Part B News

COLLECT EVERY DOLLAR YOUR PRACTICE DESERVES

www.partbnews.com

May 4, 2015 | Vol. 29, Issue 18

IN THIS ISSUE

Patient encounters 1

Use telehealth to complement your revenue stream as coverage widens

Collections 1

8 tips for choosing a debt collections agency, using it compliantly

Practice management 2

5 questions about workload, culture to answer before adding PAs, NPs

HIPAA 4

Take immediate steps to protect your practice from costly ransomware attacks

Benchmark of the week 7

E/M visits, psych consults top list of services using telehealth

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

Patient encounters

Use telehealth to complement your revenue stream as coverage widens

Lay the foundation for a telehealth service within your office now so you can take advantage of additional revenue opportunities that are coming down the pike with states and the federal government loosening longstanding payment restrictions.

Arkansas recently became the 23rd state to pass a telehealth parity law, which greatly expands the count of services physicians can get paid for via telehealth. Several provisions in the Medicare Access and CHIP Reauthorization Act of 2015 (H.R. 2) promote increased use as well.

*(see **Telehealth**, p. 5)*

Collections

8 tips for choosing a debt collections agency, using it compliantly

Know who is collecting debt from patients on your practice's behalf to avoid being on the hook for a collections agency's bad behavior (*PBN 4/27/15*).

Patients have greater cost-sharing obligations than they used to and at higher amounts because of consumer-directed health care and the Affordable Care Act, which requires consumers to obtain health insurance and has sent millions to plans on the health insurance exchanges.

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

Practice management

5 questions about workload, culture to answer before adding PAs, NPs

Along with a financial analysis, evaluate whether your practice has the right mix of procedures, patients and physician attitude when you consider taking on nurse practitioners (NPs) or physician assistants (PAs).

Several signs, including an uptick in their billing of common CPT codes, point to increased use of nurse practitioners (NPs) and physician assistants (PAs) in practice work (*PBN 4/20/15*). The trend is expected to continue: The U.S. Bureau of Labor Statistics predicts 38% growth in PA employment and 31% growth in NP, nurse anesthetist and nurse midwife employment between 2012 and 2022.

Advocates point to the lower price point on a PA's or NP's services compared with a physician's. A PA makes on average less than half of a physician's salary, and at that price, he can be a moneymaker, even if billing directly to Medicare and receiving 85% of Medicare's rate. "NPPs [non-physician practitioners] can bill incident-to, but in the majority of cases I've seen, the PAs and NPs bill under their own NPI, even if it's only 85% of Medicare," says Cynthia (Cindy) L. Dunn, an independent consultant for the Medical Group Management Association (MGMA) Health Care Consulting Group.

But to ensure you hire the right fit, look at the roles a PA or NP would play at your practice and what kind of work you'd have them do.

PA vs. NP: What's right for your practice

Understand the differences in PA and NP training to determine which you should hire. The stereotypical view is that PAs are good for working directly with physicians, while NPs are good for working on their own. This is based on their training, says Damaris Boutros, a professional patient advocate at North Shore Patient Advocates in Chicago: "Nurse practitioners graduate from nursing schools, so theirs is a very patient-centered focus," she says. PAs graduate from programs affiliated with medical schools, so "their focus is very disease-centered."

"Generally the scope for PAs and NPs depends on state law, but unlike a PA, an NP often doesn't need direct physician supervision," says Jennifer Searfoss, president of SCG Health in Ashburn, Va. NPs have full practice rights in 20 states and Washington, D.C., and varying levels of restriction in the others. "If your attitude is 'OK, they're on their own island, they can work on their own,' that's a good environment for NPs; if, however, your culture leans toward more coordination with the provider, PAs make more sense."

