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IN THIS ISSUE

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

Quality reporting

Prevent 4 hidden PQRS reporting errors that endanger your revenue

Use detailed checklists to prevent measures reporting mismatches, especially if you use claims-based reporting to satisfy physician quality reporting system (PQRS) requirements.

When you submit a measure with a claim for the wrong patient or with the wrong diagnosis code, it will not count toward successful reporting. Too many mistakes could trigger the 2% pay cut for an eligible provider, and this year that will include an additional, value-based cut for practices with 100 or more physicians.

*(see **PQRS**, p. 3)*

Coding

Latest CCI edits take sting out of allergy testing, specify new gastro code pairs

When performing a select number of allergy tests, you will get paid for assessing the nitric oxide levels of your patients with a history of a respiratory disorder, which brings an additional $19.67 (Medicare participating, national average) into your practice each time the test is delivered.

You will be able to bill code **95012** (Nitric oxide expired gas determination) with common immunotherapy administration, antigen testing and rapid desensitization tests because the edit pairs for those codes have been deleted in the latest

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

Patient encounters

Intake tip: Bring in patients for preventive services, but mind HIPAA guidelines

Ratchet up your outreach efforts to see patients for the 20-plus preventive services covered under Medicare so you don't miss an opportunity to drive preventive visits to your practice — and gain a slice of the billions of dollars in reimbursement the federal insurance program doles out annually.

If you're not conducting a mammography exam for eligible patients, for example, your patient's health is not the only thing at risk; in 2013, the latest year for which data is available, Medicare paid out more than $400 million for mammography screening (**G0202**) — or $134.80 per screening, according to 2015 Medicare physician fee schedule data.

Medicare covers about two dozen preventive services, most of which come at no cost to your patients. But research shows that fewer than one-third — 28% — of Medicare patients received annual preventive services in the seven-year period between 2007 and 2013, according to a recent study in the journal *Health Affairs*.

Drive patient visits without violating HIPAA

Solve these gaps in care and boost your marketing and outreach efforts to gain a larger slice of this market — just be sure you're not crossing any HIPAA boundaries that may trigger a costly penalty, says Margie Satinsky, president, Satinsky Consulting LLC in Durham, N.C.

- **Use care coordination outreach to bring patients in.** There can be a fine line between patient education and marketing, says Jennifer Searfoss, president of SCG Health in Ashburn, Va. Reminders are generally considered health education, but if you reach out to patients to tell them "that they have available services that they can be engaged in, that's where you border on marketing," she says.

Because the rules can be unclear, experts recommend staying far away from crossing any HIPAA violations. "I advise them to play it safe," says Satinsky, who recommends that you offer patients a consent form that will authorize your use of contact, whether by phone or mail, to alert them of potential services for which you'll be contacting them.

Once you've gained the patient's consent, regular outreach such as care coordination reminders can lead to an uptick in office visits for preventive services. "Oftentimes, that care coordination call is going to prompt actual engagement," says Searfoss. "You can use that to drum up more patients coming into your office."

- **Understand the difference between patient education and marketing, and act accordingly.** For example, you can alert a patient that within the next year, he is due for a colonoscopy, says Satinsky: "If it's a

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reminder of a service or a test that's due, that's patient education."

Be careful of a referral, however, if you have a financial relationship with a service outside your practice. Let your patient know in writing about your connection to the other entity and service, says Satinsky.

Consider this example: A primary care physician works in an outpatient clinic that contains a health and wellness center offering preventive screenings like obesity counseling (**G0447**). The physician and the wellness center have separate tax ID numbers, but the doctor has a financial stake in the wellness center. "I've advised the clinic to obtain the patient's permission" to refer them to the wellness center, says Satinsky. "Because the physician owners of the clinic and wellness center wear two hats, you would be better served asking each and every one of [your patients] to sign a statement" authorizing the release of information from the clinic to the center.

- **Use data to target patient populations.** "Medical practices have a wealth of data within their practice management and/or EHR [electronic health record] system," says Andrew Halley, MBA, CMPE, network executive, Halley Consulting Group in Westerville, Ohio. Mine this data to securely keep your patients in the loop on needed care. "Setting your EHR to trigger a letter about colon cancer screening to patients when they reach their 50th birthday would be an excellent, ethical method to provide both volume and value to the medical practice," says Halley.

