

Self's Tips And Tidings

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SUPER-COMMITTEE NOT SUPER

I'm sitting here watching the news and listening to an enormous amount of lies being told by politicians, learning that the super-committee (SC) did NOT come to a compromise. Of course, who in this country with an IQ above 50 expected them to when they loaded nothing but super liberals and super conservatives. I am glad that they did not come to an agreement, especially considering how much of an increase in taxes they wanted to pass on to us. There are many physicians that are looking at this as bad news and thinking that this is a cause for them to jump ship or abandon Medicare and I ask that you consider the following before you lower the lifeboats.

The vast majority of what the SC was debating on affects the US Budget in 2013 and later. The only two portions that go into affect Jan 2012 are the SGR reductions (27.4% reduction) and the one year automatic timeline for unemployment benefits (so - this means the people sitting at home waiting for the PERFECT job needs to get off their butts and get a job doing anything - as nothing is truly beneath anyone!) which will be reduced to six months instead of one year.

So - let's look at this SGR thing realistically. Next November, more than 50% of those

elected in the House, Senate and 1600 Pennsylvania Ave will come up for re-election. They are not complete idiots and they know what will happen in this country in January if they allow the 27.4% reduction in the Medicare SGR to happen. You have 535 members of Congress that while they may appear to be absolute morons do realize the implications if they do nothing. More than 60% of the primary care physicians in this country have said they will either opt out of Medicare (which is DUMB) or they will stop seeing Medicare patients (there is a huge difference in the two - see page 6). That will force Medicare patients to use E.R.s as their primary care as ER's cannot refuse to see them and they HAVE to accept assignment. That will cause an unrest in this country not seen since the Vietnam turmoil. Congress knows this. They may be stupid but they are not ignorant and there is a difference.

Between now and January, Congress will pass another stop-gap or perhaps a permanent fix to the SGR.

If I am wrong & they don't do so - don't have a knee jerk reaction and opt out. Very seldom is an emotional knee-jerk reaction the wisest and most prudent option to running a successful practice.

3 DAY RULE CHANGES

If you work in a physician office that is OWNED by a hospital, January 1st, 2012 will bring some changes you need to be aware of - that may greatly complicate your job when it comes to being paid for services related to hospital admissions. The November 1st Federal Register addresses changes that affect all clinics WHOLLY owned by hospitals (except for RHCs and FQHCs). It is my own opinion that most hospitals have NO IDEA how to run a physician clinic - yet many hospitals are buying clinics like crazy. This presents a problem for the clinic that have been plaguing hospital administrators and billers for years. June 25, 2010, more changes were dictated by Part A that bled over to Part B issues. One of those questions that arose from those decisions was "how do you bill for the outpatient services related to a hospital admission that occurred within 3 days of the admit?" If you ask people at Medicare, you get conflicting answers. If you ask CMS officials - you get conflicting answers. Even the November 1st Federal Register was conflicting in its statements!

Before you get too nervous about this - keep in mind that it ONLY applies to "hospital wholly owned and operated" physician clinics. If the hospital has exclusive responsibility operating and overseeing the clinic's operations - regardless if it is "hospital" based or "provider" based, then this rule will apply. It does not apply to RHC and FQHC billing, as that falls outside of this purview.

The new rule says "all outpatient diagnostic services provided within 3 days of the admission must be included on the inpatient claim. Non-diagnostic services provided up to 3 days prior to the admission will only be included on the inpatient claim if they are clinically related to the admission". They gave us a NEW MODIFIER (PD) to use on the Part B claim to show the service was meeting the 3 day payment window. So - you will use the PD modifier for the diagnostic tests done prior to 3 days (EKG, Spirometer, GBHT, etc) and that means that the physician clinic will only be paid for the professional component as the technical component will be paid to the hospital.

OK - this clears it up to some degree - FOR DIAGNOSTIC services - but what about E&M services provided in the clinic 2 or 3 days prior to the admit? This is the part that is confusing EVERYONE! You may expect the Federal Register to clarify it - but just the opposite happens!

