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

Advanced payment model

Case study part 2: Overcome operational challenges to succeed as a medical home

Editor's note: This is part two of a two-part case study on how to transition successfully to a medical home. The first part ran in the Nov. 23, 2015, issue of Part B News.

After you've taken the leap to become a patient-centered medical home (PCMH), keep an eye on ways to continually fine-tune your workflow — particularly around shared resources such as care management — to elicit long-term success.

Start the transition to a PCMH with the appropriate

(see **Medical home**, p. 5)

Compliance

Protect your practice, don't overexplain when voluntarily repaying overpayments

If you've discovered a Medicare overpayment and want to return it, be careful to pick the least suspicious accurate reason code and pay attention to details — especially the date.

Per the Affordable Care Act, providers are supposed to turn in any Medicare overpayments they've discovered within 60 days of identifying them. Some providers and even lawyers used to believe the clock didn't start running until the provider

(see **Overpayments**, p. 6)

Holiday break

Part B News will take its scheduled break next week to ring in 2016. Our next issue will be dated Jan. 4, 2016. In the meantime, stay tuned to www.partbnews.com for news updates. Best wishes for a safe and happy holiday from Karen, Roy, Richard and Scott!

Coding

New cerumen impaction removal code could add extra payment, confusion

You'll have a new CPT code to bill for removing impacted cerumen via lavage or irrigation — services that currently are considered part of the appropriate problem-focused E/M service. The new code, **69209**, brings a new payment opportunity but also potential documentation pitfalls, experts tell *Part B News*.

Starting in 2016, 69209 will describe removal of impacted cerumen via lavage or irrigation, while existing code **69210** describes removal of impacted cerumen via instrumentation. Code 69209 has no work relative value units, and the service can be rendered by a nurse, according to a clinical example from the AMA's CPT Editorial Panel.

It's important to note that use of 69209 requires that the cerumen be impacted. When cerumen is not impacted, any removal by a health care provider would continue to be billed as part of an E/M service, the AMA says in its notes for the new code.

As a result, make sure providers document that the cerumen is impacted whenever 69209 is billed, advises Maxine Lewis, president of Medical Coding and Reimbursement in Cincinnati. When the provider is removing cerumen that is not impacted, in response to a patient complaint or as a service, it can't be billed with 69209, Lewis adds.

Bilateral modifier difference

Even though both impacted cerumen codes are described as unilateral, Medicare applies different payment rules to the codes. Bilateral payment rules do not apply to 69210, so even when both ears are treated, the service is billed only one time and no modifiers are needed.

However, bilateral payment rules do apply to 69209, so this service is billed with the **LT** (left side), **RT** (right side) or **50** (bilateral) modifier as appropriate.

The difference in bilateral payment rules may prove confusing to billers as the services are similar except for the manner of removal of the impacted cerumen, Lewis says. The difference in payment is significant. Existing code 69210 pays about \$50, while the new code will pay about \$12.

One thing to note: While CPT rules prevent both codes from being billed on the same ear, the difference in bilateral payment rules mean that if impacted cerumen is removed from one ear using instrumentation and from the other ear using lavage, both 69209 and 69210 can be billed for the same encounter.

E/M billing with cerumen removal

Expect to see a Correct Coding Initiative (CCI) edit for 69209 when billed at the same time as an E/M service — an edit exists for 69210 and an E/M service.

Because the impacted cerumen removal using lavage

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or irrigation is typically done by a nurse, practices may see the code as a way to get paid extra for the cerumen removal because it likely wouldn't impact the level of a medically necessary E/M service, Lewis believes.

As an example, she cites a patient who presents to the office with ear pain. The physician would do the full workup for the problem-focused visit, and one element of the medical decision-making would be to discover and remove the impacted cerumen.

If instrumentation is not needed, then the cerumen removal would be done by the nurse, and the practice would bill 69209. The E/M service would probably be the same level in either case and there likely would be additional medical decision-making beyond just the cerumen removal, Lewis believes.