How to find the best fit

Answer these five questions before deciding whether to bring PAs or NPs on board:

Subscriber information

Here's how to reach us:

EDITORIAL

Have questions on a story? Call or email:

President: Steve Greenberg
1-301-287-2734
sgreenberg@decisionhealth.com

Vice president: Tonya Nevin
1-301-287-2454
tnevin@decisionhealth.com

Content manager, medical practices:
Karen Long, 1-301-287-2331
klong@decisionhealth.com

Editor: Roy Edroso, 1-301-287-2200
redroso@decisionhealth.com

Editor: Richard Scott, 1-301-287-2582
rscott@decisionhealth.com

SUBSCRIPTIONS

Direct questions about newsletter delivery and account status, toll free, to 1-855-CALL-DH1 or email to: *customer@decisionhealth.com*

DECISIONHEALTH PLEDGE OF INDEPENDENCE:

Part B News works for only you, the provider. We are not affiliated with any special interest groups, nor owned by any entity with a conflicting stake in the health care industry. For nearly three decades, we've been independently watching out for the financial health of health care providers and we'll be there for you and your peers for decades to come.

CONNECT WITH US

Visit us online at: *www.partbnews.com*. Also, follow us on Twitter, @partbnews.

CEUs

Part B News is approved, through Dec. 31, 2015, for AAPC CEUs. Credential holders can earn 0.5 CEUs by passing each five-question quiz, for up to 12 CEUs per year. For instructions on how to access the quizzes, log on to *www.partbnews.com/home/ceus_read_more*.

ADVERTISING

To inquire about advertising in *Part B News*, call 1-301-287-2230.

Part B News® is a registered trademark of DecisionHealth. DecisionHealth is a registered trademark of UCG. *Part B News* is published 48 times/year by DecisionHealth, 9737 Washingtonian Blvd., Ste. 200, Gaithersburg, MD 20878. ISSN 0893-8121. *pbncustomer@decisionhealth.com* Price: $597/year.

- **Do you have an appropriate specialty?**

The codes most often billed to Medicare by NPs and PAs are the kind you'd expect from general or family practices — E/Ms, injections, blood draws and quality reporting codes, according to 2013 Medicare claims data, the most recent year available. About 62.4% of NPs are in family practice but the second largest group is gerontology at 13.9%, says Ken Miller, president of the American Association of Nurse Practitioners in Alexandria, Va.

But that is only part of the picture, say Searfoss. For one thing, "a lot of their work is incident-to the physician, so there's a lot they're doing that won't show up in billing," says Searfoss.

Nurse practitioners are common in pain management because of their prescribing authority, Searfoss says. "And we see a lot of NPs coming into dermatology," she says, which makes sense if the practice treats many patients with acne. "If, however, you're doing mostly melanomas, a PA may make more sense. The service line makes the difference."

A surgical practice is usually a safe bet for PAs. In fact, sometimes PAs get hired by surgical practices to assist in the OR even if the surgeon can't bill for them, says Dunn. If the practice can do six cases instead of four because the PA is closing for them, it makes financial sense.

Tip: Check your potential PA's or NP's experience. Specialty certificates of added qualifications (CAQs) for PAs, instituted by the National Commission on Certification of Physician Assistants (NCCPA), "have not been widely adopted yet," says Kemuel Carey, the American Academy of Physician Assistants' liaison to the American Academy of Orthopaedic Surgeons and a practicing PA at Peninsula Orthopaedic Associates in Salisbury, Md. When PAs have finished their training and boards and started work with supervising physicians, "that's where the magic happens" and PAs develop their specialty skills, says Carey.

Specialty titles are more commonly used for NPs — most states require certification in a specific specialty, says Miller — but it's always a good idea to see what specific type of work the NP has done, such as sports medicine, rehab or other areas, as an indicator of his or her skills.

- **Do you do repeat procedures?** If you have procedures for which patients come in on a regular basis, an NP or PA will be more economical — and almost certainly more willing — than an M.D. "Orthopedists often use PAs for injection clinics," offers Dunn as an example. And patients appreciate the reliability and familiarity of having a trained provider doing that work every time they come in, she adds.
- **Can your M.D.s buddy up with PAs and NPs?** If you want to back up a physician, a PA is "indispensable," says Dunn — but only if he or she and the M.D. understand one another. Well-trained PAs can follow up with patients because they know the doctor's preferences and what should be assessed and documented, she says.

But this requires intensive personal training, she says — and physicians who can be worked with.

