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IN THIS ISSUE

Compliance 1
DOJ memos reduce danger of FCA prosecutions — but watch for this hidden threat

Practice management 1
4 small changes that can trim EHR screen time, increase patient interaction

Billing 2
Document thoroughly, wrap in specific history and exam when prescribing CPAPs

Coding 3
CCM and TCM: 4 tips to craft a seamless care management coding plan

Benchmark of the week 5
Growth, rewards in CPAP-related billing — but watch those denials

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

Compliance

DOJ memos reduce danger of FCA prosecutions — but watch for this hidden threat

While the Department of Justice and its prosecutors are racking up big False Claims Act (FCA) settlements in health care, two recent DOJ memos may take some of the heat off.

A Jan. 25 memo tells prosecutors to stick to the law and official regulations and to not rely on agency guidance documents — such as the sub-regulatory guidance CMS often issues in its manuals and transmittals.

*(see **DOJ memos**, p. 4)*

Practice management

4 small changes that can trim EHR screen time, increase patient interaction

As a new study finds providers' attention to electronic health record (EHR) screens outstripping attention to patients, look to small efficiencies to help restore the balance.

The study, results of which were published in the February issue of the journal *Family Medicine*, clocked 982 family physician visits and found that out of a mean visit length of 35.8 minutes, face-to-face time with patients comprised 16.5 minutes while non-face-to-face time associated with the visit — including time before, during and after the physician

*(see **EHR time**, p. 7)*

Billing

Document thoroughly, wrap in specific history and exam when prescribing CPAPs

Don't overlook Medicare's stringent documentation requirements when referring patients for continuous positive airway pressure (CPAP) devices or you may get caught up in denied claims that leave your patients without coverage.

CMS appears to be cracking down on CPAP billing after finding that 59% of orders were tied to improper payments, according to a February fact sheet that the agency released (*see resources, below*). Providers should focus on one salient point in the fact sheet in particular — the finding that 88% of improper payments are due to improper documentation, notes Larry Epstein, M.D., president and CEO of Welltrinsic and medical director of clinical sleep medicine at Brigham and Women's Hospital in Boston.

"That's the issue," Epstein says. "I think it's a matter of the paperwork required to get this done."

Providers must hit specific documentation requirements across "a whole series of steps," says Epstein. That starts with a patient's diagnosis. To initiate coverage, a patient must have a documented diagnosis of obstructive sleep apnea. Without the relevant diagnosis code on the patient's claim — in this case, **G47.33** (Obstructive sleep apnea [adult] [pediatric]) — your referring process will fail before it even gets started.

You'll want to wrap in disease-specific evaluations during the patient encounter, as well. For example, your patient history should include "signs and symptoms of sleep disordered breathing including snoring, daytime sleepiness, observed apneas, choking or gasping during sleep, morning headaches," according to a local coverage determination (LCD) covering several Medicare administrative contractors (MACs). The physical exam should include "focused cardiopulmonary and upper airway system evaluation" and a measurement of the patient's neck circumference and body mass index, notes the LCD. (*For a full list of suggested history and physical exam elements, see the LCD, link below.*)

Remember that a provider can order a sleep test — the next step in the ordering process — only after a face-to-face encounter with the patient, says Maxine Lewis, president of Medical Coding and Reimbursement in Cincinnati. "CMS is looking for proper documentation of the sleep studies for medical necessity [when] issuing CPAP machines," says Lewis.

"Every doctor I have contact with goes through a reputable sleep study lab before prescribing the machines," she says.

However, CMS does leave the door open to home sleep tests. In addition to the positive diagnosis of sleep apnea, you must also report a positive polysomnogram (PSG) that's been conducted in a sleep lab or an "unattended" home sleep test with an appropriate sleep monitoring device.

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Maintaining the extensive documentation can prove challenging for practices that are not set up to succeed, warns Epstein. The hardest documentation for a durable medical equipment (DME) company to secure are "the office notes prior to the sleep study," he says. If you refer a lot of patients to sleep studies or prescribe CPAP equipment, you might want to assign the documentation maintenance to a single individual on staff, suggests Epstein. "You need to set up a system to do this," he says.

