modifiers.
- If you have received correspondence notifying you of a patient’s enrollment in Hospice, notify staff and make sure the billing record is flagged for appropriate coding.
- If you become aware during the patient’s care that the patient you are treating is in Hospice, document the name of the Hospice and notify staff, making sure the billing record is flagged.
- Patients sometimes dis-enroll or are discharged from
Hospice, so do not assume a patient is continuing care under Hospice. When in doubt, contact the patient’s Hospice to clarify if the patient is or is not enrolled.

- A little extra leg work will not only cause your claim to be paid on time and properly, it will also keep you from having to pay back any money if improperly paid to you.

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The tweet above was sent out by a very interesting start up named Sickweather on October 19th of last year. Sickweather analyzes data from Twitter and Facebook to determine potential public health concerns by listening to the things people post on social media. If a lot of people are posting about coughing, sneezing or other symptomatic behavior, you could make the assumption that increased disease activity is more likely in the area. The tweet welcoming flu season early was not an ironclad prediction, announcement, or warning but six weeks later the Centers for Disease Control issued a press release titled “U.S. Flu Season off to Early Start.”
“The tweet welcoming flu season early was not an ironclad prediction, announcement, or warning but six weeks later the Centers for Disease Control issued a press release titled ‘U.S. Flu Season off to Early Start’.”

The 2012-2013 flu season is shaping up to be “moderate to severe” with 47 states reporting “widespread geographic influenza activity” to the CDC. Outside of the Pandemic 2009-2010 “Swine Flu” season, the reporting of Influenza Like Illness (or ILI) to care providers this year is at levels we have not seen since 2003-2004. Although reports point to this year’s season being at or near it’s peak, we thought it would be a great time to remind or readers and clients about some of the tools and resources you have at your disposal.

Protecting your Staff

- If your staff are rusty on basic flu information you can find a wealth of information for providers at the [CDC](https://www.cdc.gov) and the [Flu.gov](https://www.flu.gov) websites to catch up on basics and preparation measures.
- Rule Number One: *IF THEY ARE SICK THEY HAVE TO GO HOME.* Sick providers and employees are powerless to help
patients.

- A stronger flu season is a good time to review your staffing and preparedness plans both for pandemics specifically and disaster prep in general.

Protecting your Patients

- If you provide primary care, you are already probably dispensing the most common and effective advice against the flu: vaccination, and prevention, but patients can also be directed to more resources on their own. Tell them to check out the information available on flu shots and staying healthy at Flu.gov for further research.

- Remember who is most susceptible to flu-based fatalities and hospitalizations: the young, the elderly, and the already sick. Make sure your vulnerable patients get the information they need up front. If you don’t offer flu shots at your facility, make sure they can find somewhere that does close by.

Protecting Your Revenue Cycle

- Make sure your billing and coding departments are up on this year’s Flu Shot billing codes.

- With the 1st of the year having already rolled over, many of your patients will have new calendar-year deductibles, co-pays and other patient responsibilities. If you haven’t already, maybe now is the time to start a “Credit Card on File” Program – and we’d love to help!

What other ways do you “flu-proof” your practice each year? Tell us your tips in the comments below!
The Medicare “Billing Bible” Changes Claims Processing Instructions for PAs, NPs, CNSs, CPs, and CSWs

Chapter 12 of the “Medicare Claims Processing Manual” (Medicare Billing Bible) is about to change to reflect deleted and/or corrected information as it relates to Claims Processing Instructions for Non-Physician Practitioners (NPPs), i.e., Physicians Assistants (PAs), Nurse Practitioners (NPs), Clinical Nurse Specialists (CNSs), Clinical Psychologists (CPs), and Clinical Social Workers (CSWs) submitting claims to Medicare contractors (carriers and A/B Medicare Administrative Contractors (MACs)) for services to Medicare beneficiaries.
These changes are effective February 19, 2013.