"Often it's harder for the more senior M.D.s to accept the NPs," says Miller. "They're used to getting that level of work from residents or med students." Younger physicians, on the other hand, tend to fit more gracefully in such a team: "They may have taken classes with NP candidates, under the auspices of inter-professional education, or worked beside them in med school," he says.

- **What extra tasks can PAs and NPs do?** If you have medicine-related work that your physicians don't have time for, PAs and NPs may be of use there. For example, they're good for training the staff in clinical matters, says Dunn; she's seen practices that have them hold regular sessions for this purpose. "They can also round at hospitals if you credential them," says Dunn, "which is great because then your patient won't just see the hospitalist; they'll see someone from the office they know, and it's a comfort." And they're useful for clinics, chronic care coordination and group visits (*PBN 1/26/15*).
- **Can you treat them right?** While it's fine to ask them for appropriate clinical assistance, PAs and NPs are professionals and should be respected as such. It's not just disrespectful but also a poor use of their time to employ them, for example, as scribes, as Carey has seen done in some practices. "Treat the PA like a provider," he says. "If you don't expect the physician to room their own patients, for example, don't expect the PA to."

Tip: Check with your private payers before you make a decision and make sure they'll reimburse for your NP's or PA's services, says Dunn. Most payers have gotten on the bandwagon, but a few are holdouts, and it's better to know before you hire someone. — *Roy Edroso (redroso@decisionhealth.com)*

HIPAA

Take immediate steps to protect your practice from costly ransomware attacks

A recent cyberattack on a private duty agency should serve as a reminder to conduct regular system backups and take other steps to protect your practice from ransomware, a new trend in hacking.

Doing so will lessen chances you'll be threatened with a nightmare scenario where you either lose thousands of dollars in information or pay hundreds of dollars in ransom to get it back.

Caring Senior Service, a San Antonio-based private duty franchise, recently paid a $500 ransom during a ransomware attack. If the agency hadn't paid up, it could have lost $50,000 in time and effort to re-create the marketing material on a computer that had been attacked, says Jeff Salter, the agency's CEO/founder.

In December 2014, a Caring Senior Service employee clicked on an email from what appeared to be a known sender, Salter says. By doing so, the employee accidentally exposed the computer to a virus. A message appeared, stating that information on the computer had been encrypted and only paying a $500 ransom would allow it to be accessed, Salter says. Fortunately, that computer wasn't connected to a network and was the only one affected.

Marketing work on the computer was, indeed, made inaccessible to Caring Senior Service. A message on the computer indicated that if the ransom wasn't paid within 72 hours, information on the computer would be lost.

Ransomware attacks strike millions

The estimated number of ransomware attacks rose from 4.1 million in 2013 to 8.8 million in 2014, according to an April 2015 report by Symantec, which produces antivirus software.

Anyone can fall prey to ransomware attacks — including businesses, home computers and government agencies. A Maine sheriff's office and four towns recently paid $300 to hackers after a virus was downloaded on a computer system they share.

"In general, these are not high school kids we're talking about — these are career criminals," FBI special agent Thomas Grasso says of the attackers. "These are business people."

The FBI says it has seen an increasing number of incidents where users infect their computers "by clicking on a compromised website, often lured there by a deceptive email or pop-up window." It also notes that ransomware sometimes involves attackers locking peoples' mobile phones and demanding payments to unlock them.

For practices, the greatest damage might come from the loss of patient information or other proprietary material. It also might come from the money and effort it takes to restore or re-create files.

Hackers generally demand about $300 during ransomware attacks, Grasso says. Victims are often asked to pay with bitcoins, an electronic currency that is difficult to trace.

About 3% of those victimized pay up, says Kevin Haley, Symantec's director of security response.

What to do if this happens to you

Many factors should be considered when deciding whether to pay the attacker, says attorney Paul Hirsch of Edgewood, Ky.-based Pearson & Bernard.

Among them: Can you afford to pay the ransom, what's the value of what is being "locked up" by the attacker, what kind of disruption will come from involving law enforcement in the matter and what ethical/moral responsibility does your practice have to fight this?