- **Be careful about protected health information after you've identified whom to contact.** When marketing to a patient, it is important to review any materials that are being sent, says Halley. "A self-addressed postcard can have the patient's name, address and a reminder of the appointment date but should never have a reason for the appointment. A card that states, 'It's time for your next A1C blood test,' would be an example of a privacy violation."

That's because other eyes might see the patient's health information on a postcard, explains Halley. "However, a letter in an envelope addressed directly to the patient telling her it is time for her mammogram is not a violation." — *Richard Scott (rscott@decisionhealth.com)*

Editor's note: *See a chart of preventive services, their related codes and whether they require copays at www.partbnews.com.*

PQRS

(continued from p. 1)

All providers, especially those who are participating in the PQRS program for the first time, should have procedures in place to make sure they're meeting each measure's requirements because Medicare won't warn them if they're making mistakes.

For example, diabetes measure 3 (High blood pressure control) applies to every patient with the appropriate diagnosis and who is between 18 and 75 years old on the date of the visit. If a provider reports the measure for patients outside of the age range, Medicare will regard those reports as errors, but the doctor will receive "no warning or remittance error that the reporting of that measure will not count," says Leslie Witkin, president, Physicians First, Orlando, Fla.

The PQRS quality-data code (QDC) error report, which was last released in 2013, demonstrates that reporting mistakes were common when providers voluntarily reported three measures to earn a bonus. Part of the problem is providers don't always read the entire measure specification, says Julie Drueppel, CPC, compliance auditor, Auditing for Compliance & Education, Overland Park, Kan.

Practices may have a vague idea of the work involved in the measure instead of knowing the steps they have to take, Drueppel says.

And juggling nine measures may prove a challenge for practices that are just starting to report as well as seasoned PQRS pros. Here are four reporting errors to watch for and tips for preventing them:

1. Create measure-specific age prompts to stop age mistakes. It may seem that adding a checkbox "☐ Pt. ≥ 65" to your PQRS cheat sheets will help capture every eligible patient because PQRS is a Medicare program. However, this would spell trouble for a provider who reports perioperative measure 76 (Prevention of central venous catheter [CVC] - related bloodstream infections) because the measure applies to all patients.

Measure 128 (Body mass index [BMI] and follow-up plan) — one of the cross-cutting measures designated by Medicare — is another measure that requires close attention to the patient's age. It applies to all patients age 18 or older, but to perform the measure and assign the appropriate code or codes, providers and coders will need to know the normal, age-based BMI ranges for patients who

are 18 to 64 years old and patients who are 65 and older.

Here are the measure-specific age prompts for the two examples above: A checkbox for a diabetes measure would be ☐ Pt. ≥ 18 or ≤ 75. For BMI, two checkboxes for the appropriate ages and ranges will help keep reporting on track: ☐ 18 – 64, BMI ≥ 18.5 and < 25 kg/m^2 and ☐ 65+ BMI ≥ 23 and < 30 kg/m^2.

2. Flag gender-specific measures to avoid improper reporting. Check measures for gender requirements. Measure 48 (Urinary incontinence: Assessment of presence or absence of urinary incontinence in women aged 65 and older) is a gender-specific measure, but if a provider doesn't have a reminder, he may attempt to report it for all of his patients. Osteoporosis measures apply to men and women, with the exception of measure 40 (Screening or therapy for osteoporosis for women aged 65 and older).

Note gender-specific measures, including those that have different requirements based on the patient's gender, with the appropriate gender symbols for male ♂ or female ♀.

3. Double-check claims to prevent ICD code mistakes. Help providers match up the appropriate diagnosis code with measures such as 109 (Osteoarthritis [OA]: function and pain assessment), as mismatches cause reporting flubs, according to the QDC error report. For measure 109, you could put a note on the cheat sheet: "Any diagnosis code **715.XX** (Osteoarthrosis and allied disorders)." Coders can be a second line of defense against diagnosis errors by double-checking the code and alerting doctors when they perform the measure on a patient who doesn't have a diagnosis of OA.

You should also start staff thinking about how the ICD-10 transition will impact PQRS reporting by pulling the ICD-10 codes from the PQRS measures specifications manual. The ICD-10 switch will pose a major hurdle to PQRS reporting, Drueppel predicts.