Failing to meet the coverage guidelines can leave your patient on the hook for the expense. "The machines are not cheap," says Lewis.

Also, remember that CMS conducts audits after the fact, so keeping track of your notes and accurately filing the required elements will save you time and your patient some hassle down the line. When it comes to reporting your face-to-face encounter with the patient, your most likely bet is a regular office-based E/M code, such as **99213** or **99214**. While CMS covers a CPAP-specific CPT code — **94660** (Continuous positive airway pressure ventilation [CPAP], initiation and management) — you should reserve its use for instances where you're actively managing a patient's CPAP use and not doing the work-up beforehand (*See p. 5 for denial rates for CPAP-related codes.*).

Also, remember that 94660 is bundled with E/M services, restricting you from getting paid for both codes on the same date of service (*PBN 1/11/16*). — *Richard Scott (rscott@decisionhealth.com)*

Resources:

- Providers Compliance Tips for Positive Airway Pressure (PAP) Devices: *www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ProviderComplianceTipsForPositiveAirwayPressureDevicesAndAccessories-ICN909376.pdf*
- Positive airway pressure LCD: *www.cms.gov/medicare-coverage-database/details/article-details.aspx?articleid=52467*

Coding

CCM and TCM: 4 tips to craft a seamless care management coding plan

Sharpen your care management coding by adhering to Medicare's specific service requirements and take advantage of non-face-to-face care you already provide to your patients between office visits. Doing so will provide a revenue opportunity and help you maintain patient contact during critical times of illness.

As more practices get into the care management game, a lot of your success with transitional care management (TCM) and chronic care management (CCM) services hinges on your attention to detail, experts tell *Part B News*.

The numbers behind TCM codes **99495** and **99496** and CCM code **99490** portray an upward swing — payments have jumped significantly since the codes first debuted several years ago. Nationally, providers gained about $126 million for TCM services and $71 million for CCM services in 2016, the latest year of available Medicare claims data. That year, total CCM claims topped 2.5 million and TCM claims fell just shy of the million mark.

"I'm not surprised with the frequency [of claims]," says Jacqueline Thelian, CPC, health care consultant with Medco Consultants in Fresh Meadows, N.Y. "It kind of gives you a heads up of where health care is heading," she adds, in reference to a greater emphasis on payers prioritizing care that's not in the traditional fee-for-service mold.

However, Thelian says that understanding the specific documentation requirements may get lost on some practices, warning that some groups "are [not] getting it 100%" correct. That may lead to some untapped potential — and denial risks if you're not checking off all the boxes that Medicare requires to get your TCM and CCM claims through.

The big jump in CCM claims from 2015 to 2016 is likely a sign of things to come, notes Krista Sultan, vice president of new revenue with Wellbox Inc., a care management service provider based in Jacksonville, Fla. "CMS has invested a lot in increasing the uptick of this program," says Sultan.

She points to eased reporting requirements, new complex CCM codes (**99487**, **99489**) and a payment increase as signs that CCM is here to stay. Currently, 99490 pays $42.84 per monthly episode, according to national, non-facility rates.

As you welcome or expand your use of care management services, keep your coding up to snuff with the following tips:

- **Stick to the script to maintain coding compliance.** You must meet specific timelines and documentation elements to get your TCM and CCM claims through successfully, and missing one element can tank your efforts. Thelian finds that practices providing TCM services often miss the initial window for patient contact. "I don't see that they're making that outreach in the timeframe required," she says.

Remember that codes 99495 and 99496 require that a staff member make contact with the patient within two days of a hospital discharge. After the initial contact, 99495 requires a face-to-face visit within 14 days, and 99496, which is appropriate for high medical decision-making, demands a visit within seven days.

CCM code 99490 doesn't require a face-to-face visit, but you must meet at least 20 minutes of care per month — and that timing should be carefully documented in the record.

- **Build the service elements into your workflow.** Because TCM and CCM are not your standard E/M encounters, they require a unique approach. Century City Primary Care has found success with documentation branded specifically for TCM services. The practice has created "a special, templated transitional care message that is completed by the doctor and staff" after each element of the care plan occurs, says Penny Sue, practice administrator at the Century City, Calif., practice.