Many companies weighing those options will decide to pay even though doing so is a tough pill to swallow, Hirsch believes. Those companies would consider the issue a lesson learned and "fix their broken processes so that it doesn't happen again."

"They're asking for a relatively small amount of money," Salter adds of his decision to pay and not involve law enforcement. "It was so small it was within my level of risk."

But it's important to note that if you pay, you're putting money in your attacker's pockets and there's no guarantee you'll get your information back, Haley says.

Before anything else, after being threatened, you should take your computer to an expert to see whether information has actually been encrypted, Grasso says. If information was encrypted, ask whether the ransomware is an older version that experts have already figured out how to decipher.

How to protect your computers

- **Conduct regular system backups, and store that data offline.** That will help your practice avoid losing files because of a ransomware attack. Have daily backup systems in place, Hirsch recommends.

It's important to make sure you have at least one or two backups that are not connected to your network, adds Tatiana Melnik, health care and technology attorney at Melnik Legal in Tampa, Fla.

- **Control the websites your employees view and what they can download.** "Locking down the Internet may be annoying for those who like to mess around on the Web during work," Hirsch asks. "But why should that be a reason to stop an agency from doing what is best for itself?"

Software — especially free software — should be downloaded only from sites businesses know and trust, the FBI says. And attachments or URLs contained within unsolicited emails also might be dangerous.

Practices should block cookies and not allow Java to run without permission, Hirsch adds.

- **Make sure you have and update your antivirus software as needed.** You need to have some kind of antivirus software on your computers, Melnik says. "Windows 7 and 8 come with Microsoft products that address this, and they get updated all the time." — *Josh Poltilove (jpoltilove@decisionhealth.com)*

Resources:

- The FBI's Internet Crime Complaint Center to report being a victim of a ransomware scheme: *http://www.ic3.gov/default.aspx*
- FBI tips to protect your computers: *http://1.usa.gov/1ptuOVf*
- Symantec's April 2015 Internet Security Threat Report: *http://bit.ly/1FQfdYQ*

Telehealth

(continued from p. 1)

Similar to laws in other states, the Arkansas law, effective January 2016 for commercial payers, means that "anything you can do on an in-person basis, you can get reimbursed for by doing it with a telehealth method," such as videoconferencing, explains Gary Capistrant, chief policy officer, American Telemedicine Association, a Washington, D.C.-based trade group that has campaigned for increased parity.

State-based parity laws seek to equalize payment for providers involved in telehealth. Under the Arkansas parity law, the "originating site" physician or non-physician practitioner (NPP) — in addition to the "distant site" physician providing the consultation — is now eligible for reimbursement, according to Curtis Lowery, M.D., chairperson for the University of Arkansas for Medical Sciences' (UAMS) department of obstetrics and gynecology and founder of the UAMS Center for Distance Health.

This state-driven payment structure solves a key payment hurdle that has vexed Medicare providers in years past. Current Medicare regulations say that if you provide the telehealth consultation services at a "distant site," you're eligible to be reimbursed. But providers at the "originating site," i.e., the location of the patient, are not recompensed. According to the Medicare Claims Processing Manual: "The payment amount for the professional service provided via a telecommunications system by the physician or practitioner at the distant site is equal to the current physician fee schedule amount for the service. Payment for telehealth services … should be made at the same amount as when these services are furnished without the use of a telecommunications system."

"One of the problems that all states have is: How do you pay for the originating site?" ponders Lowery. With the Arkansas law, the providers will get some reimbursement to host the patient.

"Medicare is way behind the curve," says Regan Tankersley, attorney with Hall Render Killan Heath & Lyman in Indianapolis.

Similar to other parity laws, the Arkansas law will split the money between providers, says Lowery. "The consulting physician gets the professional fee, and the so-called site fee would go to the registering site," or the originating site. The precise reimbursement ratio will be decided by the commercial payers on a payer-by-payer basis, adds Lowery.

Medicare expansion looms under H.R. 2

Currently, Medicare covers 74 services provided via telehealth, up from 67 in 2014 and 65 in 2013. New to the slate in 2015 are psychotherapy codes (**90845**-**90847**), prolonged service codes (**99354**-**99355**) and annual wellness visits (**G0438**, **G0439**) (*PBN 11/10/14*).