Key manual revisions/updates are as follows:

- NPP assistant-at-surgery services should be billed with the “AS” modifier only.
- The health professional shortage area (HPSA) payment modifiers, “QB” and “QU” have been eliminated because they are no longer valid.
- The “AH” modifier for CPs and, the “AJ” modifier for CSWs have been eliminated because they are no longer necessary for identification purposes.
- The correct payment amount for the professional services of PAs, NPs and CNSs is 80 percent of the lesser of the actual charge or, 85 percent of what a physician is paid under the Medicare Physician Fee Schedule (MPFS.)
- Additionally, the correct payment amount for assistant-at-surgery services furnished by PAs, NPs and CNSs is 80 percent of the lesser of the actual charge or, 85 percent of 16 percent of what a physician is paid under the MPFS for surgical services.
- Procedures billed with the assistant-at-surgery physician modifiers -80, -81, -82, or the AS modifier for physician assistants, nurse practitioners and clinical nurse specialists, are subject to the
assistant-at-surgery policy. Accordingly, Medicare will pay claims for procedures with these modifiers only if the services of an assistant-at-surgery are authorized.

- Medicare’s policies on billing patients in excess of the Medicare allowed amount apply to assistant-at-surgery services.
- When a PA, NP, or CNS furnishes services to a patient during a global surgical period, Medicare contractors shall determine the level of PA, NP, or CNS involvement in furnishing part of the surgeon’s global surgical package consistent with their current practice for processing such claims.
- Billing requirements and adjudication of claims requirements for global surgeries are under chapter 12, sections 40.2 and 40.4 of the “Medicare Claims Processing Manual.”
- PAs, NPs, and CNSs must have their own “non-physician practitioner” national provider identification number (NPI) number. This NPI is used for identification purposes only when billing for PA, NP, or CNS services, because only an appropriate PA, NP, or CNS employer or, a provider/supplier for whom the PA, NP, or CNS furnishes services as an independent contractor can bill for PA, NP, or CNS services. Specialty code 97 applies for PAs enrolled in Medicare. NPs enrolling in Medicare use specialty code 50 and CNSs use specialty code 89.

The 10 Essential Health Benefits of the ACA, and Why
In late November, the Department of Health and Human Services published its proposed rules that outline how the insurance market will operate starting in 2014. The rules mean consumers will have access to the information they need to make informed decisions about their health insurance purchases, and will be able to compare plans of similar coverage and price side by side in new federal and state run health insurance exchanges.

The proposed rules cover three areas: Actuarial Value, Accreditation Standards and Essential Health Benefits.

Actuarial value is a calculation of the percentage of the cost of covered benefits that an insurance plan covers. A plan with an actuarial value of 80% pays for roughly 80% of the total costs of covered treatment for the subscriber. Plans that meet certain guidelines will earn “medal” status: plans can be designated gold, silver, or bronze medal and so on based on premiums and actuarial value.

The accreditation standards lay out the process of becoming
certified for the Health Insurance Exchanges (HIEs – not to be confused with Health Information Exchanges!), and a big part of meeting those standards will be providing coverage for the ten benefits that are defined in the rules.

The ten “Essential Health Benefits” benefits are really more areas of coverage rather than specific individual services or procedures, but all plans inside and outside of the HIEs must provide coverage in these ten areas:

1. Ambulatory patient services
2. Emergency Services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance use disorder services, including behavioral health treatment
6. Prescription drugs
7. Rehabilitative and habilitative services and devices
8. Laboratory services
9. Preventative and wellness services and chronic disease management
10. Pediatric services, including oral care and vision

Each state will have the leeway to define the minimum standards of coverage based on already available plans in the state market, but each state must provide some form of coverage in each of these ten areas.

So what does this mean for your
practice?

First of all, these ten essential benefits could represent an expansion of covered care for many of your current patients. Providers know the feeling of advising a patient to seek specialized care or other benefits that are non-covered under their current plans, only to realize that medical expenses have to be balanced against a real-world budget, job market and economy. With these ten essential benefits as part of a minimum insurance package, providers will know that these areas have at least some coverage for their patients, and this could mean long-advised suggestions for physical therapy, behavioral health, or expensive prescriptions could find a more receptive audience.

Your patients are probably already coming to you with questions about healthcare reform, insurance coverage and what it means, and giving them a better understanding of their essential health benefits under the law can help them to participate in their own care. These proposed rules also provide a great excuse for you to review which groups and specialists you refer to in the area: with benefit expansions, you can find new opportunities to connect with other providers for the benefit of your patients and your practice.

