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August 22, 2016 | Vol. 30, Issue 33

## IN THIS ISSUE



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

*Practice management*

## Negotiate for patient record access when rival practices close

Increase your patient census and practice revenue when a nearby practice closes by striking a deal for limited access to patient records without paying for the privilege.

In fact, in some cases, the closing practice may pay you.

One of the valuable tangible assets of a practice sale is the patient records that come with it. While the purchaser can't under HIPAA treat these records as their own until the patients affirm via signed waivers that they want to adopt the new provider, the fact that the buyer is holding the records provides an enormous incentive for them to do so.

*(see **Patient records**, p. 7)*

*HIPAA*

## Avoid privacy pitfalls when a patient files for bankruptcy

Pay close attention to what you send to court when you file a claim against a patient who is seeking federal bankruptcy protection. If you provide too much information, you can be liable for violating privacy rules established by the bankruptcy regulations, HIPAA and state law.

WakeMed Health and Hospitals, a Raleigh, N.C.-based health care system, is learning this lesson the hard way. An attorney representing a number of patients who had filed for

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

*Patient encounters*

## Warn physicians of the increasing scrutiny of hospital post-op notes

Tell your physicians to expect more scrutiny of their post-operative records and more demand for immediate progress notes as CMS and The Joint Commission (TJC) crack down on failures in that documentation. Failure to comply may result in pressure from hospital leadership.

Surveyor concerns are related to quality, continuity of care and patient safety, but also note that improperly maintained medical records can lead to delays or denial of payment by CMS and other insurers.

CMS' interpretive guidelines for hospital surveyors, found in the State Operations Manual Appendix A, cite requirements under **Tag A-0959** of the Surgical Services Condition of Participation: §482.51(b)(6) — "An operative report describing techniques, findings and tissues removed or altered must be written or dictated immediately following surgery and signed by the surgeon."

Tag A-0959 outlines 10 specific pieces of information that need to be in that post-op record and explains the guideline for CMS surveyors to pull at least six random medical records to check that the post-op notes were done correctly. (*To read the requirements, see box on p. 3.*)

Likewise, TJC surveyors will review records as well. TJC's Record of Care standard regarding records for patients undergoing surgical or other high-risk procedures and the use of moderate or deep sedation in hospitals also outlines what must be in the post-op report, aligning with the requirements under Tag A-0959.

The main difference between the CMS and TJC hospital requirements is that the commission adds the specific requirement that the information must be completed "before the patient is transferred to the next level of care." However, TJC does add two caveats: If the full post-operative report cannot be done immediately, a shorter progress note is allowed as long as it contains certain information or the report can be done at the next level of care if the clinician accompanies the patient there.

The full post-op report must then be written or dictated within a time that is outlined by the hospital.

Problems occur when the progress note is not properly dated and signed, the note leaves out required elements, practitioners fail to enter the information into the EHR in the timeframe dictated by the hospital or the hospital cannot document whether the clinician accompanied the patient to that next level of care.

It's important for physicians to get into the habit of supplying the required post-op information — including dating and signing the note — in the immediate aftermath of a surgical or other high-risk procedure, say compliance officers and consultants.

Some hospitals may use a paper or electronic template for physicians to record immediate post-operative procedure notes. *(For a sample template, go to partbnews.com)*

Enforcement also may be handed off to medical leadership as the hospital seeks to avoid survey deficiencies.


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Some hospitals are also making compliance part of physician ongoing professional practice evaluations (OPPEs). If compliance problems are severe enough, TJC may require leadership to show evidence of how they will tackle the problem, which they will do because without hospital accreditation, CMS will deny Medicare payments and likely so will other payers.

Compliance is mandatory. "[TJC] expects it, the feds expect it and the payers expect it," says Kurt Patton, a former TJC director of accreditation services and founder of Patton Healthcare Consulting, a hospital accreditation consulting firm in Naperville, Ill. — *A.J. Plunkett (pbnfeedback@decisionhealth.com)*

*Patient encounters*

## What are CMS requirements for post-operative reports?

The following is an excerpt from CMS' interpretive guidelines for its hospital surveyors, State Operations Manual Appendix A, Tag A-0959, Surgical Services Condition of Participation: §482.51(b)(6) — "An operative report describing techniques, findings and tissues removed or altered must be written or dictated immediately following surgery and signed by the surgeon."

