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Number 9

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Medical Practice News

Monitoring Chronic Diseases Through Social Networking

A project coordinated by Children's Hospital Boston researchers found that social-networking tools such as Facebook and Twitter, when paired with personal health records (PHRs), could be valuable in monitoring chronic disease, according to a study published in *PLoS ONE*.

Dr. Kenneth Mandl, an associate professor of medicine at Harvard Medical School and director of the Children's Hospital Informatics Program's Intelligent Health Laboratory, and Elissa Weitzman, an assistant professor of pediatrics at Harvard Medical School and of adolescent medicine at Children's hospital, were co-principal investigators for the project.

The project used a social website run by a not-for-profit foundation for diabetes patients, www.tudiabetes.org, to invite users to anonymously share their personal data regarding the common diabetes control measure hemoglobin A1c status. Data was submitted through an application called TuAnalyze, which is based on the hospital's PHR program. Data then was shown on county- or state-level maps in real time. (Merrill, *Healthcare IT News*, 4/26)

One in five users of the social website signed up for the application, and 81 percent of the application's users shared their data, the researchers noted.

"There is growing recognition that online communities not only provide a place for members to support each other, but also contain knowledge that can be mined for public health research, surveillance, and other health-related activities," Mandl said in the release.

"We were hoping to gauge the community's willingness to share their personal data for public health surveillance and give them a tool that allowed them to securely share their data."

Source: Evans, M., "Boston researchers analyze social media as a disease-monitoring tool," *ModernPhysician.com*, April 2011

Doctors Take It Online

To improve office efficiency, answer patient demand, and increase patient satisfaction and engagement, doctors and patients alike are saying it's time they took advantage of easy-to-use technology and move their relationship online.

According to an Intuit Health Patient Engagement SurveyMonkey® Study, conducted in April 2011, 95 percent of doctors want their patients to fill out medical and registration forms online before their appointment. Intuit Health surveyed patients, as well, and 81 percent said they'd fill out forms online.

The survey also identified many opportunities for practices to become far more efficient, including many areas where they could save time and money, and build stronger, ongoing relationships with patients. According to the Intuit study:

- Nearly one of every four health care providers who do not offer an online communication solution feels it is difficult for patients to reach them to ask questions, make appointments, or receive lab results.
- Nearly half of the providers reported their practices are running 30-60 minutes behind schedule.
- One-third of the providers say their staff spends three or more hours each day trying to reach patients to communicate follow-up information.

- Eighty-three percent of doctors say their staff has to remind their patients more than once before a patient pays a bill.
- Forty-five percent say phone interruptions happen so frequently they impact office efficiency.
- Seventy-two percent say patients complain about having to repeatedly fill out the same paper forms
- Fifty percent say their patients complain about spending too much time in the waiting room.

The research also identified how offering bills that are easier to understand can improve a doctor's ability to get paid in a timely manner.

Source: Intuit Health (healthcare.intuit.com/portal/media-room.jsp)