In addition, cerumen removal is a service more likely needed by older patients, who likely need treatment for chronic conditions, especially during encounters with family physicians or internal medicine doctors, Lewis adds. — *Scott Kraft* (pbnfeedback@decisionhealth.com)

Ask Part B News

NPPs doubling as scribes: Legal but not cost-effective; experts say it's a waste

Question: *Can non-physician practitioners (NPPs) serve as scribes?*

Answer: Sure — but why would they? Practices have been known to seek ways to make some money from providers who are under contract but not yet enrolled with payers (*PBN 9/28/15*). Sometimes they'll try to get them to fill in as scribes. "I hear about it all the time," says Michael Murphy, M.D., CEO of ScribeAmerica in Fort Lauderdale, Fla. "There's one hospital in New York City — I won't name them — where the surgeons have physician assistants do their notes for them."

But this amounts to making the PAs into "very expensive scribes," says Murphy. Hourly prices for scribe services on a temp basis range from \$13 to \$35 approximately (*PBN 10/27/14*). The mean hourly wage for a PA, on the other hand, is \$46.77 per the U.S. Bureau of Labor Statistics.

No laws prevent NPPs from serving as scribes, but doing so "puts the PA at risk of fraud if claims are not

submitted appropriately" because of confusion about their role in the process, says Deirdre Middleton, vice president, communications and media relations for the American Academy of Physician Assistants in Alexandria, Va.

"As providers themselves, they may be tempted to interpret the case and insert some of their own judgment," agrees David Zetter, president of Zetter Healthcare Management Consultants in Mechanicsburg, Pa. When an NPP is serving as a scribe, "you can't embellish. If you see the provider doing something without saying it, you can't add that in." If an NPP is going to do this work, he and the provider he's serving have to get their heads straight about that. "Before you write, state your name and that you are a scribe of this provider then write only what he says — none of your own comments and none of your own judgments," says Zetter.

It's best that PAs who come aboard before they're credentialed just devote themselves to "learning the ropes of the practice" and forget about billing for any services until they can do what they were trained to do, says Kemuel Carey, the American Academy of Physician Assistants' liaison to the American Academy of Orthopaedic Surgeons and a practicing PA. — *Roy Edroso* (redroso@decisionhealth.com)

ICD-10

Flexibilities reduce denials and cash flow, but details point to problems

To reduce the negative impact of the ICD-10 transition, CMS announced on July 6 that it would allow a certain amount of leeway on ICD-10 coding (*PBN 7/13/15*). Respondents to *Part B News*' November ICD-10 survey believe the flexibilities are very helpful for code selection (39%) and claims payment (40%). But a closer look at the data for these respondents indicates a mixed bag of results.

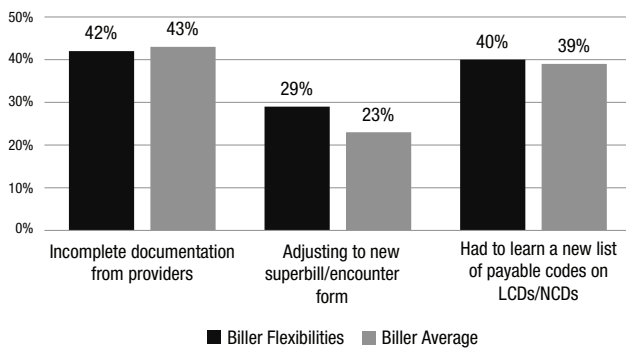
According to the survey, the average respondent said their denials were 18% higher than normal in the first few weeks after the transition. Respondents who found the flexibilities very helpful reported a smaller denial bump: 12%.

Fans of the flexibilities also reported the launch of ICD-10 did not impact their cash flow as much as the

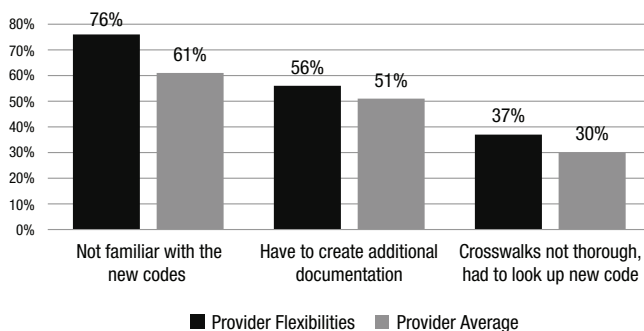
What about ICD-10 slows billers, providers, coders

The following charts show what about the ICD-10 transition is affecting the productivity of billers, providers and coders and comparing whether those staffers use CMS' flexibilities (*PBN 8/3/15*). The results are from *Part B News'* post-launch ICD-10 survey.