And finally, the shift from volume reimbursement to accountable care models means that more than ever, the bottom-line success of a practice is explicitly tied to the healthcare outcomes of their patients. This means that providers need to have all the wellness and treatment weapons in their arsenal that they can find.

What is your practice doing now to get ready for the changes coming to the insurance system in 2014?
The Big Idea for 2013: Show Me Your Fees

Private practices, hospital-owned practices and affiliated group practices are facing big changes from healthcare reform, demographic shifts, and economic and reimbursement pressure. The industry is re-evaluating itself from top to bottom and looking for new business models, ideas and opportunities to make medical practice feasible. Health insurance is changing as employers and payers are reducing benefits and shifting costs to patients. High deductible health plans (HDHPs) are becoming more popular, and with that patients are thinking more like customers, and making their healthcare decisions based on out-of-pocket costs.

Patients want access to pricing info, and are not satisfied with “it’s complicated” as an answer. The industry as a whole is moving towards rewarding performance over volume, and patients will also be armed with more publicly available performance and safety data.

In short, bedside manner and reputation are not enough anymore: practices now have to compete on price and quality in a more explicit way than ever before. We are advising our medical practice clients to take a long hard look at how they set their prices. Setting your prices does not have to be a complicated exercise when you have a basic understanding of
your overhead. If you understand what it costs to produce each RVU of service to your patients, than you can understand what a self-pay or high-deductible patient needs to pay in costs and margin. **Then tell your customers what your services cost.** This is what what other businesses do.

Price transparency improves patient satisfaction and trust because patients can relate what they are paying for to the value they are getting. It eases conversations about patient financial responsibility. Patients want to understand the money behind the treatment they are getting, because they have more financial “skin in the game” than ever before. Engage your patients in this process immediately by publishing your fees!

**For almost as long as I’ve been in healthcare, telling patients what services cost has been an issue and here’s why –**

**Fee schedules are set for insurance companies, not for patients.** When a practice signs a contract with an insurance company, the assumption is that in exchange for the insurance company delivering volume (lots of patients) the practice can afford to deeply discount their fees. The practice supplies their fee schedule and the insurance company cuts it down. The practice wants to start with a high enough fee schedule that a significantly cut schedule will still be much better than Medicare. This is what is referred to as “not leaving any money on the table” – setting your fee schedule high enough to capture everything an insurance company will potentially pay.

**Medicare and Medicaid don’t pay physicians enough to cover expenses.** To make up for this, practices charge commercial payers more to cover what government payers don’t pay.
Every payer/insurance company negotiates a different rate. Unless the practice has negotiating power, the physicians are usually forced to take what the insurance company is offering. Especially if the insurance company has a strong presence in the community, the physician may feel s/he has no choice but to take what is offered. This is why many physicians are opting to join megapractices or hospital organizations.

The rise of uninsured patients and high-deductible insurance plans has changed the number of patients paying 100% for their healthcare. For the past 5 years, the payment for healthcare has dramatically shifted and medical practices and patients have not been ready. Against rising healthcare costs, insurance plans and employers have shifted payment to patients in the way of increased cost-sharing, increased deductibles, increased co-pays and co-insurance and decreased benefits. Patients have often been the only ones paying the full retail cost for healthcare – the full fee schedule.

How do you place a price on healthcare services?

1. **Calculate what your services really cost.** One way is to take the last 12 months of practice expenses and divide them by the work Relative Value Units (wRVUs) you produced over the same period. This will tell you what it costs you to produce each unit of work. Look at it with the physician’s pay included and without the physician’s pay included.

2. **Calculate what portion of your expense is related to filing and collecting insurance payment.** This is primarily your coding, billing and insurance staff, their workspace and equipment and everything related to filing insurance and collecting. Reduce your fees by this cost for uninsured patients.
Why should you take this radical advice?

1. **Consumers deserve to know what your service costs.** Why would anyone buy anything without knowing what it costs? Consumers should know both the value of the service as well as knowing what is their personal responsibility to pay. Does the fact that healthcare sets their prices above what the market can bear mean we are part of the healthcare problem?