CMS: ACO Prototype Succeeds

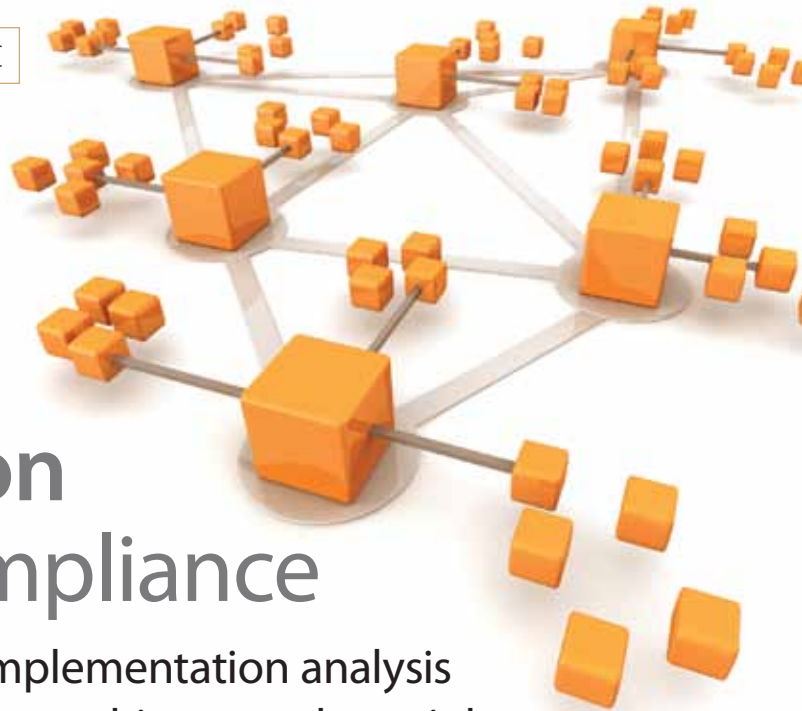
The Physician Group Practice (PGP) Demonstration—a five-year project with 10 physician group practices that helped define the Accountable Care Organization (ACO) model—is a success, the Centers for Medicare & Medicaid Services (CMS) says.

"After five years, this demonstration has shown positive results, including significant progress in areas of both quality improvement and savings in Medicare expenditures," CMS said in a press release.

The ACO model provides incentives to health care providers to treat patients across health care settings, including doctors' offices, facilities, and long-term care settings. The Medicare Shared Savings Program rewards ACOs that lower growth in health care costs while meeting performance standards on quality of care and "putting patients first," CMS maintains.

Continued on page 28

By Phoebe Moore, CPC, CPC-H, CHC



Use **EHR** Implementation to Improve Compliance

Taking full advantage of pre-implementation analysis provides an opportunity to ensure things are done right.

Electronic health records (EHRs) provide an opportunity for practices to establish or improve internal compliance standards and more effectively monitor and enforce them. To reap these rewards, however, you'll need to keep in mind these key issues before, during, and after the implementation process.

Scope of Duties

It's not uncommon for staff to act outside the scope of their licensure. For example, you might be surprised to find out exactly who is selecting diagnosis codes, writing orders, entering lab findings, or making billing decisions. EHRs can help to reduce these types of compliance risks by setting parameters on user access to the system and ensuring access rights are appropriately set for each individual.

Consider a physician office where a longtime front office employee has gradually assumed the responsibility of selecting the level of physician evaluation and management (E/M) services, or assigning diagnosis codes on a pre-printed charge ticket. Clearly, the provider should be selecting the codes because only he or she can determine the patient diagnosis and the amount of work performed at the encounter. The EHR can be set up to prevent improper access to restricted billing screens by anyone other than the provider who performed the service. The EHR becomes an effective tool for enforcing compliant behaviors when accompanied by education on ethics, the appropriate use of passwords, and consequences for non-compliance.

Order Entry

An EHR can also help establish gold standards for entering lab findings or writing orders. In a paper record, auditors search for orders to support the medical necessity for a particular test. Without the written order, payments may be denied. If initial operational assessments during the EHR implementation reveal that medical assistants or nursing staff are performing these tasks without a written order, this is an opportunity to imbed compliant protocols within the practice. In the EHR, only the appropriate person will have access to the physician order screen. This will trigger the printer to create the lab slips, prescriptions, patient labels, or assign the task to the appropriate nurse, medical assistant, or staff person.

Adopt Complete, Standard Forms

The EHR transition also allows you to standardize forms and ensure that all necessary prompts are included. This is a specialty-specific and time-intensive exercise because providers deliver services in unique and individual ways. You may have to customize templates, while being sure to include specific language to confirm clinical findings, attest to physical presence, or support documentation requirements. If templated statements are not compliant, the error is repeated again and again.