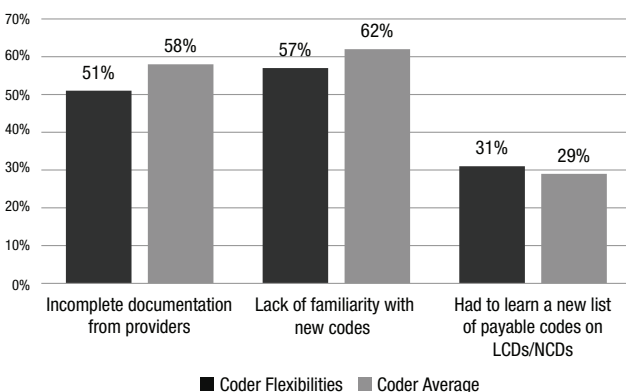
Reasons billers' productivity slows with ICD-10



Reasons providers' productivity slows with ICD-10



Reasons coders' productivity slows with ICD-10



average respondent. For example, 2% of people who found flexibilities very useful reported they saw cash flow slow by more than 50%, compared with 4% for the average respondent.

However, practices taking advantage of the flexibilities were more likely to have used emergency funds to help them cope with cash-flow disruptions. For example, 70% of average respondents dipped into the cash reserve while 74% of flexibility users stated they had done so.

Using the flexibilities isn't reducing the extra time coders, billers and providers are spending in the office. A coder at a practice that found the flexibilities very useful is spending an average of five additional hours a week at work. A coder from the average population spends six. Billers whose practices use the flexibilities also save an extra hour — they work three hours compared with four for billers whose practices do not use flexibilities. But providers saw no change — their work week is two hours longer thanks to ICD-10, with or without reliance on the flexibilities.

What may change is why different members of a practice's administrative and clinical team are staying at work later, as shown by the charts with the top three reasons staff say they're working longer on p. 4.

For example, coders at a flexibilities practice are more likely to report learning new LCDs and NCDs is taking up their time, while billers point to new superbills or encounter forms as the key reason for their longer weeks. Providers find lack of familiarity with the new codes to be the biggest problem. — *Julia Kyles, CPC-A (@jkyles@decisionhealth.com)*

Strategize: Preserve your post-op block pay



For the second year in a row, CPT® has introduced new post-op pain block codes. With the new codes come new revenue opportunities, but coding these services remains a challenge for anesthesia practices. Ensure your practice is ready for 2016 post-op blocks during **Post-op blocks 2016 — Learn to report new blocks, use best practices to preserve your post-op block pay** on Jan. 21. For more information, visit www.decisionhealth.com/conferences/A2649/index.html.

Medical home

(continued from p. 1)

steps that include preparing for payer negotiations and deciding on your group's size (*PBN 11/23/15*). But don't sit back and think you're all done — you may find that the strategies you implement at launch will need to be tweaked and twisted, according to leaders at Adirondack Health Institute (AHI), a medical home initiative in New York with about 230 physicians and non-physician practitioners (NPPs).

The care management aspect of AHI's medical home program "has evolved quite a bit" since the program's inception in 2008, explains Bob Cawley, director of health system transformation with AHI in Glen Falls, N.Y.

For instance, care management interventions originally focused on common, high-cost conditions, such as diabetes and hypertension. But as the medical home grew, so did the necessity for a new approach. "Instead of having a condition focus, we needed to have a patient focus," explains Cawley.

This shift in thinking ultimately meant big changes to the day-to-day workflow, including revised staff responsibility and the need for more advanced support systems, such as health IT infrastructure. Learn from AHI's hard-earned lessons with the following tips to get ahead of potential revisions before you embark on the transformation to a medical home.

- **Divide up your providers and build your organizational structure around smaller groups**, particularly if you're working with a large medical home program with many providers. Because its medical home program spans about 50 distinct practice sites across a large, rural region in New York, AHI decided to split up the sites into separate units, or what it calls "pods."