One one page of the 11-1-11 Register, it says "Professional services are not considered to be operating costs of inpatient hospital services and, accordingly, are not subject to the 3-day payment window policy." And then again on another page 663, it states, "...makes **no change** in how provider-based physician practices currently bill Medicare for the professional work of physician and non-physician practitioner services. Those services are **not** subject to the 3-day payment window policy." Yet - on another page, it says "*However, any service that a wholly owned or wholly operated physician practice would bill separately from the global surgical package, such as a separate initial evaluation of a problem by the surgeon to determine the need for surgery or separate diagnostic tests, would continue to be subject to the 3-day payment window policy.*"

This takes us back to the early 1990s when the 3 day window DID include any services provided prior to the admission. Again - if you ask folks at CMS and Medicare, they are just as confused as we are. We will have to wait and see what clarification comes from CMS prior to January 1st for those clinics that are owned and operated by hospitals. Look for more on this subject next month!

BRIEFS



HIPAA LOTTERY

There are more than 800,000 physicians, nurses, hospitals, diagnostic services, home health providers, clinics and health plans in the USA. The Office of Civil Rights has announced that they are going to be auditing these entities for HIPAA compliance. Let's look at some numbers. In June, the OCR awarded a \$9.2 million contract to consultant KPMG to conduct the audit program and awarded nearly \$180,000 for a contract to consultant Booz Allen Hamilton to help identify audit candidates. \$180,000 to a consultant to help IDENTIFY who to audit? I would love that contract, especially considering they are only planning on auditing 150 entities between now and Dec. 31, 2012!

So - how are they starting? They have 5 "winners". Notification letters were mailed out on November 4 to the 5 entities that will be the first of 20 to be audited. If you've been worried about getting audited, consider the odds of being one of the 150 out of 800,000. I think you have a better chance of winning a lottery, but you still need to make sure you comply with all HIPAA rules. By the way - yesterday I was in another practice that had gotten rid of their sign-in sheet for patients because "we were LIED TO & told that it is a HIPAA requirement".

CMS Delays 5010 by 90 Days

November 17, 2010 -The Centers for Medicare and Medicaid Services (CMS) announced that they will be delaying the period of enforcement discretion for 5010 compliance by 90 days. The new deadline for 5010 compliance is March 31, 2012.

CMS said it decided to provide a 90-day discretionary enforcement period based on testing feedback indicating low compliance among some trading partners and reports that many covered entities are still awaiting software upgrades.

HHS BEING SUED FOR OBSERVATION CARE

Medicare wrongfully denies thousands of beneficiaries coverage of acute, post-acute and prescription drug expenses each year because hospitals do not "admit" them as inpatients for at least three days as they should, claims a class action lawsuit filed by two advocacy groups - against HHS & Medicare.

Instead, the care of these patients is classified under the controversial "[observation](#)" category intended for a period of up to 48 hours even though their hospital stays may last as long as seven days and sometimes longer. In each case, the lawsuit says, patients "received a hospital level of care and should have been formally admitted." The [Center for Medicare Advocacy](#) and the [National Senior Citizens Law Center](#) filed their petitions this month against Health and Human Services Secretary Kathleen Sebelius and names seven patients as plaintiffs. They ask for declaratory, injunctive, and mandamus relief in the U.S. District Court in the District of Connecticut. The result is that this case may prompt Medicare to change the rigid DRG requirements for admission - thereby reducing the number of observation visits billed.

WHY DID DON STOP SELLING ULTRASOUNDS?

Although there are many devices and varied medical equipment that we sell, I have been trying to convince clients to not buy ultrasounds for a few years due to changes we saw coming. In addition to the reduced reimbursements by Medicare and other carriers for U/S, we have new payment rules starting January 1st with Medicare on CTs, MRIs & Ultrasounds.

Payment for both the PC and TC will be cut for CT, MRI's and ultrasounds. Providers will be paid @ 75% of reimbursement for Professional Component for multiple imaging for same patient/same day. For interpreting tests, the highest reimbursed test will be reimbursed @ 100% and 75% for all subsequent interpretations same patient/same day.

IN CASE YOU PASS AWAY....