Accurate language can make the difference between payment and denial. For example, physicians in teaching hospitals are aware that, for billing purposes, the teaching

physician must personally attest to his or her physical presence at the patient encounter. When a resident participates in providing the service and documents the progress note, the teaching physician will typically document an attestation statement such as, “I personally examined the patient, discussed the case with the resident, and agree with the findings as documented above.” A statement such as, “I discussed the case with the resident and agree with the findings as documented,” would not suffice because it would not establish the face-to-face physical presence of the physician with the patient during the encounter. Medicare contractors will deny payment for such documentation.

As a second example, consider the Centers for Medicare & Medicaid Services’ (CMS) guidance requiring specific language to support time-based E/M codes. Physicians must clearly state both the total time of the patient visit and the amount of time spent in counseling or coordination of care. With the EHR, a compliant, templated statement, such as, “I spent more than half of this (45) minute visit with Mrs. Jones discussing (fill in the blank),” can be put in place during implementation. This will prevent the physician from documenting a statement such as, “I spent 45 minutes with Mrs. Jones.” This documentation is perhaps an attempt to meet the time-based requirement, but it would not support a specific level of E/M service. If the template language is correct, the physician will get it right every time.

Hold and Review Your Initial Claims

It is common for physicians to under-document services until they become accustomed to the EHR. Often, physicians select a code that may reflect the service provided, but which might not be supported by documentation. Conversely, procedures may be documented without a corresponding CPT® code. I have also begun to witness the results of “cut-and-paste” and “pull forward” documentation, unsupported services, incorrect time stamps, missing credentials, incomplete documentation, and password misuse.

For all of the above reasons, and more, I recommend that, after “go-live,” qualified auditors hold all charges in a pre-billing queue pending documentation review. An immediate review will quickly identify individuals requiring additional support, and will ensure that unsupported claims are not submitted. This is an opportunity to provide relevant, one-on-one compliance education that can be integrated into the institution’s annual compliance plan.

Providers should receive immediate feedback, and documentation reviews can be concluded after accuracy thresholds are reached. This is also an opportunity for the providers to explain their concerns and challenges, and to suggest improvements to the EHR.

Call on Compliance Experts to Ease the Transition

A supportive, proactive, hands-on compliance presence throughout the implementation process can help to reduce risk and encourage a culture of compliance. A dedicated compliance specialist should attend EHR planning sessions and be part of the vendor selection process. This person also should be available to research questions, participate in education sessions, and provide support for the clinicians, staff, and implementation team. This individual must possess a broad understanding of compliance rules and regulations, scope of practice requirements, medical record documentation requirements, billing and coding rules, and privacy and security protocols.

During the go-live phase of EHR implementation, technical staff is typically on site to support users. They may assist with locating the correct screens and templates, resolving issues, and performing system troubleshooting. Their focus and expertise does not include compliance, however. With dedicated compliance oversight, you can quickly identify template deficiencies, interface issues, user errors, and a variety of system glitches that may go unnoticed by others.

After the EHR is fully implemented in a clinical area, compliance specialists can assist with the transition back to the ongoing compliance plan, standard documentation review processes, and education initiatives. It’s helpful to develop an EHR on-boarding education and audit plan for new providers who join the practice. It’s also very important to follow through with requested IT changes. Adjustments to the implemented EHR can take weeks, and may require additional discussions, compliance research, education, and user training.

EHR implementation is expensive and often takes months or years to complete the rollout. Understandably, institutions are looking for ways to economize; but it is in an institution’s best interest to include compliance professionals to take full advantage of the very thorough pre-implementation analysis. This is a unique opportunity to ensure compliance in the redesign of the many areas of the medical practice that EHRs will touch. MPD



Phoebe Moore, CPC, CPC-H, CHC, senior consulting manager, IMA Consulting, has over 18 years of progressive consulting experience in billing, coding, and documentation of physician and hospital services. In her most recent role, she provided compliance and issues resolution related to Epic EHR implementation for a large academic medical center, with a focus on professional fee documentation and compliance. Phoebe is experienced in CDI, physician education, and auditing of professional fee services for all specialties.