This makes information- and resource-sharing far easier to manage, explains Cawley. "The pods are a community resource for quality improvement initiatives and care management resources," he explains.

The drawn-back size of AHI's pods — they operate three pods, ranging from eight sites to about two dozen sites within each pod — also creates more touchpoints between the practice sites and each pod's leadership team, the latter of which acts as a regional problem-solver.

For instance, if a specific practice has a question about its electronic health record (EHR) or requires addi-

tional care management support, the local pod leaders can provide solutions, notes Karen Ashline, assistant vice president, Adirondacks ACO and a local pod coordinator. The close working relationship between the pod leaders and physicians in the community means fewer delays in troubleshooting problems, she says.

Creating manageable practice groups also solves potential financial challenges, explains Cawley. A portion of the \$8.4 million that payers provide AHI regional practices in annual per-member payments goes directly to the pods and pays for the salary of the care management staff as well as the quality-improvement support that Cawley mentioned, such as ICD-10 training.

- **Centralize care management and share your resources.** One of the most tangible benefits of AHI's pod system is the ability to manage care management operations, which are an essential part of a medical home program. At first, the care management aspect of the medical home program — which employs professional care managers to work alongside practices to focus on the health and mitigate cost burden of high-risk patients — was met with skepticism, notes Ashline.

"Building care management has been difficult because it was unknown," she says. Providers would say, "What's the care manager really going to do for me?" recalls Ashline.

Yet providers' uncertainty, while tangible at the outset, didn't last long. AHI leadership drove home to wary providers the larger shift defining their industry — the encroachment of value-based care, Ashline recalls. When providers wondered aloud how they could track patients and perform follow-up care in the current environment, the leadership team countered with the benefit of extra hands.

"It really felt to them that we were piling on burden after burden," recalls Ashline. "So we said, 'Let us build a team to help you.'"

What's more, the organizational structure abetted the physician buy-in. "The care managers exist at the pods, and they are assigned and embedded into practices," explains Cawley, who adds that larger practices may have "a single, dedicated care manager."

He provides an example of how this works in practice: The primary care provider identifies a high-risk patient and notifies the care manager. "Together, they work with the patient to develop a care plan. The care manager goes into more depth with the patient about achieving

specific goals,” he says. For a diabetic patient, that might be losing weight; for a hypertensive patient, it’s getting blood pressure under control.

Ultimately, the practice’s ability to manage high-risk, high-cost patients is crucial to the quality metrics it’s agreed to meet with payers (*PBN 11/23/15*). Over time, AHI’s providers embraced this helpful hand, seeing the concrete benefits of their work; readmission rates, a telltale quality metric that speaks to high-quality transitions of care, have fallen to about 9% from a high of 16% since 2011 for AHI-affiliated patients, according to Ashline. “Now we have providers saying, ‘Can I have my care manager more often?’” she says. “That’s a real win for us.”

- **Create a physician committee to get feedback, stay ahead of challenges.** One of the most important steps AHI made to get a true sense of on-the-ground challenges and opportunities was the creation of a local executive committee, comprised of physicians, to provide feedback. In Ashline’s pod, which consists of 24 practice sites, a physician executive committee provides oversight of important areas ranging from “operations and finance to quality and best practices,” she says.

The executive committee began as a volunteer organization, but in the program’s third year the pod leaders sought — and received — nominations from the provider community. “This group — unless there are resignations or new interest — are reappointed each year,” says Ashline.

The executive committee meets monthly and steers the use of intrapod resources. For example, the executive committee made the initial decision to split the per-member payments into two halves, with 50% going to the practices sites and the other half going to the pod to be “pooled to support care management operations,” says Ashline. “Without this strong stance on resources, much of what we are able to do today would not be possible.” — *Richard Scott* (rscott@decisionhealth.com)

Overpayments

had completed his investigations, but the on-notice interpretation has been confirmed by court decisions in cases such as *Kane vs. Healthfirst Inc.*

The rules for returning overpayments also are evolving. Amy Fehn, an attorney with Fehn, Robichaud & Colagiovanni, PLLC, Troy, Mich., previously would tell clients not to send their contractors letters, but rather “just send a check” to “meet your obligation to refund without raising a red flag.” Now Medicare administrative contractors (MACs) have simple forms for voluntary overpayments at their websites, and they expect them to be filled out. (See this example from CGS: http://cgsmedicare.com/forms/j15oh_voloverrefund.pdf.)