The following is from a biller whose advice based on her experience should be listened to by everyone who has any business (medical practice, billing agency, etc). "Back in February of this year I made a post regarding a practitioner I did billing for who unexpectedly passed away. He was a solo practitioner, a doctoral-level psychologist, with no partners, no office staff, no one knew what was going on in the practice except him & no one had authority to cash checks, handle the HIPAA protected records, etc...

Don suggested I contact our state licensing board, who said they had no authority now that he had passed. I did speak with his sister, who advised me she had hired an attorney to determine what to do next, since I could not legally give her the records, per HIPAA. Long story short, that attorney said "do nothing" and she ended up hiring a second attorney. That attorney got her (and her sister) appointed executors of the estate and ruled they have access to his financial and business documents given the circumstances. It turns out she is a nurse in Washington state so she was familiar with HIPAA. I told her I would need a copy of the court order saying I could talk to them, which they did provide.

I prepared a list of checks I had received ERAs for which had not been reported as received by the practitioner before he died. She did the follow-up calls to the insurance companies to find out if they had been cashed, and except for one, they had been. She requested that check be reissued, which it was. The second attorney advised her not to pursue collections on old balances or attempt to reconstruct his final month's billings, so they have decided not to do that.

I have since shredded and/or deleted the clinical records as they were no longer needed. As it turned out, the court did authorize the two sisters to proceed on the practitioner's estate's behalf, and it all went very well. Some of his clients even got a huge break as they owed him money the sisters decided, based on advice of counsel, not to pursue. If you have solo practitioners out there for whom you do billing, I hope you can get them more prepared for this type of thing than my client was when he passed. It was very hard on the family to sort it all out and could easily have been prevented had he had a back-up plan in place. It did, however, turn out fine in this case.

Roxy Lewis

PAYING PER CLICK OR PER PATIENT

For many years (probably more than 15), I have recommended to clients that they NOT enter into an arrangement with a supplier of technical services (ultrasound, vestibular, autonomic, etc) to bring technical equipment into the physician's office and test patients, while paying the tech service on a per patient basis. Recently, I had a client follow the advice I give in making sure consultants can back up what they say with something legal, and a client asked me to prove my belief that CMS and the OIG penalizes for that kind of payment structure. I looked on every CMS and OIG site my fingers could find on the keyboard and did NOT find what I was looking for. I put the word out to those that I look to for guidance (7 other consultants in the country with expertise in their own field) and while each agreed with the recommendation to avoid the per click arrangements - none could quote a source either. I then contacted a healthcare attorney I trust, Robert Liles, JD and asked him if my advice to avoid those kind of arrangements was incorrect. He replied:

"You are not wrong. HHS-OIG hates just about every form of "pay-per-click" contract there is. In the early years, we used to see a number of variations of this theme by providers, trying to incorporate some semblance of this payment scheme. As early as March 2003, HHS-OIG stated in Advisory Opinion 3-08:

"Per patient," "per click," "per order," and similar payment arrangements with parties in a position, directly or indirectly, to refer or recommend an item or service payable by a federal health care program are disfavored under the anti-kickback statute. The principal concern is that such arrangements promote over-utilization and, in circumstances like those here, unnecessarily lengthy stays.

More recently, last year HHS-OIG wrote in Advisory Opinion 10-23:

The OIG cautioned that per-click arrangements are "inherently reflective of the volume or value of services ordered and provided." The OIG also found problematic that the arrangement involved marketing by a person with a direct stake in the success of the promotional efforts.

The bottom line is pretty clear to me – don't get involved in those relationships unless they are extensively analyzed by a qualified health lawyer prior to moving forward. The presumption is that such an arrangement would be problematic and likely represent a violation of the Anti-Kickback statute."

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(If you need a healthcare attorney you can trust, contact Robert. He is good!!)

5010 DISALLOWS PO BOX AS ADDRESS

Do you use a P.O. Box or lock box address as your billing provider address to receive payments? If you submit claims electronically, you will be required to use only a street address or physical location as the billing provider address. Continuing to report a P.O. Box in the billing provider address field will cause your claims to reject.