Diligent record-keeping also comes in handy for medical review. "Keeping it separate as a special message helps to create the documentation necessary in case of an audit," says Sue.

- **Consider a vendor to fulfill your CCM services.** Numerous vendors offer full-suite CCM packages — and that's something that CMS has virtually endorsed since the CCM code debuted (*PBN 12/4/17*). "When they started the CCM program, they really started an entire industry around that," says Sultan. Her company, Wellbox, is one of the many CCM service providers out there.

She says that vendors offer different approaches, and many "handle everything except being the physician to review notes." That includes extracting patient data from a practice's electronic health record (EHR), contacting eligible patients, enrolling them in the program and coordinating care. Some vendors even offer a smartphone app that patients can access to track their care plans, says Sultan.

- **Be honest about the resources you'll need to get started.** The No. 1 mistake practices can make is to think they can allocate a staff member, such as an RN, to set up a program and start providing care management to several patients a day, says Sultan. Chances are you'll need to make a larger investment in setting up a program, and that could mean reaching out to your EHR vendor to ask about care management templates. You also should ask about how to sift through your patient data to identify eligible patients. While TCM and CCM can be lucrative, it'll take some time and attention to maintain a program that works. — *Richard Scott (rscott@decisionhealth.com)*

Resources:

- CMS, chronic care management services: *www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf*
- CMS, transitional care management services: *www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Transitional-Care-Management-Services-Fact-Sheet-ICN908628.pdf*

DOJ memos

(continued from p. 1)

"Effective immediately for [affirmative civil enforcement] cases, the department may not use its enforcement to effectively convert agency guidance documents into binding rules," the memo says. "The department should not treat a party's noncompliance with an agency guidance document as presumptively or exclusively establishing that the party violated the applicable statute or regulation."

"I believe this is an effort by the administration to distance itself from longstanding policy documents implemented by prior administrations, theoretically yielding [the Trump administration] more discretion in enforcement decisions," says Mark Silberman, partner in the health care and life sciences practice group at Benesch, Friedlander, Coplan & Aronoff in Chicago.

The memo clearly "wouldn't be enforceable against DOJ by a defendant," says David Honig, attorney with the law firm Hall, Render, Killian, Heath & Lyman in Indianapolis. So the question for providers is "how closely the government will hew to the memo when faced with alleged violations based upon guidance."

Take the old "not documented, not done" standard for denial of claims — "that guidance comes from guidelines, and in some cases, e.g. E/M, from MedLearn Matters, which doesn't even rise to the level of the Medicare manuals," says Honig. "I think insufficient documentation can still serve as a basis for audits and recoupments because that is all internal to the agency and the reasonableness of their interpretations. But the question is whether the DOJ, if it sticks to the memo, will stop it there, rather than letting such claims be the basis for FCA enforcement."

(continued on p. 6)

Benchmark of the week

Growth, rewards in CPAP-related billing — but watch those denials

Use of codes related to sleep apnea and continuous positive airway pressure (CPAP) continues to grow, but denial rates show providers have to be careful.

The denial rate for the main CPAP CPT code, **94660** (Continuous positive airway pressure ventilation [CPAP], initiation and management), spiked to 31% in 2016 — which seems to justify CMS' current crackdown (*see story, p. 2*).