"The operative report includes at least:

- Name and hospital identification number of the patient;
- Date and times of the surgery;
- Name(s) of the surgeon(s) and assistants or other practitioners who performed surgical tasks (even when performing those tasks under supervision);
- Pre-operative and post-operative diagnosis;
- Name of the specific surgical procedure(s) performed;
- Type of anesthesia administered;
- Complications, if any;
- A description of techniques, findings and tissues removed or altered;
- Surgeons or practitioners name(s) and a description of the specific significant surgical tasks that were conducted by practitioners other than the primary surgeon/practitioner (significant surgical procedures include: opening and closing, harvesting grafts, dissecting tissue, removing tissue, implanting devices, altering tissues); and
- Prosthetic devices, grafts, tissues, transplants or devices implanted, if any."

*Physician payments*

## CMS on diabetes program: 12-month billing delay, no ceiling to payments

CMS shed light on the Medicare Diabetes Prevention Program (MDPP) covered in the proposed 2017 Medicare physician fee schedule during an Aug. 9 provider call (*PBN 7/25/16*). The call was conducted by Darshak Sanghavi, group director, Preventive and Population Health Care Models Group, Center for Medicare & Medicaid Innovation (CMMI), and Carlye Burd, team lead on the Diabetes Prevention Program, Division of Health Care Delivery, CMMI.

Among the clarifications made in the call:

- **Providers are allowed.** While new entrants who enter Medicare to provide MDPP are instructed to enroll as suppliers, currently enrolled Medicare providers will not have to add that enrollment.
- **You need a 12-month head start.** Suppliers of MDPP are required to have full or "preliminary" recognition from Centers for Disease Control and Prevention's (CDC's) Diabetes Prevention Recognition Program (DPDR). CDC does not have a preliminary status for recognition yet — it offers either full or "pending" status — but is working with CMS to create one for the final rule. (*See the recognition standards in the resources.*) CMS requires a year of DPDR-compliant involvement in the program before claims can be filed to Medicare. Note that the program launches Jan. 1, 2018. Burd said this is because many providers and suppliers "will be brand new to Medicare" and CMS wants them up to speed before they provide the service for Medicare reimbursement.
- **Compliant beneficiaries can attend in perpetuity.** At the end of the first six months of MDPP, the beneficiaries who make and maintain their weight target of 5% below baseline at the start may continue with a monthly "maintenance" session for another 12 months, states the proposed rule. Burd said that so long as the patient's weight is maintained, beneficiaries can continue with the program and providers/suppliers can continue to be paid for it "for as long as they like."
- **MDPP data are protected health information (PHI).** MDPP providers/suppliers must maintain beneficiary data for seven years. This data will be subject to the same requirements as any other PHI. Currently weight and attendance are, along with beneficiary information, all that the program requires, but Burd warned that CMS

may eventually want MDPP coaches to collect other data for quality-reporting purposes.

Comments on MDPP and the entire proposed rule will be accepted until Sept. 6 at regulations.gov. — *Roy Edroso (redroso@decisionhealth.com)*

**Resources:**

- Proposed rule: *www.federalregister.gov/articles/2016/07/15/2016-16097/medicare-program-revisions-to-payment-policies-under-the-physician-fee-schedule-and-other-revisions*
- Diabetes Prevention Recognition Program Standards and Operating Procedures: *www.cdc.gov/diabetes/prevention/pdf/dprp-standards.pdf*

*Ask* Part B News

## To get assistant paid on '0' claims, tell why they're needed

***Question:*** *For CPT codes with an indicator of 0 (Assistant only allowed with supporting documentation), how do you recommend the surgeon document the need for an assistant? Currently I am seeing the assistant's name documented at the beginning of the op note, but then no further mention of his role throughout the procedure. I have several claims like this where Medicare denied after review of the records.*

**Answer:** Because the 0 modifier means, as administrative contractor WPS puts it, "payment restrictions for assistants at surgery apply to this procedure unless supporting documentation is submitted to establish medical necessity," you need to show that the assistant was as important to the procedure as the anesthesiologist or the scalpel.