While the count is small, the constricted number of

reimbursable services might not last for long — at least for providers involved in an alternative payment model (APM), such as an accountable care organization (ACO) or patient-centered medical home. With the passage of H.R. 2, APMs play a significant factor in Medicare reimbursement in the coming years, rewarding providers with up to a 5% pay jump starting in 2019 (*PBN 3/30/15*). According to H.R. 2, providers involved in an APM will not be subject to Medicare's fee-for-service reimbursement restrictions for telehealth services.

The ultimate impact of the permanent "doc fix" law is yet to be seen, but with it, Medicare is "recognizing that these other approaches, including telehealth and telemedicine, should be paid if they are medically reasonable and necessary," points out Reid Blackwelder, M.D., board chair of the American Academy of Family Physicians (AAFP).

"From a general practice standpoint, there is going to be an incentive to be able to provide these services," advises Tankersley.

Physician involvement in value-based payment models will jumpstart "the next big phase in telehealth expansion" because seamless, in-network care, such as connecting your patient with a specialist or sub-specialist from your office, will be the natural result "when you start putting the hospitals and physicians at risk for the care delivery," predicts Lowery.

You may be able to use telehealth to your advantage under the Merit-Based Incentive Payment System (MIPS), the combined quality reporting system that launches in 2019 (*PBN 4/13/15*). Within the MIPS eligible reporting criteria under its clinical practice improvement activities section is "the subcategory of care coordination, such as timely communication of test results, timely exchange of clinical information to patients and other providers and use of remote monitoring or telehealth." — *Richard Scott (rscott@decisionhealth.com)*

Resources:

- H.R. 2 — Medicare Access and CHIP Reauthorization Act of 2015: *www.congress.gov/bill/114th-congress/house-bill/2*
- 2015 State Telemedicine Legislation Tracking, American Telemedicine Association: *www.americantelemed.org/docs/default-source/policy/2015-ata-state-legislation-matrixEF9F3AD41F02.pdf?sfvrsn=18*

Debt

(continued from p. 1)

"Some plans [on the exchanges] have $5,000 deductibles," warns David Zetter, president of Zetter Healthcare Management Consultants in Mechanicsburg, Pa., and a member of the National Society of Certified Healthcare Business Consultants (NSCHBC).

The health insurance exchanges also allow patients to obtain coverage and medical care right away but take 90 days to pay their insurance premiums (*PBN 4/14/14*). If they don't pay the premium by the end of that period, they lose their coverage and your practice has to chase down those payments.

(continued on p. 8)