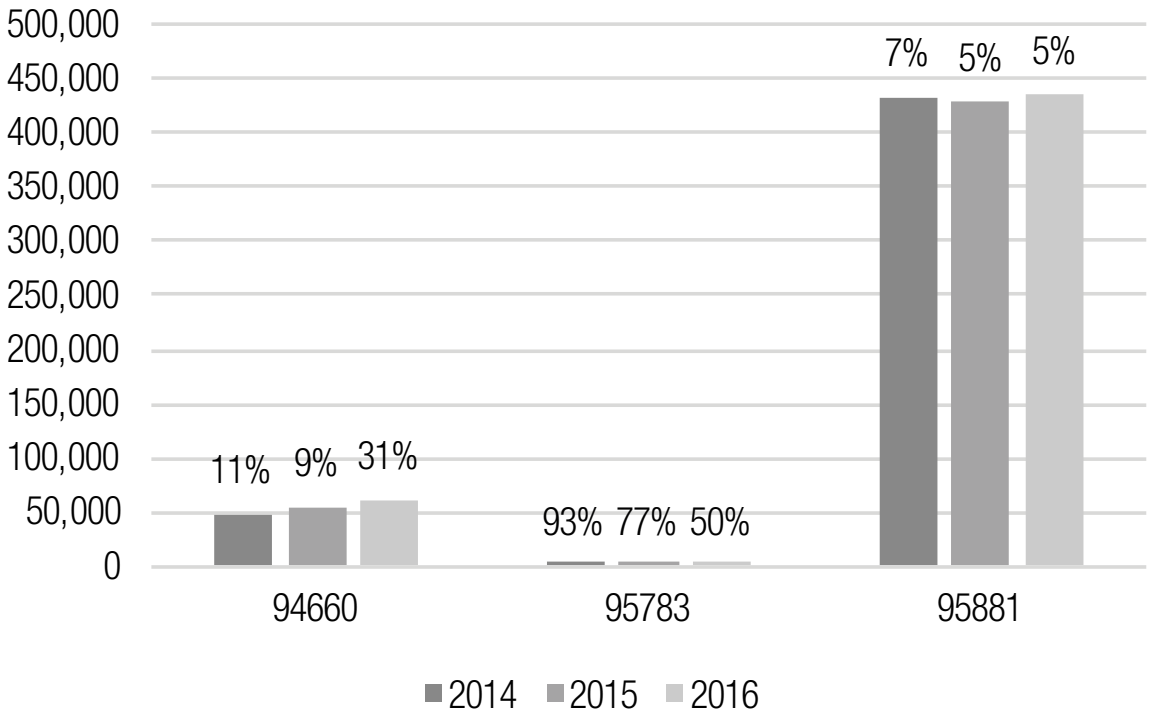
Code 94660 is bundled with E/M codes, which may be why it only got on 61,227 claims in 2016 — though that number is up from the previous two years. Note that the CPAP-related HCPCS codes total nearly 5 million claims, which suggests that many providers are using office E/M codes to diagnose conditions that necessitate CPAP prescriptions. Considering that the national non-facility par rate for 94660 is only $66.24 and the denial rate is high, it hardly seems like a provider's best bet.

In 2016, the specialty that billed this code the most by far was pulmonary disease; it had 25,448 claims versus No. 2 specialty neurology's 9,822. But the pulmonologists' denial rate was 21% and the neurologists' was 23%. Among the 10 specialties that billed this the most often, the lowest denial rate was 16% for cardiologists — but they only billed it 1,771 times.

There is a lot more use of the code for the sleep apnea test, **95811** (Polysomnography; age 6 years or older, sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bilevel ventilation, attended by a technologist); indeed, use of that code has been growing for many years (*PBN 1/16/06*). The denial rates aren't bad, either, and the code pays well — $671.03 non-facility par. When split between professional and technical fees, with the modifiers **26** and **TC**, that payment is parsed out as $129.60 and $541.43, respectively. Again, pulmonologists billed this code more than any other specialty, but their denial rate was just 4%.

Use of the code for the device itself, **E0601** (Continuous positive airway pressure [cpap] device), has been growing and also has a decent denial rate — 5% in 2016 and 2015, down from 7% in 2014. — *Roy Edroso (redroso@decisionhealth.com)*

CPAP CPT codes utilization and denial rates, 2014-2016



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

(continued from p. 4)

The other memo, issued Jan. 10, suggests a change in standards when prosecutors consider a relator's *qui tam* case and when and whether "to decline intervention" or, in some circumstances, seek dismissal of the case outright. As the memo seems to lean on reasons to decline or seek dismissal — for example, "a decision not to intervene in a particular case may be based on factors other than merit, particularly in light of the government's limited resources" — observers expect it to lead to fewer rather than more DOJ interventions.

Silberman hopes this will lead to fewer questionable *qui tam* cases. "Ideally, DOJ will actually implement a meaningful policy regarding the dismissal of meritless cases brought in the name of the government," he says. "Doing so could convert the False Claims Act back into a beneficial tool for remedying fraud against the government and discourage the initiation of baseless claims hoping for a 'lottery ticket' case or quick settlement being driven by the high cost associated with evaluating and defending these claims."