Refunds to MACs don’t absolve you

Mistakes or billing errors should be refunded to the contractor, but if “there’s fraud or suspicion of fraud”

(continued on p. 8)

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PAS 2015

*Benchmark of the week***Small practices report fuller documentation for ICD-10 diagnosis coding**

You're likely not receiving the full documentation details you need to code correctly in the ICD-10 era, and that could be hampering your office's productivity and success rates.

About 86% of physician practices report that they have less than 100% of the documentation details they need, according to a November *Part B News* survey of medical practice professionals. Four in 10 practices (39%) state they receive 70% or less of the detail they need to code successfully, according to the survey.

Yet the practices that report inadequate documentation may surprise you. When looking more closely at the data, small practices receive more complete patient notes on average than do larger practices; those with five or fewer physicians report receiving 80% of the needed details on average, while practices with 100 or more providers get the full details only about 67% of the time.

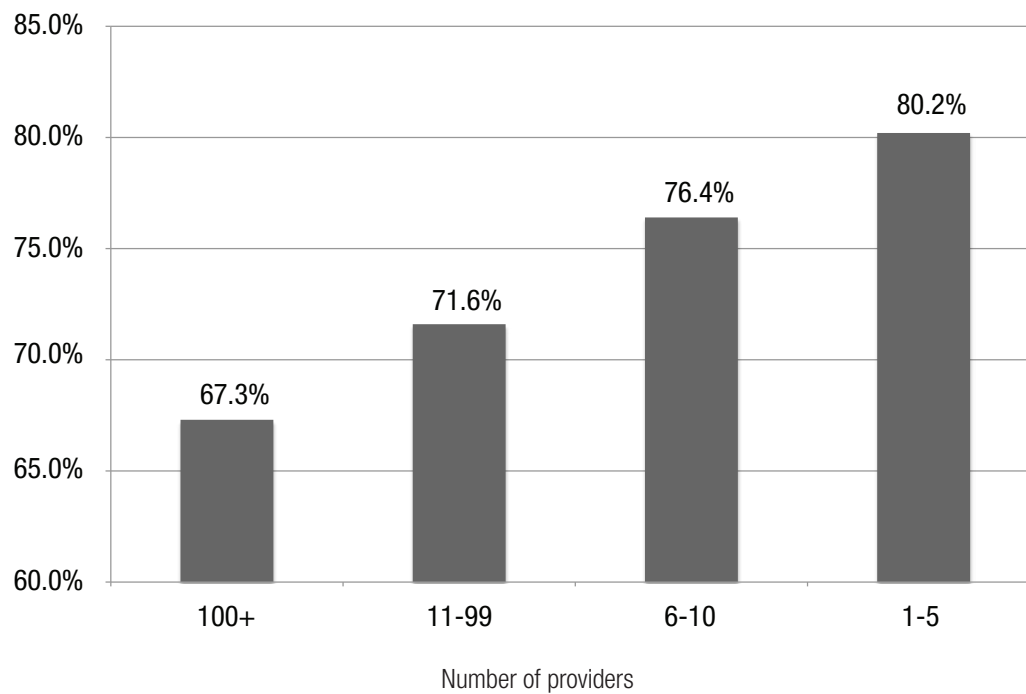
Experts tell *Part B News* that you can take steps — focusing on communication first — to improve your documentation accuracy and keep the productivity lag to a minimum.

Use transparent discussions with physician staff to reinforce the importance of complete documentation, urges Jody McIntyre, compliance officer and security officer with Arizona Community Surgeons in Tucson. "By including the providers in the process, with full disclosure of what a non-specific note means to the compliance outcome, they were more than willing to participate."

Sometimes this requires a delicate touch. "I have my coders communicate with the physicians they code for," she explains. "If my coders do not have great communication skills, then I step in."