Benchmark of the week

E/M visits, psych consults top list of services using telehealth

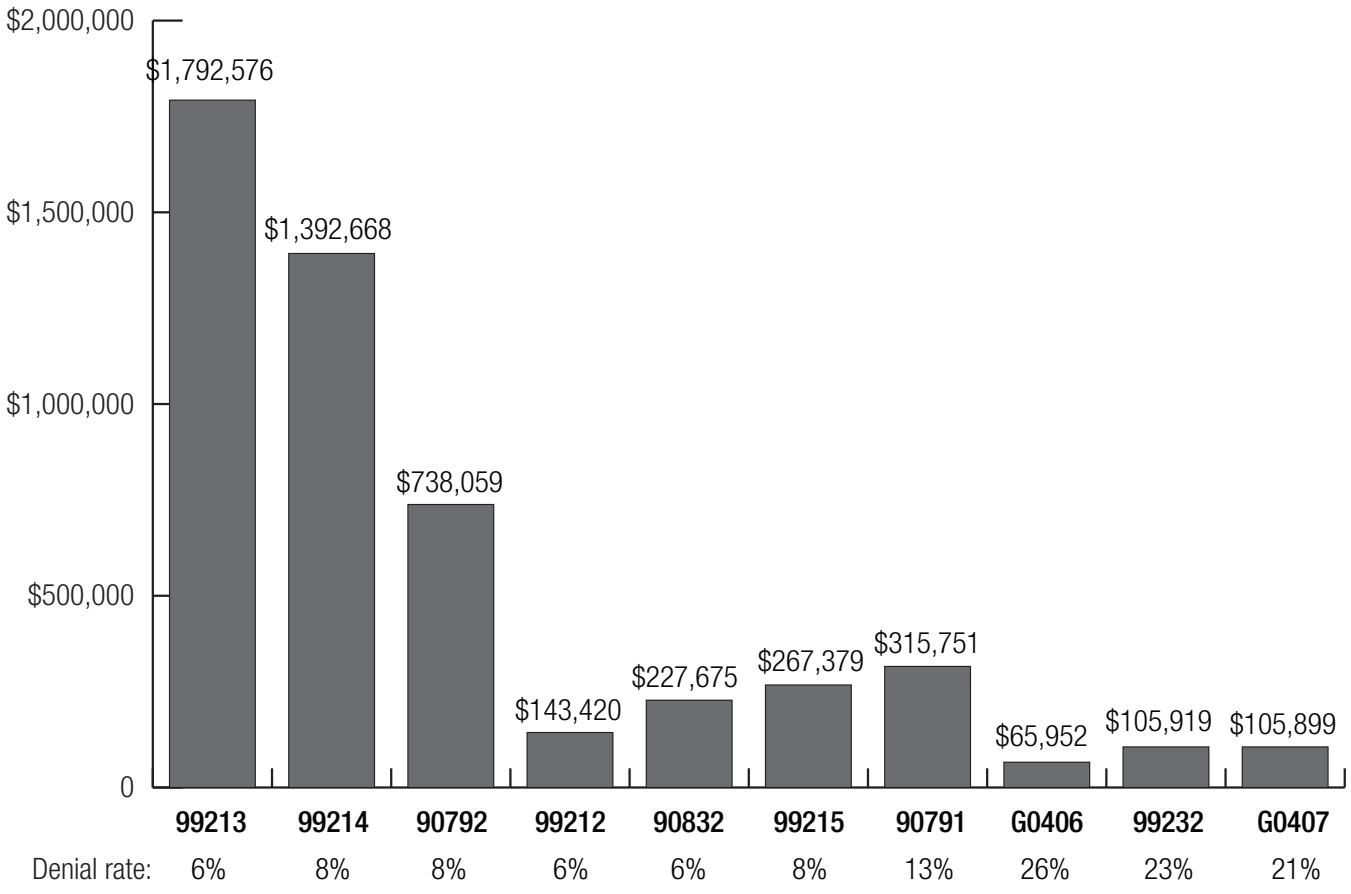
You can provide 74 distinct services via telehealth in calendar year 2015 and get paid for them, which marks a 10% boost in the number of telehealth services Medicare now covers compared with 2014.

Medicare paid out approximately $6.9 million for telehealth services in 2013, according to the latest available claims data. That number is expected to rise this year and in the coming years as telehealth restrictions slowly loosen *(see story, p. 1)*.

The chart below represents the most commonly provided telehealth services — marked by the **GT** telehealth modifier — that are listed sequentially by total service claims. Leading the way in both service count and payment amount is **99213** (Established patient office or other outpatient visit, typically 15 minutes), with about 53,000 services provided and $1.8 million reimbursed, followed by the next-level of E/M intensity, **99214** (Established patient office or other outpatient visit, typically 25 minutes), billed about 27,000 times.

Psychiatric code **90792** (Psychiatric diagnostic evaluation with medical services) takes the third slot, with about 9,200 claims billed and $738,000 paid by Medicare. Several other psych codes and low-level E/M codes round out the top 10, in addition to inpatient code **99232** (Subsequent hospital inpatient care, typically 25 minutes per day). — *Richard Scott (rscott@decisionhealth.com)*

Total payments for most-used telehealth services



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

(continued from p. 6)

Some practices don't have good internal debt-collection practices, which means they often carry more debt than they should.

"Doctors often don't want to use hard-core collection efforts on patients, their collection people are understaffed and they're not using the right processes," says Reed Tinsley, a Houston-based private practice accountant and also a member of NSCHBC. For example, many doctors send three billing statements to a patient when it's clear that a patient who ignores the first statement won't be paying attention to the later ones.