Recent trends show big recoveries

In 2017, DOJ bagged more than $3.7 billion from FCA cases — $2.4 billion of which "involved the health care industry, including drug companies, hospitals, pharmacies, laboratories and physicians," says DOJ. It was the department's eighth straight year of $2 billion-plus health care recoveries.

Experts don't expect that to slow soon. "I think there has been an uptick in the past few years in the amount of energy and resource DOJ has put into prosecuting health care fraud criminally and civilly," says Jason Mehta, a former assistant U.S. attorney for the Middle District of Florida, now a partner in the government enforcement and investigations practice group at Bradley Arant Boult Cummings LLP in Tampa, Fla.

"Given the increasing complexity of regulations, even well meaning providers may wind up in DOJ's crosshairs," Mehta says. While multimillion-dollar cases of obvious fraud get most of the publicity, there are plenty of smaller cases in which "well meaning institutions [that] through lack of diligence were submitting upcoded claims" get in trouble too, says Mehta, who says he "had several cases" like those while he was a federal prosecutor.

Those prosecutions are generally based on data analysis as prosecutors parse Medicare and other data for outliers, such as practices doing far more of a certain type of service or procedure than their peers.

Among the targets, says Mehta: "pain management clinics, for example, who billed every patient for a toxicology test — yet still prescribed opioids to those patients. Why are we testing, quantifying them, yet never changing prescription habits?" Also, orthopedic groups whose "MRI [ordering] doesn't add up with their peers in the market."

In addition to those data-driven actions, there's also the threat of *qui tam* suits — "when a whistleblower is

trying to capture overpayments by categorizing them as false claims, to extrapolate that into an intentional fraud case," says Mehta. Such cases are usually brought by employees within an organization who, having had no luck getting patterns of abuse turned around by internal means, go to the law to bring action and hope to be joined by government prosecutors so they get a cut of whatever settlement the government shakes out of the defendant.

Change in lawyers' roles

There's a wrinkle in such cases, however, that Honig says he's been noticing lately: *qui tam* actions brought, not by employees or former employees, but by lawyers who have caught wind of abusive billing patterns while prosecuting malpractice cases and who use that information to claim whistleblower status for themselves.

That was made possible by the Affordable Care Act (ACA), which included amendments to the False Claims Act, including one that broadened the sources from which *qui tam* intelligence could be drawn.

As before, information previously revealed by "a federal criminal, civil or administrative hearing in which the government or its agent is a party" or "a congressional, Government Accountability Office or other federal report, hearing, audit or investigation" or "from the news media" cannot lead to a civil action on false claims charges. However, under the ACA, information uncovered by actions involving the state rather than the feds may be considered, and that would include malpractice suits, says Honig.

"We've seen incidents where [counsel for malpractice complainants] use discovery on behalf of a client then go on to become whistleblowers themselves," says Honig. "Discovery requests can be so broad that your malpractice attorney wouldn't recognize it as something about FCA rather than malpractice."

Such a request could involve counsel looking for "a history of all billing for similarly situated cases" or "all calendars or schedules which may show prior failures of supervision," says Honig.

Before the ACA, "state-filed malpractice cases were public disclosure," says Honig, and the courts would not admit evidence from those in subsequent *qui tam* suits. "But now state cases don't act as a bar. That's the statutory difference."

Tip: Have your own, FCA-savvy lawyer on hand in malpractice cases. "When you're represented in a malpractice case, you're usually not hiring a lawyer; your insurer provides one," says Honig. Such a lawyer probably won't be thinking of your FCA exposure. Therefore, bring your own — one who would "know when to move to quash [plaintiff motions] on the grounds it's not relevant to the case, a fishing expedition to pursue other actions."

Whether or not that lawyer can stop disclosure that could lead to an FCA action, he or she could at least spot the danger if it emerges and "suggest self-disclosure to beat 'em to the door." — *Roy Edroso (redroso@decisionhealth.com)*

Resources:

- Jan. 10 DOJ memo: *https://assets.documentcloud.org/documents/4358602/Memo-for-Evaluating-Dismissal-Pursuant-to-31-U-S.pdf*
- Jan. 25 DOJ memo: *www.justice.gov/file/1028756/download*

EHR time

(continued from p. 1)

encounter — totaled 19.3 minutes. The authors found this "similar" to earlier studies, such as one that showed physicians spending "an average of 3.08 hours on office visits and 3.17 hours on 'desktop medicine' each day."