You also can seek ways to ease the documentation burden on physicians with customized superbills and cheat sheets, according to experts (*PBN 12/7/15*). — Richard Scott (rscott@decisionhealth.com)

Percentage of detail in documentation by practice size



Source: Part B News analysis of DecisionHealth's ICD-10 survey, November 2015

(continued from p. 6)

behind your overpayment, you're supposed to notify the Office of Inspector General (OIG) and possibly the U.S. Attorney for your area as well, says Regan E. Tankersley, an attorney with Hall, Render, Killian, Heath & Lyman in Indianapolis (*PBN 11/23/15*).

"If what you want is a release from claims liability, you won't get that from the MAC, even if they cash your check," says Tankersley. The MAC may send your case up the chain to OIG. Plus it may ask you for more money. Tankersley recalls one voluntary refund case involving claims that were incorrectly billed as hospital services when they should have been billed as physician office or clinic services. "The client repaid the difference in payment based on the remedy in the Medicare provider-based rule," she says. But the contractor wanted all of the payments on those services refunded — not just the difference — and instructed the provider to rebill with the proper place-of-service code. Then it was too late for timely filing, says Tankersley.

But if you discover that you've received overpayments, it's far better to voluntarily repay than wait for contractors or the OIG or U.S. Attorney to come knocking at your door, says Arthur "Abbie" N. Leibowitz, M.D., executive vice president and chief medical officer of West Corporation's cost management practice Health Advocate in Plymouth Meeting, Pa. It may take a while, but you should get from the contractor both a receipt of your filing and a letter saying your payment has been accepted. "It's like dealing with the IRS," says Leibowitz. "Make sure you do what you're supposed to do and have a paper trail to prove you did it."

6 tips for voluntary repayment

- **Confer with a lawyer.** The forms make the process look simple, but talk to counsel about your situation and your choices before filing anyway, says Fehn. For one thing, the attorney can offer a valuable opinion as to whether you should notify OIG and/or the U.S. Attorney.

- **Pick "error" if it's an error.** There is some slight variation among contractors in the listing of reason codes for your overpayment on the form. But all of them have some version of "billed in error," and Fehn recommends that if it genuinely applies to your case, don't mess around with other codes on the grounds that they might equally apply. If you accidentally billed twice for the same procedure, for example, "service not rendered"

is technically correct, but so is "billed in error," and "billed in error" is less likely to prompt an investigation.

- **Add a cover letter if it's complicated.** If you expect the contractor to have questions, pre-empt them with a cover letter, says Tankersley. "Explain the issue: how you discovered it, how you're addressing or have resolved the issue moving forward, how you determined that it's a billing error as opposed to fraud and how you calculated the amount you owe," she says. "Give them a comfort level that you did your own diligence."

- **Use one form for multiple claims — but check first.** The contractor forms generally instruct you to provide certain information — such as the HIC number and amount overpaid for each claim — and to accompany a form for every claim. But what if you're submitting repayment on dozens, even hundreds of claims? Tankersley advises that you put all the requested information in a spreadsheet. This will also allow you to include — if you think it will help your case — extra information for each claim, such as CPT codes and payment rates on all the claims and how you calculated the total amount of the refund. But call the contractor and get approval first so its auditors aren't confused or annoyed when they get the information, says Fehn.

- **Send hard copies to the contractor and get delivery receipts,** says Tankersley.

- **Don't forget the date** "to show you're responding within the 60 days" required for the overpayment, says Fehn. And no, you can't backdate it. — *Roy Edroso* (redroso@decisionhealth.com)

Part B News brief

CMS: Use CPT rules for counting time for advance care planning. A unit of time for advance care planning is attained when the midpoint of the 30-minute service is passed, CMS confirmed during a Dec. 9 open door forum, reports Betsy Nicoletti, president, Medical Practice Consulting, Northampton, Mass. In response to a listener's question, a CMS speaker said a half-hour of the end-of-life discussion codes introduced in the final 2016 Medicare physician fee schedule would be accepted at the 16th minute. The two codes, **99497** for the first 30 minutes and add-on code **99498** for each additional 30 minutes, pay a nationalized non-facility fee of \$85.99 and \$74.88, respectively, starting Jan. 1 (*PBN 11/9/15*).

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