By G.J. Verhovshek, MA, CPC

Get Comprehensive Information on **PCMHs**

Know how patient-centered medical homes fit into your health care delivery model.

As patient-centered medical homes (PCMHs) have garnered greater attention, many providers are seeking specifics about this health care delivery model. What effects might they have on the health care landscape? Have medical homes been effective at cutting costs and improving outcomes? What about credentialing?

What Are PCMHs?

The PCMH is not a facility, but an idealized, metaphorical “home” where the patient feels welcome, secure, and looked-after. Under this model, a personal physician directs all care for an individual patient. This physician leads a team of specialists and providers, who collectively assume responsibility for the patient’s health across all care settings. The goal is comprehensive, coordinated, and highly personalized care. Advocates promise improved patient access and health outcomes, greater satisfaction for providers, and lower overall health costs.

The idea of the PCMH arose in the late 1960s, and initially found support among pediatricians and general practitioners. In recent years, the PCMH model has experienced a renaissance. In March 2007, the American Academy of Family Physicians (AAFP), American Academy of Pediatrics (AAP), American College of Physicians (ACP), and American Osteopathic Association (AOA) came together to create the “Joint Principles of the Patient-Centered Medical Home.” Since then, 19 other physician organizations, including the American Medical Association (AMA), have endorsed the PCMH concept.

Just Another HMO?

Critics—citing the largely unfavorable patient response to health maintenance organizations (HMOs)—have painted medical homes as just another “gatekeeper model,” designed to keep patients from getting the care they need. Several organizations, including the American College of Emergency Physicians (ACEP), American Optometric Association (AOA), and American Psychological Association (APA), have expressed concern that specialists could be marginalized under the medical home model.

Dr. Sam Romeo, a family doctor of 40 years and long-time PCMH advocate, disagrees. “The personal physician is a gatekeeper of sorts, sure. But we’re not there as a barrier to care,” he says. “The patient is at the center of all decisions. We’re there to ensure that the proper care is delivered at the proper time.”

Whatever the arguments for or against a gatekeeper, providers within a medical home will have to become more comfortable with shared decision-making, and demand for primary care physicians will likely increase. Romeo believes we are already experiencing a shortage of primary care. “We’re going to see a reversal in the trend toward specialization, and a rejuvenation of family medicine,” he says.

Do Medical Homes Deliver?

The popular appeal of the PCMH stems from the prospect of improved care at lower costs. Proponents say that enhanced patient access and a systematic approach to lifetime wellness drive both results.

“We spend nine months preparing a child for life, but we fail to provide even nine minutes to prepare those at the end of life. The majority of health expenditures occur during the final six weeks of life. It makes no sense.”

“For too long our health care system has focused too exclusively on treatment,” Romeo says. “Care is given only when disease or sickness is already present. The medical home model favors prevention and regular contact. It rewards me for keeping people healthy. That’s what I got into medicine to do.”

This “whole patient orientation” not only boosts patients’ perceptions of care, it is efficient and cost-effective, Romeo says. For instance, if the patient’s first point of contact is the family physician, many costly emergency department (ED) visits could be eliminated, as could many unnecessary or repetitive tests. “The point is to keep patients healthy and out of the hospital in the first place.”

Romeo believes that end-of-life planning can also help to allocate health care resources more efficiently. “We spend nine months preparing a child for life, but we fail to provide even nine minutes to prepare those at the end of life. The majority of health expenditures occur during the final six weeks of life. It makes no sense.”

Studies have suggested a positive correlation between medical home models and cost savings, and reviews of pilot programs have also been positive. For example, in 2006, Group Health piloted a PCMH redesign at a Seattle-area clinic. Group Health decreased the number of patients each primary care doctor was responsible for, and invested \$16 more per patient, per year to staff the medical home pilot clinic. According to a 2010 analysis by Health Affairs and the Robert Wood Johnson Foundation, Group Health generated a return of \$1.50 for every \$1 invested in the medical home demonstration.