Under the Health Insurance Portability and Accountability Act (HIPAA), all physicians and other health care providers that submit claims electronically are required to transition to the Version 5010 transactions by Jan. 1. One of many data reporting changes in the Version 5010 transactions is the requirement to report only a street address or physical location as the billing provider address. Practices that wish to continue having payments sent to a P.O. Box or lock box will report this address in the "pay-to" address field.

MEDICARE PAR, NON-PAR & OPTED-OUT

Participating: means you will accept assignment on every covered Medicare covered service you provide. As a participating physician, you have a 5% higher Medicare allowed amount than you would have if you were non-participating. You're already required to file the claims and you're going to be subject to the same scrutiny and coding requirements, regardless if you're par or non-par. Being a par physician does NOT mean that you have to see every Medicare patient that calls for an appointment, but it does mean you'll accept Medicare's assignment on each one you do see.

Non-Participating: If you failed to sign the participation agreement, when you requested your Medicare number, then you are non-par and you have the choice whether to accept assignment or not accept assignment on a claim by claim basis. If you're non-par, you can accept the assignment on one patient and then not accept it on the next patient, if you wish. If you do accept assignment, your allowed amount will be 5% less than it would be if you were a participating physician. If you're going to see patients in the hospital or in the nursing home, where you'll probably accept assignment anyway, you'll make 5% less than if you were participating. Your fee to the Medicare patient can be collected at the time of service, from the patient, but your fee will be limited to the LIMITING CHARGE. That Limiting Charge is 15% above the non-par Medicare allowed amount, so you cannot charge and collect from the Medicare patient any amount you wish to. You are also still required to accept assignment on certain claims and specific services, such as clinical lab tests, regardless if you're par or non-par.

Opted-Out: These are physicians that have sent a letter to the Secretary of the Health & Human Services (HHS) notifying them that for a period of **not less** than 2 years, they will opt-out of the Medicare program and any services they provide to Medicare patients (other than emergency services) will not be reimbursed by the Medicare program to ANYONE! I do not EVER recommend this option to any primary care physicians.

There are several reasons why I recommend all primary care physicians enroll in participating and they are mostly centered on the increased income that their clinics will enjoy by participating.

Not only do they get the 5% increased allowed amount, and the hospitals are required to refer patients to participating physicians, but 25 years of working with physicians have taught us that physicians will accept assignment routinely on specific patients, including:

1. Hospital patients (Physicians seem very reluctant to pick through the patient's purse or pants while they are seeing hospital patients to get their money).
2. Skilled and Non Skilled Nursing Home patients: Ditto – the same thing
3. Office patients that receive expensive or extensive diagnostic testing in the clinic. The problem is also that the physicians that choose to not accept assignment are less likely to order or perform the diagnostic tests that the patients truly need, if they have to ask the patient for the money – thereby resulting in mediocre or inferior medical care being rendered to the patient.
4. Patients with Medicaid as secondary insurance (Patients with Medicaid as secondary usually – but not always – have very little money, so the opportunity to collect the Limiting Charge at the time of service is reduced).

So - if CONGRESS doesn't act prior to January 1st and your doctor OPTS-OUT, and then in March, they retroactively fix it and instill INCREASES, your doc's knee jerk reaction just screwed them for the next 2 years.

A SINK IN EACH EXAM ROOM?

A client asked whether they have to have a sink in each exam room, per OSHA. [The OSHA guidelines \(29CFR Bloodborne pathogens. - 1910.1030\) state the following:](#)

Definition: Hand-washing Facilities means a facility providing an adequate supply of running potable water, soap and single use towels or hot air drying machines.

[The statement SHALL PROVIDE is not negotiable, this also means a violation of this reg may result in the upper \\$\\$\\$\\$ of fines.](#)

[1910.1030\(d\)\(2\)\(iii\)](#) Employers shall provide hand-washing facilities which are readily accessible to employees.

[1910.1030\(d\)\(2\)\(iv\)](#) When provision of hand-washing facilities is not feasible, the employer shall provide either an appropriate antiseptic hand cleanser in conjunction with clean cloth/paper towels or antiseptic towelettes. When antiseptic hand cleansers or towelettes are used, hands shall be washed with soap and running water as soon as feasible.