"Submit an operative report or other medical documentation with enough clinical detail to show why the assistant surgeon was needed," says Haidy Rodriguez, director of quality improvement for Accountable Care Options in Boynton Beach, Fla. For example, "there is extensive scar tissue. Or the patient's body habitus is large or due to other conditions, prolonged exposure to anesthesia is dangerous."

Then "the surgeon would state exactly what the assistant surgeon did" to address that issue, says Rodriguez. "Assisted in creating additional access sites for the scope, cutting away scar tissue as the scope was inserted, etc."

Ruby O'Brochta-Woodward, subject matter expert for DecisionHealth, publisher of *Part B News*, gives an arthroscopic meniscectomy as an example: You can note that the patient's size resulted in the leg not fitting in the leg holder used in the procedure, so "an assistant was needed to hold and manipulate the extremity. You also need to show why that couldn't be done by the surgery tech or hospital intraoperative staff" — for example, they weren't available in that time slot.

Maxine Lewis, president of Medical Coding and Reimbursement, Cincinnati, has a further suggestion: Have the assistant make the note. The assistant is not required to do it, but it could cut some ice with the contractor.

Lewis cites a reasonable standard for getting the assistant on record in the note: Were there to be a malpractice suit, you would want it to be "very clear what the assistant did" in the procedure; you should us e the same standard for billing. — *Roy Edroso (redroso@decisionhealth.com)*

*Ask* Part B News

## Default to E/M codes, check payer policies when conducting group visits

***Question:*** *I have a provider who does group counseling for drug and alcohol dependence, after which the provider writes individual progress notes for each patient. Would it be appropriate to bill an E/M code based on time or is there a more appropriate code to use? The provider is not a psychiatrist.*

**Answer:** Before sending in a claim for a group visit, check with your individual payer or payers because no binding, national policy exists for billing group medical visits, notes Betsy Nicoletti, president of Medical Practice Consulting in Northampton, Mass.

If you scan available CPT codes, you'll find a number of codes that appear to match the group visit criteria as described above, including **98961** (Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient each 30 minutes; 2-4 patients), **98962** (… 5-8 patients) and **99078** (Physician or other qualified health care professional qualified by education, training, licensure/regulation educational services rendered to patients in a group setting [e.g., prenatal, obesity or diabetic instructions]).

But be careful — those codes are bundled under Medicare, and you'll receive a swift denial if you try to bill them.

*(continued on p. 6)*

*Benchmark of the week*

# Group visits prove challenging for practices billing prevention, intervention codes

With few options and unfavorable outcomes, providers nationally face a difficult time gaining reimbursement when providing group visits for their patients.

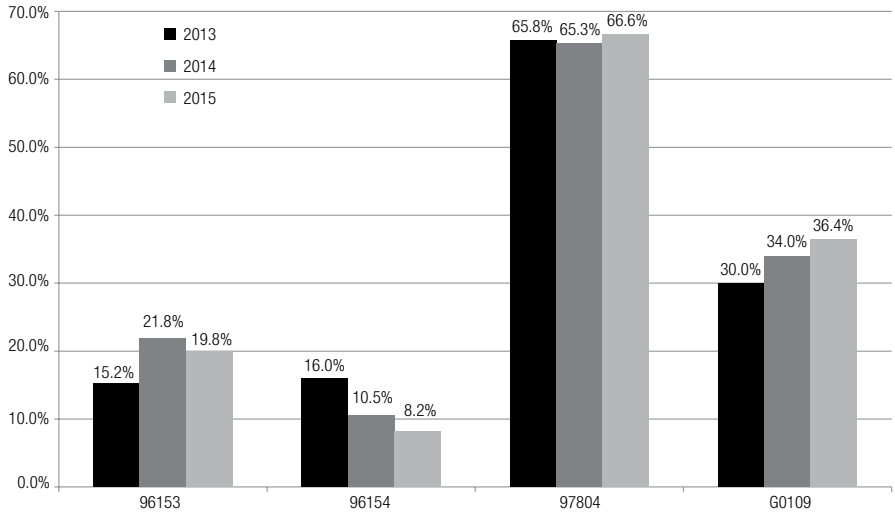
Currently, Medicare does not pay for a number of CPT codes that correlate to group visits, leaving providers little recourse but to select E/M codes, which might be hedging the edges of correct coding practice (*see story, p. 6*). A look at claims data on accepted group-visit codes shows that providers largely struggle with accepted codes as well.