Similarly, Pennsylvania-based Geisinger Health System began implementing a PCMH model in 2005. The system offers physicians \$1,800 monthly payments and stipends of \$5,000 per 1,000 Medicare patients to pay for additional staff. Despite these expenditures, data as of late 2010 suggests that the PCMH model has produced a 7 percent savings in total medical costs. Romeo says that, in his experience, organizations committing to the PCMH model and a “patient invested way” can show up to a 30 percent reduction in costs.

A crucial requirement to the success of a medical home—and a potential “wild card”—is patient involvement. Optimal cost savings will depend on a patient population that takes an active part in health maintenance, and that is willing to follow physician directives and make healthy life-

style choices. The hope is that earlier, more often, patient/physician interaction and education will facilitate positive patient behaviors.

An additional concern is that hospitals do not have a clearly defined role within medical homes; however, an American Hospital Association (AHA) Synthesis Report, issued in September 2010, concluded with the statement, “Many analysts believe that hospitals will begin a migration to embrace the PCMH model in coming years as a natural extension of clinical IT investments and increasing care coordination.” To view the AHA’s report, “Patient Centered Medical Home,” go to: www.hret.org/patientcentered/patient-centered.shtml.

Does Accreditation Provide Value?

Providers considering a PCMH may also be pondering the value of certification. Is it worth the effort?

“Absolutely, yes,” says Romeo, who is also chair of a task force that created the Accreditation Association for Ambulatory Health Care (AAAHC) 2011 Medical Home Standards, which is one of four PCMH accreditation programs now available. In Romeo’s opinion, the value of accreditation is that it provides the structure around which to build a quality, patient-centered organization. “Our accreditation handbook lays the groundwork for success with continuous improvement. It shows you how to audit your own processes; to be sure you are taking care of the basics in the best possible way.”

As a secondary benefit, Romeo believes accreditation will help medical homes attract and retain the primary care physicians whom he expects will be in such demand in future years.

Provider organizations have overwhelmingly favored accreditation. To assess whether a given practice is delivering care based on the PCMH model, the AAFP, AAP, ACP, and AOA—who have long supported “the need for robust recognition and/or accreditation programs”—in February 2011 jointly offered the “Guidelines for Patient-Centered Medical Home Recognition and Accreditation Programs.” (For more information, see the accompanying article, “Where Do I Find PCMH Credentialing Programs?”)

In addition to the AAAHC 2011 Medical Home Standards already mentioned, accreditation programs now include The Joint Commission: Primary Care Medical Home 2011 Standards and Elements of Performance, URAC: Patient-Centered Health Care Home (PCHCH) Practice: Standards 2011, and The National Committee for Quality Assurance (NCQA): Standards for PCMH 2011.

Where Do I Find PCMH Credentialing Programs?

You can find PCMH credentialing program information online at:

1. **The Joint Commission:** “Approved Standards & EPs for The Joint Commission Primary Care Medical Home Option” (www.jointcommission.org/assets/1/18/Primary_Care_Home_Posting_Report_20110519.pdf)
2. **URAC:** Patient-Centered Health Care Home (PCHCH) Practice Assessment Standards 2011 (www.urac.org/healthcare/prog_accred_pchch_toolkit.aspx)
3. **The Accreditation Association for Ambulatory Health Care (AAAHC):** 2011 Medical Home Standards (<https://application.aaahc.org/MedicalHome.aspx>)
4. **NCQA:** PCMH 2011 Standards and Guidelines (www.ncqa.org/tabid/629/Default.aspx#pcmh)

Medical Group Management Association (MGMA) has outlined how the four available credentialing programs compare to each other (including cost estimates) and to the “Guidelines for Patient-Centered Medical Home Recognition and Accreditation Programs.” “The Patient Centered Medical Home Guidelines: A Tool to Compare National Programs” can be found at: www.mgma.com/Store/ProductDetails.aspx?id=1366580.