[1910.1030\(d\)\(2\)\(v\)](#) Employers shall ensure that employees wash their hands immediately or as soon as feasible after removal of gloves or other personal protective equipment.

[1910.1030\(d\)\(2\)\(vi\)](#) Employers shall ensure that employees wash hands and any other skin with soap and water, or flush mucous membranes with water immediately or as soon as feasible following contact of such body areas with blood or other potentially infectious materials.

[The Directive which the OSHA inspectors follow CPL 2-2.69 "Enforcement Procedures for the Occupational Exposure to Bloodborne Pathogens" states:](#)

4. Paragraphs (d)(2)(iii) through (d)(2)(vi). These paragraphs require employers to provide hand-washing facilities which are readily accessible to employees. Hand-washing with soap and at least tepid running water must be performed as soon as feasible, particularly in cases of gross contamination, to adequately flush contaminated material from the skin.

a. Paragraph (d)(2)(iv). This paragraph allows the use of alternative hand-washing methods as an interim measure when soap and water are not a feasible means of washing the hands or other parts of the body. In such cases, the employer must provide either antiseptic hand cleaner and clean cloth/paper towels, or antiseptic towelettes. When these types of alternatives are used, employees must wash their hands (or other affected area) with soap and running water as soon as feasible thereafter.

The Compliance Officer may see these types of alternative washing methods used by ambulance-based paramedics and emergency medical technicians (EMT's), fire fighters, police, and mobile blood collection personnel who are exposed to blood or OPIM but have no means of washing up with running water at the site of the exposure (e.g., a crime scene, traffic accident, fire).

b. Paragraph (d)(2)(v). This paragraph requires employers to ensure that employees wash their hands immediately or as soon as feasible after removal of gloves or other PPE. There is no requirement for hand-washing upon leaving the work area unless contact with blood or OPIM has occurred or gloves/PPE have been removed.

CITATION GUIDELINES. If the compliance officer finds that required hand-washing facilities are not being provided, paragraph (d)(2)(iii) should be cited unless the employer demonstrates that hand-washing facilities are not feasible. If unfeasibility is demonstrated, paragraph (d)(2)(iv) should be cited when the required alternatives are not used. If hand-washing is not performed by the employees immediately or as soon as feasible after exposures or removal of gloves, paragraphs (d)(2)(iv), (v), or (vi) should be cited. A citation for one or more of these paragraphs may be grouped with the pertinent training paragraphs of (g)(2) if employees have not been adequately trained in hand-washing procedures.

At a fixed establishment, if hand-washing facilities are not readily accessible, i.e., within a reasonable distance from the area the employee is exposed, (d)(2)(iii) should be cited. For example, if an employee must leave the work area and thread his/her way through doorways and/or stairs to wash, there is a reasonable chance of resultant environmental surface contamination. This situation is a violation.

So - if you have the sink in the hallway, you may be ok as long as you do not have to thread your way through "doorways" (plural) and it is easily accessible.

(Thank you to our expert, Ann Moll, on OSHA for this data. If you have not had an OSHA compliance expert such as Ann visit your practice, you really should consider it. Her fees are a fraction of the typical \$40,000 OSHA fine. If you need to get hold of Ann - contact me and I'll get you together)

ANNUAL WELLNESS VISIT -ONLY G0438 IN 2011

Since code G0438 is for the initial annual wellness visit and G0439 is for subsequent ones, and these codes were only effective January 1, 2011 - you can only use the G0438 in 2011. I kinda think they should not have even created G0439 until next year to reduce confusion - but that isn't what happened.

LET'S NOT RAISE THE DEBT CEILING

Folks, I know I may upset one or two folks reading this, but please contact your elected folks and tell them to not raise our debt ceiling. Per the US State Department, in 2008 when President Obama was elected, the US was in debt \$4.6 Trillion. Today - it is more than \$9.2 Trillion. Today, he wants it raised again. If you have a toilet that malfunctions and it fills your house with waste, you don't just raise the ceiling & live in it... You clean up the house and get rid of the waste. We need to do the same thing! Let's reduce some of the waste that we're paying for today instead of raising the ceiling, raising the taxes and raising the burden on our children, grandchildren and future generations.

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