"Most of us can get there in our minds; we know the osteoporosis codes are in the **733** range. But we can't do that for ICD-10," Drueppel says.

4. Report at the right frequency. Quality reporting experts tell providers to report every applicable measure at each patient encounter and the PQRS' irregular frequency requirements are one reason why. Many measures must be reported once per patient per year. However, a handful of measures, including 130 (Documentation of current medications in the medical record) and 131 (Pain assessment and follow-up), must be reported at each visit.

If your providers balk at reporting measures when they don't have to, highlight measures that require per-visit reporting with a symbol or abbreviation such as PV or EE for each encounter. — *Julia Kyles (jkyles@decisionhealth.com)*

CCI

(continued from p. 1)

version of the National Correct Coding Initiative (CCI 21.1). The new edits go into effect April 1. Because the edit pairs have been deleted, you'll be allowed to bill 95012 and an appropriate immunotherapy service separately when provided to the same patient on the same date of service.

The most common services you may use with 95012, according to 2013 Medicare data, the latest available, include:

- **95165** (Preparation and provision of single or multiple antigens for allergen immunotherapy), with 6.9 million services billed;
- **95117** (Injection of incremental dosages of allergen, 2 or more injections), with 2.4 million services billed;
- **95144** (Preparation and provision of single-dose vials of allergen antigens for allergy immunotherapy), with 195,000 services billed.

The latest CCI edits also unbundle rapid desensitization testing (**95180**) from the nitric oxide test. If you bill 95180 alone, you're in line to receive $134.80 from Medicare, according to 2015 final Medicare physician fee schedule data; with the additional 95012 respiratory test, that total jumps to $154.47.

Fun fact: You can stick your patients with insect venom and still get reimbursed for the additional nitric oxide test. For example, use code **95130** (Preparation, provision and injection of one stinging insect venom) with 95102 to get reimbursed for both services. Or provide a whole body extract using **95170** (Preparation and provision of whole body extract of biting insect or arthropod antigens) to get paid for warding off a spider or other arthropod allergy.

The CCI edit unbundles 95102 from codes 95117-95180.

CCI refines billing of new gastro codes

Be careful what you bill in conjunction with four gastro codes that took effect Jan. 1. According to the latest CCI code pair edits, only specific codes can be billed on the same date of service as the following four G codes:

- **G6019** (Colonoscopy through stoma; with ablation of tumor[s], polyp[s], or other lesion[s] not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique).
- **G6020** (Colonoscopy through stoma; with transendoscopic stent placement [includes predilation]).
- **G6024** (Colonoscopy, flexible; proximal to splenic flexure; with ablation of tumor[s], polyp[s], or other lesion[s] not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique).
- **G6025** (Colonoscopy, flexible, proximal to splenic flexure; with transendoscopic stent placement [includes predilation]).

The lesion removal codes — G6019 and G6024 — can be billed on the same date of service, if medically necessary, as codes **44403** (Colonoscopy through stoma; with endoscopic mucosal resection) and **93355** (Echocardiography, transesophageal [TEE] for guidance of a transcatheter intracardiac or great vessel[s] structural intervention[s]), both of which are effective as of Jan. 1 as well.

The colonoscopy with stent codes — G6020 and G6025 — can be billed with 99355 on the same date of service, according to the CCI edits.

However, CCI has bundled the G codes with a number of other services, which means you're not allowed to bill any of the four colonoscopy codes named above with TAP block codes (**64486–64489**). For G6024 and G6025 only, others on the do-not-bill list include **0377T** (Anoscopy with directed submucosal injection of bulking agent for fecal incontinence), **45349** (Sigmoidoscopy, flexible; with endoscopic mucosal resection) and **45350** (Sigmoidoscopy, flexible; with band ligation[s] [e.g., hemorrhoids]). — *Richard Scott (rscott@decisionhealth.com)*

Resource:

- NCCI coding edits: *http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/NCCI-Coding-Edits.html*

Practice management

Prep EHR, staff, medical partners for when storms shut your practice

A little advance planning on your electronic health records (EHR) and with medical partners in your area can keep your practice and your patients from getting stuck when the weather shuts you down.