The chart below depicts the three-year trends on total use and denial rates of four group-visit codes that Medicare currently accepts. Three of the codes — **96153** (Health and behavior intervention, each 15 minutes, face-to-face; group [2 or more patients]); **96154** (Health and behavior intervention, each 15 minutes, face-to-face; family [with the patient present]); and **97804** (Medical nutrition therapy; group [2 or more individuals], each 30 minutes) — garner fewer than 50,000 claims per year, gaining about $384,000 in reimbursement in 2015, the latest year of available data.

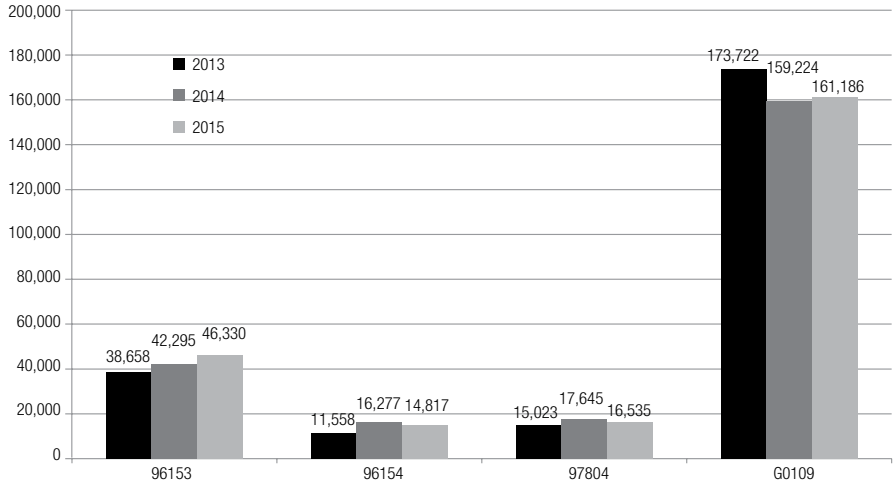
Billed more often, the group diabetes training code, **G0109** (Diabetes outpatient self-management training services, group session [2 or more], per 30 minutes), averaged about 164,000 claims over the three-year period — but it also averaged a 33.5% denial rate.

Overall, providers gained about $1.5 million in reimbursement for the four codes in 2015, yet also saw a cumulative 32.7% denial rate, led by a 66.6% denial rate on group medical nutrition therapy code 97804. Remember to note the rules governing group training to help those claims go through (*PBN 5/11/15*). — *Richard Scott (rscott@decisionhealth.com)*

**Denial rates for four group visit codes, 2013-2015**




**Total claims submitted for four group visit codes, 2013-2015**




***Source:*** Part B News *analysis of Medicare claims data*

*(continued from p. 4)*

Unless you're billing a group visit that Medicare has specifically stated it will cover, such as diabetes self-management training (DSMT) or medical nutrition therapy (MNT), your best bet is to default to an E/M office code, advices Nicoletti (*PBN 5/11/15*).

CMS appeared to open the door to using E/M codes for group visits in response to a question from the American Academy of Family Physicians (AAFP), explains Nicoletti. In that response, CMS stated that "a physician could furnish a medically necessary face-to-face E/M visit (CPT code **99213** or similar code depending on level of complexity) to a patient that is observed by other patients." (*See resources, below.*)

This reflects the practice's stance, backed by the green light that Medicare appears to give to E/M codes, that "the reason we're using the E/M code is that there's a perfectly good CPT code that no one will pay us for," says Nicoletti.

Discovering that one or all of your payers will accept an E/M code for a group visit, ensure your code choice meets the billing requirements. "Just like individual office visits, group visits … are typically billed according to the level of medical care delivered and documented using traditional E/M billing codes," explains Ed Noffsinger, Ph.D., author of *The ABCs of Group Visits: An Implementation Manual for Your Practice*, Santa Cruz, Calif.