2. **Publishing fees makes you justify them.** Medical practices may not want to post their fees if they aren’t sure what their services truly cost. Other businesses charge what their services or goods cost plus a profit, why don’t we?

3. **You will find out if your prices are not competitive in the market.** Patients will tell you. Then you will have to decide if you want to be competitive. If you are worried you can’t compete with a hospital-sponsored practice if they know your prices, stop worrying. The hospitals already know your prices.

4. **Publishing your prices will open the door for things to be simpler.** Publishing fees will liberate you and your staff to talk much more openly with patients about their financial responsibility.

*Part of this post was originally published under “The Big Idea: Healthcare Price Transparency” on LinkedIn.*
2013 Medicare Parts A, B, C and D Deductibles and Premiums

The Part B Medicare deductible for 2013 is $147.00.

What should you do with this information? You should avoid taking a big financial hit in the first quarter of 2013 by collecting deductibles at time of service. How do you do that?

- Let all patients know in advance that you collect deductibles by making it part of your communication with them. Put it in your financial policy (get a copy of my preferred financial policy below), put it on your website, and let patients know when you schedule their appointment, or make an appointment reminder with verbiage like:

  “We look forward to seeing you at your appointment. Please bring your insurance cards and all medications to your visit. We will collect your co-pay, your deductible, and any co-insurance required by your insurance plan.”

- Explain what a deductible is. Get my sample patient
Train front desk staff on deductibles and get them comfortable discussing deductibles with patients and answering their questions.

Do not collect deductibles for Medicare patients who also have Medicaid, or for Medicare patients with supplemental insurance as there most likely will not be a balance that the patient will owe.

It is ideal to use a Credit Card On File program to charge the patient’s credit card at time of service, or when the EOB (Explanation of Benefits) arrives in 15 days.

Other important Medicare numbers for 2013

Part A: Hospital Insurance Premium for 2013—$441.00 per month. Most 65+ patients get Part A for free if they already receive retirement benefits from Social Security or Railroad Retirement due to taxes paid during working years. Part A includes coverage for:

- Inpatient care in hospitals
- Skilled nursing facility care
- Hospice care
- Home health care – skilled nursing care, physical therapy, occupational therapy, speech therapy, medical social services, dietary and home health aides (100% covered with no co-pay) for homebound patients after a 3-day hospital stay

Part B: Medical Insurance Premium for 2013—$104.90 per month for most, but not all patients. Some patients automatically get Part B, others may have to pay more based on their IRS tax return from 2011. Part B includes coverage for:
Services from doctors and other health care providers
- Outpatient care (includes emergency room and observation services for physician charges)
- Home health care – services provided to a homebound patient when the patient has not been hospitalized for 3 days prior to need
- Durable medical equipment
- Some preventive services

**Part C: Medicare Advantage Plans** – also called a Medicare Replacement Plan because it replaces traditional or original Medicare with a plan offered by a Medicare-approved private insurance company (BCBS, UHC, etc.) Premiums vary with individual Medicare Advantage Plans. Medicare Advantage Plans:

- Include all benefits and services covered under Part A and Part B
- Usually include Medicare prescription drug coverage (Part D) as part of the plan
- May include extra benefits and services for an extra cost
- Cannot be used in combination with a Medigap policy

**Part D: Medicare Drug Coverage for 2013** – monthly premiums will vary based on income, and whether or not Part D is included if the patient opts for Part C coverage. Some plans have deductibles and some do not. Most drug plans have a coverage gap referred to as the “donut hole”, which means coverage is temporarily limited after the patient and drug plan have spent a certain amount for covered drugs. In 2013, once the patient reaches the donut hole, they pay 47.5% of the plan’s cost for covered name-brand drugs and 79% of the plan’s cost for covered generic drugs until the end of the donut hole is reached. In every successive year after 2013, the donut
hole will shrink until 2020 when the donut hole will cease to exist.

**Medicare Supplement Insurance (also called Medigap) –** Policies are sold by private insurance companies and help pay some of the health care costs that Medicare doesn’t cover. Patients have a one-time 6-month Medigap Open Enrollment Period which starts the first month they are 65 and enrolled in Part B. This period gives patients a guaranteed right to buy any Medigap policy sold in their state regardless of their health status.