Recent snowstorms in the U.S. knocked out some transportation options as well as some practices whose staff and patients couldn't get to their offices. Some patients didn't get the service they were expecting because of the snowstorm and were upset about it — like one Washington, D.C., blogger who complained publicly when the staff at her physician's office couldn't tell her for sure whether the doctor would be coming in (he didn't).

But if the weather problem had been a little more severe — as it was in 2012, when Hurricane Sandy made medical treatment an issue for many providers in the New York-New Jersey area — unprepared practices could have had it much worse. A study of that disaster published last year found that a lack of preparation led to inefficient re-routing of medical care and delivery of incomplete medical files, impacting patient care and leading to changes in protocol, says author Amesh A. Adalja, M.D., senior associate at the Center for Health Security of the University of Pittsburgh Medical Center and School of Medicine.

Why you need to have a plan

Recent weather events should convince you that no one is immune to a weather-related shutdown. "In areas with tornado and hurricane dangers, this is a normal plan — knowing what facilities have shelters, where you get to when there is flooding, etc.," says Laura Palmer, director, professional development, Medical Group Management Association (MGMA) in Englewood, Colo. She thinks disaster planning should be a regular part of practice business, like workplace security drills (*PBN 5/27/13*).

Practices should obtain "business disaster training" from a reliable vendor that would run staff through several appropriate "what if" scenarios having to do with computer backups, inability to get to patients, and staff attrition, says Drew Stevens, president and chief strategy officer of Stevens Consulting Group in Eureka, Mo. (*For more planning basics, see box, p. 6.*)

4 tips to prepare your practice for disasters

1. Arrange with your local hospital's emergency management department to coordinate in the event of a disaster, recommends Adalja. The hospital will see this as a benefit to themselves because they'll want to route patients to you in an emergency. But it will also benefit your practice because the purpose is to distribute patients for maximum benefit, and you may be the one who needs help, says Adalja.

"People don't just show up at hospitals [in a crisis]," Adalja says — you may get overflow from locals who can't make it to the ER or their regular provider. "I've heard about injured patients who presented at outpatient radiology sites" in a disaster, says Adalja. "When people are injured and hurt, they present at the closest place." If you established partnerships and wind up with more patients than you can handle, you can "rely on coalition partners" for help, he says.

2. Establish referral protocols with other service partners the hospitals may not have engaged, such as minute clinics, recommends Stevens. Set up thorough and, where practicable, formal agreements on crucial details — for example, what constitutes an emergency.

3. Back up records on the cloud. If you haven't moved to the cloud yet, the prospect of an emergency should make you think harder about it. One of the advantages of a cloud-based EHR system is that they're backed up remotely — meaning if a hurricane knocks out your

Emergency planning basics

Get ready for weather or other disasters with this quick list of preparedness must-dos for practices from Laura Palmer, director, professional development, Medical Group Management Association (MGMA) in Englewood, Colo. (*See more about emergency planning in the related story, p. 5.*)

1. **Back up your IT every day** either to cloud or remote servers so you can access information if you have power.
2. **Have cell phone numbers for all staff** so you can keep them informed. Create an emergency contact list.
3. **Carry your power cords and adapters** with you so you can access power where you find it.
4. **Establish a weather or disaster phone number** so all can check in and you can update status.
5. **Print out the appointment schedule the day before** an anticipated power failure or office closing, with patient contact information so you can assign staff to make patient calls.
6. **Establish the triage plan** with staff and providers before events occur. "Real time" is not a plan.
7. **Work with local emergency facilities** by secure text, phone or encrypted email to send patients with immediate needs to the closest location. Provide clinical background such as medication history to assist the facility with treatment.
8. **Use your patient portal** to publish updates for those who have Internet access during the weather or emergency situation.