That means, in answer to the question above, that you should base your E/M codes on history, examination and medical-decision making — but not on time. "It would be extremely difficult to ascertain the precise amount of time spent with each person individually in the group setting," notes Noffsinger.

Like medical visits, services you provide in the behavioral health arena "are typically billed by existing E/M codes according to the level of individualized medical care delivered and documented," advises Noffsinger. Also, they're typically provided by psychiatrists.

However, Medicare does cover alcohol and drug screening for individuals when provided by a medical physician, so not all intervention programs fall under the domain of behavioral health experts (*PBN 6/27/16*).

Check with your Medicare administrative contractor (MAC) to find out how they want you to report group visits — and try to get their billing requirements in writing as insurance against future claim adjustments. Check with your private payers too, and be prepared to add unused CPT codes to your arsenal; some private insurers, including PriorityHealth in Grand Rapids, Mich., cover group-visit codes 98961 and 98962 (*see resources, below*). — *Richard Scott (rscott@decisionhealth.com)*

**Resources:**

- AAFP group visits: *www.aafp.org/practice-management/payment/coding/group-visits.html*
- PriorityHealth: *www.priorityhealth.com/provider/manual/billing-and-payment/services/group-visits*

## Patient records

*(continued from p. 1)*

It isn't necessary for the buyer to purchase the entire assets of the practice either, notes Patrick Stanley, an attorney with Comitz | Beethe in Scottsdale, Ariz. Patient records may be included in a limited asset purchase agreement. As with a complete purchase, the retiring practice would then give patients notice and direct them to the purchaser to retrieve their records or, if they choose, continue their care with the new practice. Remember that the patients would have to sign on and have the final say. **Note:** Laws on the disposition of medical records may vary by state.

### How to take custody of records

Vasilios "Bill" Kalogredis, chairman of the health law department of Lamb McErlane in West Chester, Pa., says he has negotiated several arrangements between practices that were closing down and practices that wanted to pick up their patients.

"I see this a lot," says Kalogredis. "A solo practitioner is retiring and he can't sell the practice, or he's leaving one state for another. Hospitals and other practices may not want to buy, but they're interested in the patients."

Propose a "custodial" arrangement if buying the practice or part of it is too rich for your blood. In that case, your practice just takes responsibility for the safekeeping of the other practice's records. Under such an agreement, when the retiring practice gives notice to its patients, it also would inform them that they can retrieve their records from you and that you also are available to provide continuity of care.

The custodial agreement also should address the length of time that the records will be retained, says D.J. Jeyaram, owner and health care attorney at Jeyaram & Associates in Atlanta.

Consult your legal counsel and malpractice insurance carrier before entering into an agreement to make sure you're handling things properly from the legal and ethical perspectives, Kalogredis suggests.

Some practices may even receive a fee for accepting this responsibility. But note that while receiving a fee for the storage of medical records would be kosher, an arrangement whereby you pay a fee for the right to store the records "could be seen as remuneration for referrals under the federal anti-kickback statute or its state equivalents," says Jeyaram.

### Mind HIPAA rules

Note that in a custodial arrangement, you would be only holding the patient records — they're not really your records unless and until the patient releases them to you. "HIPAA only allows for the exchange of protected health information (PHI) without a written release if the transfer is between current or prior health care providers for the purposes of providing treatment," says Jeyaram.

In this circumstance, under HIPAA, you would be a business associate (BA) of the transferring practice that remains the covered entity, says Jeyaram, and you should execute a business associate agreement (BAA) (*PBN 7/11/16*).

The BAA, which ensures HIPAA compliance in the transfer and storage of records, should be referenced in the custody agreement, Jeyaram says.

Note that though it varies by state, responsibility for retention of medical records is usually seven years or longer; be prepared to follow through on that if you accept responsibility.

Remember: A custodial arrangement gives you a good shot at inheriting these patients, but it's not "exclusive" — in some states and under some contracts, other providers from the closed-down practice may take their patient lists with them and reach out to these patients too. In the end, it's always the patient's choice (*PBN 5/2/16*). — *Roy Edroso (redroso@decisionhealth.com)*

## Privacy

*(continued from p. 1)*

bankruptcy discovered that WakeMed had included a former patient's personal information when it submitted its claim for unpaid medical services by the hospital and WakeMed Physician Practices, which is in violation of the bankruptcy rules.