Accreditation may include physician/staff surveys and on-site visits or assessments, among other requirements. Several programs offer more than one type of accreditation. For example, the NCQA offers three levels of recognition, while URAC offers either “Practice Achievement” or “Practice Achievement with Electronic Health Records” designations.

Accreditation programs differ in their particulars, but all four stress patient-centered care as their cornerstone. “Chapter 1 of our accreditation handbook is ‘The Rights of Patients,’” Romeo notes. URAC, NCGA, and the Joint Commission profess similar commitments, and like the AAAHC suggest that accreditation guidelines are meant to be descriptive, rather than proscriptive. That is, the guidelines are meant to demonstrate best practices, rather than to create narrow requirements without regard to “real world” considerations. For instance, although electronic health records (EHRs) and quality reporting are recognized as valuable tools that support evidence of continuous, comprehensive care, they are not the centerpieces of accreditation.

Romeo estimates that he has done 50 to 60 site visits on behalf of the AAAHC in the past year. Of those, approximately one-third were considering becoming a medical home, a dozen have gone through the process to become fully certified as a medical home, and the rest are actively pursuing certification.

Take Away Points

The PCMH is an up-and-coming health care delivery method with demonstrated potential to deliver cost savings and improved patient health.

Under this model, primary care physicians will be in greater demand and play a larger role in

coordinating patient care. Medical homes stress shared decision-making—with patients and among providers—and a greater emphasis on preventive care. Patient involvement and compliance are integral to success of the model. For those who wish to form a PCMH, there are a variety of credentialing options that provide valuable resources and instruction to allow you to observe the protocols and enjoy the potential benefits of the medical home model. ^{MPD}

PCMH Recognition and Accreditation Programs

The “Guidelines for Patient-Centered Medical Home Recognition and Accreditation Programs,” a concerted effort of the American Academy of Family Physicians (AAFP), American Academy of Pediatrics (AAP), American College of Physicians (ACP), and American Osteopathic Association (AOA), outlines 13 points that a PCMH should achieve to earn recognition or accreditation:

1. Incorporate the joint principles of the Patient-Centered Medical Home (www.medicalhomeinfo.org/downloads/pdfs/jointstatement.pdf). These include:
 - **A personal physician in a physician-directed, team-based medical practice**
 - **Whole person orientation**
 - **Coordinated and/or integrated care**
 - **Quality and safety**
 - **Enhanced access**
 - **Payment that appropriately recognizes the added value provided to patients who have a PCMH**
2. Address the complete scope of primary care services.
3. Ensure the incorporation of patient and family-centered care emphasizing engagement of patients, their families, and their caregivers.
4. Engage multiple stakeholders in the development and implementation of the program.
5. Align standards, elements, characteristics, and/or measures with meaningful use requirements.
6. Identify essential standards, elements, and characteristics: these should include, but not be limited to.
 - **Advanced access principles (e.g., same day appointments, extended hours, group and e-visits, and patient portals)**
7. Address the core concept of continuous improvement that is central to the PCMH model.
 - **Comprehensive practice-based Services (e.g., acute and chronic care, prevention screening and ancillary therapeutic, support, or diagnostic service)**
 - **Effective care management (e.g., demonstrated capacity to execute population management)**
 - **Care coordination (e.g., between providers and other practices, subspecialty care, hospitals, home health agencies, nursing homes, and/or community-based care resources)**
 - **Practice-based team care**
 - **Guarantees of quality and safety (e.g., incorporation of evidence-based best practices, clinical outcomes analysis, regulatory compliance, risk management, and medication management)**
8. Allow for innovative ideas.
9. Care coordination within the medical neighborhood.
10. Clearly identify PCMH recognition or accreditation requirements for training programs.
11. Ensure transparency in program structure and scoring.
12. Apply reasonable documentation/data collection requirements.
13. Conduct evaluations of the program’s effectiveness and implement improvements over time.

For complete information on each of the above points, visit the ACP website: www.acponline.org/running_practice/pcmh/understanding/guidelines_pcmh.pdf.