(continued on p. 8)

Benchmark of the week

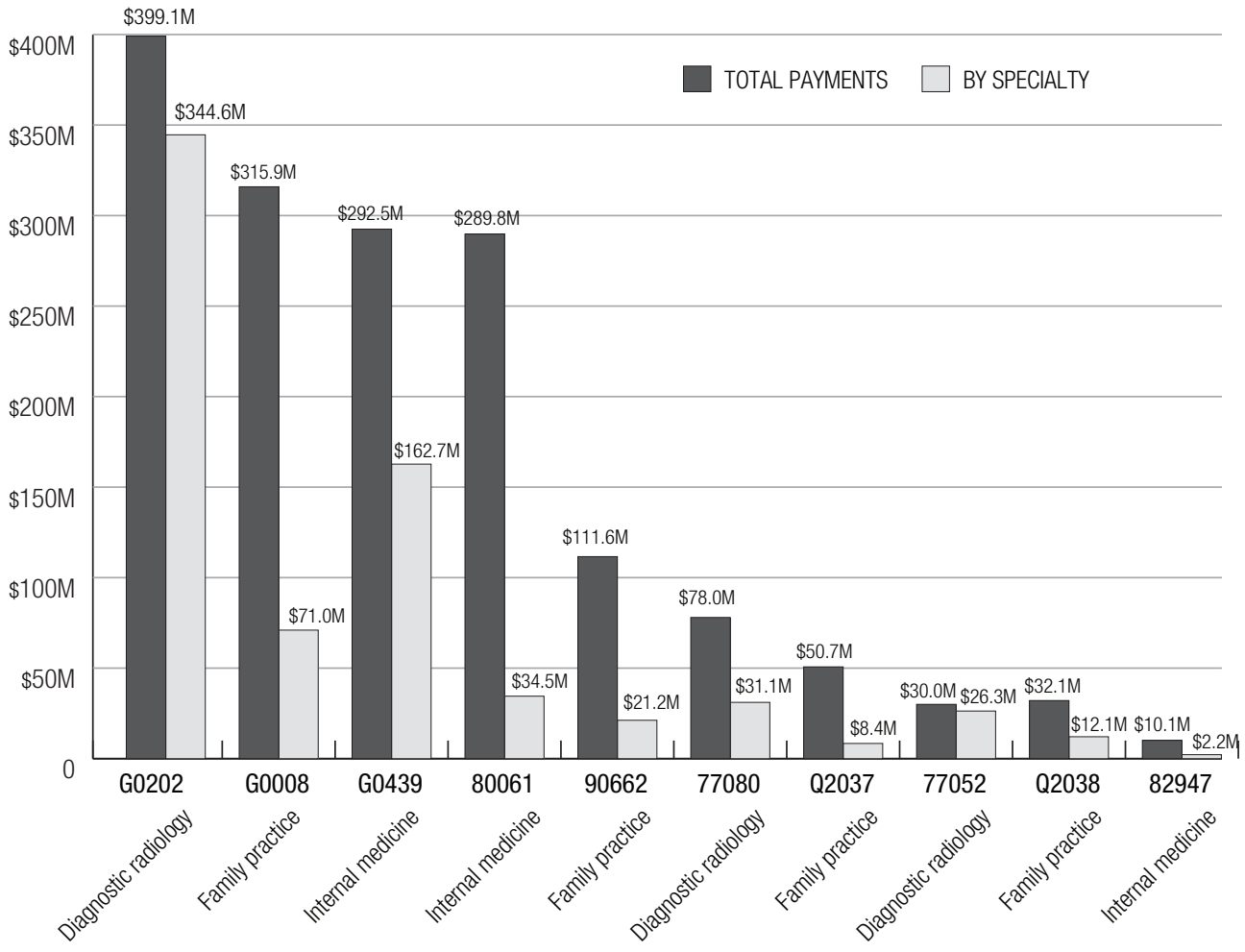
Radiology, family practice, internal medicine lead specialty utilization of preventive services

As national physician data shows, there's money in prevention. According to 2013 Medicare data, the latest available, the 10 most commonly administered preventive services covered under Medicare Part B totaled $1.6 billion in payments — or about 60% of the roughly $2.5 billion paid to physicians in total in 2013 for the array of 20-plus preventive services (*see story, p. 2*).

A big chunk of the payments went to family practice and internal medicine, which topped payment-by-specialty among seven of the 10 most used codes, including **G0008** (Administration of influenza virus vaccine) and **G0439** (Annual wellness visit, includes personalized prevention plan of service (pps), subsequent visit), which together accounted for more than $600 million in payments.