It turned out not to be an isolated incident. The attorney discovered that WakeMed had submitted the personal patient information of no fewer than 158 of the attorney's clients. The information included names, Social Security numbers, physician names, dates of service and birth dates. It is unknown how many other patients also had their private information exposed in that manner.

The attorney has filed a motion for contempt, sanctions and damages against WakeMed. Depending on how the bankruptcy court in North Carolina rules, WakeMed could be required to pay the cost of clearing the debtors' credit records, attorneys' fees and punitive damages.

WakeMed has issued a notice to patients, stating that while it has no reason to believe that the information has been improperly used, it is offering the affected patients one year of free credit monitoring and identity theft protection services.

## Safeguards make mistakes hard to defend

When people file for personal Chapter 7 (liquidation) or Chapter 13 (reorganization) bankruptcy, they include a list of all of their creditors. The local bankruptcy court mails a notice to each creditor and invites them to file claims with supporting documentation for the money owed. The claims are put on a claims register, which becomes part of the public record of the bankruptcy proceeding, explains attorney Cecily Dumas with Pillsbury Winthrop Shaw Pittman in San Francisco.

However, rule 9037 of the federal bankruptcy procedure regulation requires creditors to make sure personally identifiable information is not included on the claim or in the supporting documentation and, if necessary, delete or redact it by making the information illegible. For example, the documentation should include only the last four digits of a Social Security number or a birth year, not the full birth date.

A creditor that uses the electronic claim form also must check a box to verify that it understands that it must comply with the redaction rules before it is able to log in to the bankruptcy court's filing system.

But even though the bankruptcy claim forms alert creditors to this requirement, many creditors are either not familiar with the rules or gloss over them and submit too much information, says Dumas.

What likely exposed WakeMed to the complaint was that it apparently checked the box for the electronic filing form without reviewing the documents for the 158 patients to ensure that the personal information had actually been redacted, thus exposing the information.

"These filings are public record. These are all public documents," says Dumas. "It's a significant issue which could be affecting a lot of consumers and providers."

Millions of debtors who file for bankruptcy have medical debt, and many providers who file in bankruptcy court make the same mistake as WakeMed, Dumas says.

## HIPAA, state law create more risk

A health care provider's violation of this bankruptcy rule exposes the provider to additional liability because providers also are subject to HIPAA and state privacy laws. So a bankruptcy breach also triggers breach-notification requirements, a potential HHS Office for Civil Rights investigation and other consequences.

Government investigators likely are not going to be forgiving. "The fact that these are providers is important because they should be aware of the privacy laws even if they don't know about the bankruptcy rules," Dumas points out.

## 4 tips to prevent bankruptcy privacy violations

Providers can greatly reduce this risk by taking a few steps, says Dumas:

**1. Make sure the staff members who file claims are aware of the bankruptcy rules** in your area's bankruptcy court, including privacy protection rule 9037.

**2. Have specific procedures for dealing with bankruptcy claims**, such as oversight of what supporting documentation is included and how to redact it.

**3. Have the person who prepares and files bankruptcy claim forms pull and attach the supporting documentation** so that the filer knows what is being filed and can delete or white out the problematic identifying information.

**4. Add bankruptcy claims to your compliance program.** That should include monitoring and internal auditing for compliance.

## Don't ignore a bankruptcy breach

If your practice has erred and filed a creditor claim with personally identifiable patient information, you need to correct it, which is best accomplished by bringing the problem to the court's attention. You'll most likely need to file a motion with the court asking it to seal the offending document, says Dumas.

You can contact the bankruptcy clerk question desk and find out what steps to take to proceed. "They'll help you fix it. They don't want to punish you. The worst thing you can do is ignore it," Dumas warns.

Don't forget HIPAA and state privacy laws. For example, if you've exposed patient protected health information this way, you'll need to report the breach to HHS and the affected patients. — *Marla Durben Hirsch (pbnfeedback@decisionhealth.com)*

**Resources:**

- Rule 9037: *www.law.cornell.edu/rules/frbp/rule_9037*
- WakeMed's notice to patients: *www.wakemed.org/documents/billing/WakeMed_SubNotice_12.29.15.pdf*

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