G.J. Verhovshek, MA, CPC, is managing editor at AAPC-PS.



Word on the Street

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By Dr. David Edward Marcinko, MBA, CMP, and
Hope Rachel Hetico, RN, MHA, CMP

Understand the Art of Selling Your Practice

Part Two of Medical Practice Valuation

Last month, we discussed how to establish fair market value (FMV) for a medical practice in the article, “Establish Your Practice’s Fair Market Value.” This month, we’ll review important terms and conditions for the sale transaction.

Valuation Types

Unfortunately, as a general rule, medical practice worth is presently deteriorating. A good medical practice is no longer a good business necessarily, and selling doctors can no longer automatically expect to extract a premium sale price. Nevertheless, appraising your medical practice on a periodic basis can play a key role in obtaining maximum value for it.

Competent practice valuation specialists typically charge a retainer to cover out-of-pocket expenses. Fees should not be based on a percentage of practice value, and a valuation may take 30-45 days to complete. Flat fees should be the norm because a sliding scale or percentage fee may be biased toward over-valuation in a declining marketplace. Fees range from \$7,500-\$50,000 for the small to large medical practice or clinic.

Expect to pay a retainer and sign a formal, professional engagement letter. Seek an unbiased and independent viewpoint. Buyer and sellers should each have their own independent appraisal done, using similar statistics, accounting measures, and economic assumptions.

At the Institute of Medical Business Advisors, Inc. (www.MedicalBusinessAdvisors.com) we use three engagement levels that vary in intensity, purpose, and cost:

1. **A comprehensive valuation** provides an unambiguous value range. It is supported by most all procedures that valuers deem relevant, with mandatory onsite review. This gold standard is suitable for contentious situations. A written “opinion of value” is applicable for litigation support activities like depositions and trial. It is also useful for external reporting to bankers, investors, the public, Internal Revenue Service (IRS), etc.
2. **A limited valuation** lacks additional suggested Uniform Standards of Professional Appraisal Practice (USPAP) procedures. It is considered to be an “agreed upon engagement,” when the client is the only user. For example, it may be used when updating a buy/sell agreement, or when putting together a practice buy-in for a valued associate. This limited valuation would not be for external purposes, so no onsite visit is necessary and a formal opinion of value is not rendered.
3. **An ad-hoc valuation** is a low level engagement that provides a gross non-specific approximation of value based on limited parameters or concerns involved parties. Nei-

ther a written report nor an opinion of value is rendered. It is often used periodically as an internal organic growth/decline gauge.

Structure Sale Transactions

When the practice price has been determined and agreed on, the actual sales deal can be structured in a couple of ways:

(1) Stock Purchase vs. Asset Purchase

In an asset transaction, the buyer will receive a tax amortization benefit associated with the intangible value of the business. This tax amortization represents a non-cash expense benefiting the buyer. In this case, the present value of those future tax benefits is added to the business enterprise value.

(2) Corporate Transactions

Typical private deals in the past involved some multiple (ratio) of earning before income taxes (EBIT)—usually a combination of cash, restricted stock, notes receivable, and possibly assumption of liabilities. For some physician hospital organizations, and public deals, the receipt of common stock can increase the practice price by as much as 40-50 percent (to accept the corresponding business risk, in lieu of cash).

Complete the Deal

The deal structure will vary depending on whether the likely buyer is a private practitioner, health system, or a corporate partner. Some key issues

... sellers who will take less money up front can command a higher than average price for their practice, while sellers who want more down usually receive less in the end.

to consider in the “art of the deal” include:

- **Working capital (in or out?):** Including working capital in the transaction will increase the sale price.
- **Stock vs. asset transaction:** Structuring the deal as an asset purchase will increase practice value due to the tax amortization benefits received by the buyer for intangible assets of the practice.
- **Common stock premium:** The total sale price can be significantly higher than a cash equivalent price for accepting the risk and relative illiquidity of common stock as part of the payment.
- **Physician compensation:** If your goal is to maximize practice value, take home a lower salary to increase practice sale price. The reverse is also true.