**Click here to receive a free copy of a financial policy and a patient handout explaining deductibles.**

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**Medicare Audit Guidelines for Provider Signatures**

**Medicare Signature Requirements**

The purpose of a rendering/treating/ordering practitioner’s signature in patients’ medical records, operative reports, orders, test findings, etc., is to demonstrate the services have been accurately and fully documented, reviewed and authenticated. It confirms the provider has certified the
medical necessity and reasonableness for the service(s) submitted to the Medicare program for payment consideration. For medical review purposes, Medicare requires that services provided/ordered be authenticated by the author.

Let’s define some terms first.

**Handwritten Signature** – a handwritten signature is a mark or sign by an individual on a document to signify knowledge, approval, acceptance or obligation and of the document.

**Digitized Signature** – a digitized signature is an electronic image of an individual’s handwritten signature reproduced in its identical form using a pen tablet.

**Signature Log** – A signature log is a typed listing of the provider(s) identifying their name with a corresponding handwritten signature. This may be an individual log or a group log. A signature log may be used to establish signature identity as needed throughout the medical record documentation. On behalf of a health care provider, the practice manager may create a signature log at any time, and Medicare Contractors will accept all submitted signature logs regardless of the date on which they were created.

**Signature Attestation** – A signature attestation is a statement that must be signed and dated by the author of the medical record entry and must contain sufficient information to identify the beneficiary. SAMPLE verbiage:

_I, [print full name of the physician/practitioner], hereby attest that the_
medical record entry for ____[date of service]___ accurately reflects signatures/notations that I made in my capacity as ____[insert provider credentials, e.g., M.D.]___ when I treated/diagnosed the above listed Medicare beneficiary. I do hereby attest that this information is true, accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to administrative, civil, or criminal liability.

**Electronic Signature** – Electronic signatures usually contain date and timestamps and include printed statements, e.g., “electronically signed by,” or “verified/reviewed by,” followed by the practitioner’s name and preferably a professional designation. Note: The responsibility and authorship related to the signature should be clearly defined in the record. Example of an acceptable electronic signature: “Electronically Signed By: John Doe, M.D. 08/01/2008 @ 06:26 A”

**Digital Signature** – a digital signature differs from an electronic signature in that it is an electronic method of a written signature that is typically generated by special encrypted software that allows for sole usage.

**NOTE:** Be aware that electronic and digital signatures are not the same as “auto-authentication” or “auto-signature” systems, some of which do not mandate or permit the provider to review an entry before signing. Indications that a document has been “signed but not read” are not acceptable as part of the medical record.

**Signature stamp** – a signature stamp is a likeness of a handwritten signature used by administrative staff on medical records. **Signature stamps on medical records are N0 longer recognized as valid authentication for Medicare signature purposes and may result in payment denials by Medicare.**
Rules Medicare Auditors Use for Signatures

- If the signature is illegible or missing from the medical documentation (other than an order), the review contractor shall consider evidence in a signature log or attestation statement to determine the identity of the author of a medical record entry.

- If the signature is missing from an order, the review contractor shall disregard the order during the review of the claim (i.e., the reviewer will proceed as if the order was not received). Signature attestations are not allowable for orders.

- For a signature to be valid, the following criteria must be met:
  
  - Services that are provided or ordered must be authenticated by the ordering practitioner.
  - Signatures are handwritten or electronic. **Stamped signatures are not acceptable.**
  - Signatures are legible.

- Medicare does not accept retroactive orders. If the practitioner’s signature is missing from the medical record, the practice should submit an attestation statement from the author of the medical record.

- Your contractor may offer specific guidance regarding addenda to medical records. If the order is unsigned, you may submit progress notes showing intent to order the tests. The progress notes must specify what tests you ordered. A note stating “Ordering Lab” is not sufficient. If the orders and the progress notes are unsigned, your facility or practice will be assessed an error, which may involve recoupment of an overpayment.
• You may submit a signature log or attestation statement to support the identity of the illegible signature. If the original record contains a printed signature below the illegible signature, this may be accepted.

• Documentation must contain enough information to determine the date on which the service was performed or ordered. If the entry immediately above or below the entry is dated, medical review may reasonably assume the date of the entry in question.