Diagnostic radiology led the way on three of the commonly used codes, including **G0202** (Screening mammography, producing direct digital image, bilateral, all view), by far the pace-setter among the 10 codes with a total outlay of nearly $400 million, **77080** (Bone density measurement using dedicated X-ray machine) and **77052** (Computer analysis of screening mammogram to assist detection of cancer).
— *Richard Scott (rscott@decisionhealth.com)*

Payments and leading specialties for most used preventive services



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

server, another one far away, where it's sunny, will keep going. "When you have a cloud-based system, it will have several network operation centers that are geographically distributed," says Tom Giannulli, M.D., chief medical information officer for EHR vendor Kareo in Irvine, Calif.

Also, unlike other types of records, imaging data may not be viewable if you're not on the cloud, says Morris Panner, CEO of medical image exchange vendor DICOM Grid in Phoenix. Your established virtual private network (VPN) won't work if your server goes down. You'd have to get a CD, and even then it might not be compatible.

Giannulli points out another EHR feature that can be useful in a blackout — the patient portal. "Even if the phones are down, if your patient's on mobile and your server's on the cloud, he can get in touch with you via the portal," he says.

4. Prepare if your staff has to stay in the office. Being stuck away from the office isn't the only possible outcome — a sudden event might leave you stuck inside the office. "Have enough medical supplies on hand — along with food, water and fuel — to last at least three weeks," says Phil Cox, CEO of storable food company Legacy Food Storage in Salt Lake City, which may be overcautious unless your location is very remote. He also advises you keep "72-hour kits" for employees and patients that would include a first-aid kit, flashlight, radio, changes of clothing and ponchos. These items will be needed especially if employees need to leave or be evacuated, says Cox.

Other standby items Cox suggests are an emergency generator and "long-lasting, shelf-stable diethylene glycol canisters" for heat or cooking. — *Roy Edroso (redroso@decisionhealth.com)*

Part B News briefs

- **PQRS report: Participation up 21% in five years.** The 2015 National Impact Assessment of the CMS Quality Measures Report, an analysis of seven CMS quality reporting programs including the physician quality reporting system (PQRS) between 2006 and 2012, shows that 95% of measures across all programs showed improvements in care and patient outcomes. But the study also shows that provider participation in PQRS has only increased 21% between 2007 and 2012. CMS' Center for Clinical Standards and Quality offers some reasons for this, including practice size, and proposes that CMS make "data collection easier and less expensive for physician practices by emphasizing EHR-based reporting and measure alignment between quality measurement programs." The full report is available at *www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Downloads/2015-National-Impact-Assessment-Report.pdf*.

- **"Next generation" ACO model introduced.** A new accountable care organization (ACO) model CMS announced March 10 will allow "provider groups to assume higher levels of financial risk and reward than are available under the current Pioneer Model and Shared Savings Program (MSSP)." Called the Next Generation ACO Model, it appears to conform to the ambitious standards CMS set in its "Track 3" proposal for the ACO program last December (*PBN 12/8/14*). CMS asks that interested groups submit a letter of intent no later than 11:59 p.m. EDT May 1 and that it expects to accept 15 to 20 entrants. See CMS' Next Generation page for more at *http://innovation.cms.gov/initiatives/Next-Generation-ACO-Model/*.

- **CMS invites your PQRS measure suggestions.** You can submit "quality measure suggestions for potential inclusion in the proposed set of quality measures in the Physician Quality Reporting System for future rule-making years." The process is open-ended, but submissions received prior to June 15 "may be considered for inclusion on the 2015 MUC [Measures Under Consideration] list for implementation in PQRS as early as 2017." Guidelines for submission are available at *www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/CallForMeasures.html*.

- **Medical identity theft up almost 22% in 2014** from 2013, an increase of about 500,000 victims, according to the fifth annual medical identity theft survey conducted by the Ponemon Institute. Overall, medical identity theft incidents have nearly doubled in the past five years. Out-of-pocket costs also have grown; unlike credit card theft, which by law limits the victims' financial costs, medical identity theft costs an average of $13,500 to resolve the crime, as well as an average of 200 hours working with insurers and others. Almost 80% of the survey respondents said it was important for health care providers to secure the privacy of their records; 48% said they would consider changing providers if their patient records were lost or stolen. For more information, visit *http://medidfraud.org/2014-fifth-annual-study-on-medical-identity-theft/*.

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