It also can be difficult to determine how much the patient owes because some health insurance exchange plans make it hard to verify eligibility and benefits; it's also hard to know how much of the deductible a patient has met. "It's a moving target," says Zetter.

How to vet your collections agency

That's when practices turn to collections agencies. When selecting a collections agency, "a lot of times people select agencies based on a handshake and friendship. But you need to exercise due diligence," says attorney Rozanne Andersen, vice president and chief compliance officer for Muncie, Ind.-based receivables management company Ontario Systems. For instance, make sure that the agency maintains applicable certifications and has or is working on procedures to comply with the upcoming Consumer Financial Protection Bureau (CFPB) and New York settlement obligations.

Also ask about complaints against it and its litigation history. "Don't be afraid to put out a request for proposal," says Andersen. And don't forget to check references, Tinsley says.

7 more tips to collect debt properly

- **Choose an agency that specializes in health care debt.** The agency should have at least 50% of its work in medical debt, says Andersen. You need a specialist who knows the industry, she notes.
- **Make sure that you and the collection agency are complying with HIPAA.** For example, if the agency will have access to patient protected health information, you need a business associate agreement with the collections agency, says Tinsley. You also need to include in your Notice of Privacy Practices that patient information may or will be turned over to a collections agency if the patient doesn't pay his or her bills. If you do share patient data with the agency, provide only the minimum necessary for the agency to do its job.
- **Ask how the agency communicates with debtors** and make sure you're comfortable with the agency's approach. You should see the collection notices and the agency's script and know how often it contacts the patient, says Andersen. See whether the agency is aware of financial assistance plans that may be available to patients and is sensitive to patients' needs. You don't want to alienate patients or cause them to post complaints on social media or file complaints with the CFPB, which is how medical debt ended up on the CFPB's radar. "Consumers are to be treated with dignity and respect," she adds.
- **Reconcile payments with the collections agency frequently, if not daily.** Patients often are contacted by an agency then pay the provider directly, Andersen explains. Without reconciling in those cases, the agency's records may be incorrect. When it reports unpaid debt to the three national credit reporting agencies (CRAs), the erroneous numbers can get the agency and your practice into trouble.
- **Use a "soft collection" process with the agency**. Some agencies will send out a letter in the name of the doctor, with the agency invisible to the patient, after a practice's internal collection has failed. Others will send a softer "pre-collection" letter on the agency's letterhead before putting the debt into regular collections. Those types of letters are less expensive, says Andersen. If they don't spur the patient to pay what he owes, then the debt goes into regular collections and you pay the agency as you would normally.
- **Double-check your contracts with payers.** They may have restrictions on billing and collection that you may need to comply with, Zetter warns.
- **Be familiar with state laws regarding charging interest or collection fees.** Some states don't allow them; others require advance notice to the patient, says Zetter. — *Marla Durben Hirsch (pbnfeedback@decisionhealth.com)*

Get LinkedIn with *Part B News*

Join your peers on the social networking site LinkedIn and stay up to date on the payment and reimbursement issues directly impacting your practice — all while expanding your business network and connecting with likeminded professionals. Join *Part B News* on LinkedIn here: *www.linkedin.com/groups/Part-B-News-3061445/about*.

How did you get this email?

It is illegal to forward **Part B News Online** to anyone else.

It is a free benefit only for the individual listed by name as the subscriber. It's illegal to distribute **Part B News Online** to others in your office or other sites affiliated with your organization.

If this email has been forwarded to you and you're not the named subscriber, that is a violation of federal copyright law. However, **only the party who forwards a copyrighted email is at risk,** not you.

Reward: To confidentially report suspected copyright violations, call our copyright attorney Steve McVearry at 1-301-287-2266 or email him at *smcvearry@ucg.com*. Copyright violations will be prosecuted. And **Part B News** shares 10% of the net proceeds of settlements or jury awards with individuals who provide essential evidence of illegal electronic forwarding of **Part B News Online** or photocopying of our newsletter.