While screen time doesn't necessarily mean worse care — "not all face-to-face time is good time and not all EHR time is wasted time," says Vinay U. Vaidya, M.D., vice president and chief medical informatics officer at Phoenix Children's Hospital — providers often complain that EHRs distract from and reduce their attention to the patient. While there's not much providers who take federal dollars can do about their requirement to make "meaningful use" of EHRs, some experts suggest trims that could at least shift the balance more in the patient's favor.

1. Have someone else do it. Hire scribes or increase your delegation of screen work to non-physician practitioners (NPP) in your office. This is the simplest solution but can cost money. The U.S. Bureau of Labor Statistics cites a median salary for medical transcriptionists, its closest equivalent to scribes, of $35,720 per year, or $17.17 per hour; *Part B News* previously found the hourly range for scribes to run from $13 to $35 (*PBN 12/21/15*).

Hiring a scribe "was the best thing I did for myself this past year," says C. Nicole Swiner, M.D., a partner at Durham Family Medicine in Durham, N.C. "This allows the doctor to spend the large majority of the visit actually

looking at the patient and spend less time staring at the computer screen." Swiner recommends that cash-strapped practices use "pre-med or med students that are available and would love the experience in the clinical setting." Do, however, make sure you assign them properly and aren't employing them beyond their legal scope, just as you would a student NPP (*PBN 2/8/16*).

2. Analyze your EHR use and make design improvements. Shelley Iocona, founder of strategic consultancy On Its Axis, says when working with health care clients, "we work to ensure the solution meets the needs of key users by observing their behavior and workflow prior to rolling out to the entire group," including "ease or difficulty entering data in the EHR."

This includes the sort of "user experience" analysis common with website design, in which they "watch providers work with the system modifications to the user interface, pre-population of data and system triggers that serve as a checklist to guide users through the documentation process." Iocona's team might even track user eye movements to see how they're relating to the screen.

This data is then analyzed and improvements recommended — such as modifications of the design of screens and reordering data arrays, says Iocona. EHR vendors are usually open to working with clients to make changes that will make them more efficient, particularly if such a service is written into your contract (*PBN 3/1/18*). The result "can shave seconds off key data entry points and those seconds add up," leaving more time free for patient interaction, says Iocona.

Creating templates also can make providers more efficient. At Phoenix Children's Hospital, the EHR system accommodates not only specialty-specific templates but also disease-specific templates, which makes the providers' work easier and shaves some time, says Vaidya.

You also should coordinate your system with other information systems you're using, says Bennett Lauber, chief experience officer for The Usability People in Fairfax, Va. "There are many individual settings or clinical defaults that should be adjusted or configured to best match the actual working medical environment of the specific EHR used in a unique clinical context," he says. For example, your scales may be metric and your system make take weight in pounds and ounces or vice versa. That's best handled on the front end "instead of requiring nurses and other staff to manually multiply by 2.2 to convert to kilograms," says Lauber.

3. Use an integrated system. "Many practices have standalone EHR, practice-management and patient-engagement solutions that are at best loosely connected," says Naveen Sarabu, vice president of product management at EHR company AdvancedMD. "This leads to duplication of effort, possible data entry errors and inefficient communication." Switching to a single-vendor suite of product makes small efficiencies from log-in to read-out that can add up to more patient time, says Sarabu.

4. Save screentime for after the visit. "I dictate notes after the visit," says Swiner. "Doctors could consider taking notes on paper during the visit or not at all and, immediately after the visit is over, step outside the room and dictate or voice text the notes." This takes a little extra time from you — and gives it to your patient. — *Roy Edroso (redroso@decisionhealth.com)*

Resource:

- "A Time-Motion Study of Primary Care Physicians' Work in the Electronic Health Record Era," Family Medicine: *https://journals.stfm.org/familymedicine/2018/february/young-2017-0121/*

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