• Reports or any records that are dictated and/or transcribed, but do not include valid signatures “finalizing and approving” the documents are not acceptable for reimbursement purposes. Corresponding claims for these services will be denied.

• Acceptable signature phrasing is
  • ‘Electronically signed by’ with provider’s name
  • ‘Verified by’ with provider’s name ‘Reviewed by’ with provider’s name
  • ‘Released by’ with provider’s name
  • ‘Signed by’ with provider’s name
  • ‘Signed before import by’ with provider’s name
  • ‘Signed: John Smith, M.D.’ with provider’s name
  • Digitalized signature: Handwritten and scanned into the compute.
  • ‘This is an electronically verified report by John Smith, M.D.’
  • ‘Authenticated by John Smith, M.D.’
  • ‘Authorized by: John Smith, M.D.’
  • ‘Digital Signature: John Smith, M.D.’
  • ‘Confirmed by’ with provider’s name
  • ‘Closed by’ with provider’s name
  • ‘Finalized by’ with provider’s name
  • ‘Electronically approved by’ with provider’s name
Unique Signature Situations

**Incident-to Services** – a physician’s professional services means that the services or supplies are furnished as an integral, although incidental, part of the physician’s personal professional services in the course of diagnosis or treatment of an injury or illness. Only the Past, Family, and Social History (PFSH) and Review of Systems (ROS) may be documented by ancillary personnel incident to and incorporated in to the E/M documentation, which must be reviewed and signed by the billing provider.

**Services of non-physician practitioners (NPPs)** – ordinarily performed by the physician such as minor surgery, setting casts or simple fractures, reading x-rays, and other activities that involve evaluation or treatment of a patient’s condition are also covered as services incident to a physician’s professional services. If the NPP performs an entire service incident-to the physician (office/clinic/home settings only), the medical record may be signed by the NPP or the physician.

**Split/shared services** –

- **Office setting:** When an E/M service in an office setting is a shared/split encounter between a physician and a non-physician practitioner (NP, PA, CNS or CNM), the service is considered to have been performed “incident to” if the requirements for “incident to” are met and the patient is an established patient. The service is reported using the physician’s billing number. The physician must sign. If “incident to” requirements are not met for the shared/split E/M service, the service must be billed under the NPP’s billing number, and payment will be made at the appropriate physician fee schedule payment. The billing NPP provider must sign.

**Hospital-based setting:** When a hospital
inpatient/hospital outpatient or emergency department E/M is shared between a physician and an NPP from the same group practice and the physician provides any face-to-face portion of the E/M encounter with the patient, the service may be billed under either the physician’s or the NPP’s number. However, if there was no face-to-face encounter between the patient and the physician (e.g., even if the physician participated in the service by only reviewing the patient’s medical record) then the service may only be billed under the NPP’s number. Payment will be made at the appropriate physician fee schedule rate based on the billing number entered on the claim. The billing provider (physician or NPP) as determined above must sign.

**Assistant at surgery** — It is not required that a surgical assistant also sign the operative report in addition to the responsible surgeon when reference is made in the note that identifies the assistant, provided that the report contains an acceptable signature by the responsible surgeon.

**Physician was present at the visit, but was unable to sign the record due to death or relocation** — If the provider is in a group practice, another provider within the group may sign on his/her behalf; however the following information must be provided:

The submitting provider, John W. Smith, M.D., is unable to sign this medical record because he expired on 10/08/08.

or

John W. Smith, M.D. relocated to Colorado on 10/08/08 and was unable to sign this medical record.

**Dictated Notes and Use of Initials**

The physician must review the transcribed note to correct any errors and affirm the note’s contents for it to be considered
the final documentation of the service.

- It is not sufficient that the provider is designated as dictating the note or his/her name is present in the record.
- If an illegible handwritten signature is present and the record contains no other identification of the author (i.e., printed name below, or letterhead with name) a signature log or attestation statement must be included with a response to the auditor documentation request.
- If the record is missing a signature, an attestation statement must be included in the response to the auditor’s documentation request.
- A legible signature that includes the provider’s full name and credentials is always the best practice.
- Initials are acceptable if signed over a typed or printed name.
- Without a typed name to identify the author, a signature log or attestation statement must be submitted or services may be denied.