Private Deal Structure

Assuming a practice sale is a private transaction, deal negotiations are based on the following pricing methodologies:

Seller financing: Many transactions involve an earn-out arrangement where the buyer puts money down and pays the balance under a formula based on future revenues, or gives the seller a promissory note under similar terms. Seller financing decreases a buyer’s risks (the longer the terms, the lower the risk). Longer terms demand premiums, while shorter terms demand discounts. Premiums that buyers pay for a typical seller-financed practice are usually more than what you would expect from a simple time value of

money calculation, as a result of buyer risk reduction from paying over time, rather than up front with a bank loan or all cash. Remember to obtain a life insurance policy on the buyer.

Down payment: The greater the down payment for acquisition of a medical practice, the greater the risk is to the buyer. Consequently, sellers who will take less money up front can command a higher than average price for their practice, while sellers who want more down usually receive less in the end.

Taxation: Tax consequences can have a major impact on the price of a medical practice. For instance, a seller who obtains the majority of the sales price as capital gains can often afford to sell for a much lower price and still pocket as much or more than if the sales price were paid as ordinary income. Value attributed to the seller’s patient list, medical records, name brand, good will, and files qualifies for capital gains treatment. Value paid for the selling doctor’s continuing assistance after the sale and value attributed to a non-compete agreement are taxed at ordinary income. A buyer willing to allocate more for items with capital gains treatment, or a seller willing to take more in ordinary income, can frequently negotiate a better price. This is the essence of economically prudent practice transition planning.

Common Buyer Blunders

Here are 10 blunders to avoid as a buyer:

1. Believing the selling doctor’s attestations. Always verify data through an independent appraisal.

2. Wanting to change the culture of the practice. Be careful: Patients may not adjust quickly to change.
3. Using all available cash without keeping a reserve for potential contingencies.
4. Creating a conflict with the seller by recognizing a weakness and continually focusing on it for a bargain price.
5. Failing to realize that managed care plan contracts can be lost quickly or may not be always transferable.
6. Suffering from analysis paralysis. Money cannot be made by continually checking out a medical practice, only by actually running one.
7. Not appreciating the uniqueness of each practice, and using inaccurate “rules of thumb” from the golden age of medicine.
8. Not realizing that practice worth and goodwill value have plummeted lately and continue to decline in most parts of the country.
9. Not understanding that practice brokers may play both sides of the buy/sell equation for profit. Brokers usually are not obligated to disclose conflicts of interest, are not fiduciaries, and do not provide testimony as a court-approved expert witness.
10. Not hiring an appraisal professional who will testify in court, if need be, using the IRS-approved USPAP methods of valuation. Always assume that the appraisal will be contested (many times, it is).

After pricing and contracting due diligence has been performed, the next step in the medical practice sale process—as Donald Trump might say—is just good, old-fashioned negotiation. **MPD**

Additional Reading:

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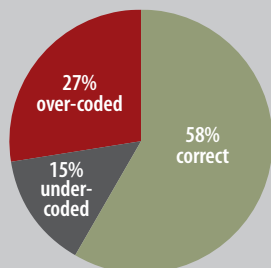
and member of the American Society of Health Economists and the Healthcare Information and Management Systems Society. Dr. Marcinko is also editor of the institutional journal *Healthcare Financials*: (www.HealthcareFinancials.com). He is available to colleagues and the media at the Atlanta Office of iMBA, Inc. (770-448-0769 or MarcinkoAdvisors@msn.com).



Hope R. Hetico, RN, MHA, CMP, received a nursing degree from Valparaiso University and a master's degree in Health Administration from St. Frances University in Joliet, Ill. She specializes in identifying business innovations and accelerating their adoption by the medical community. Ms. Hetico is also managing editor of the textbook *Business of Medical Planner* (www.BusinessofMedicalPractice.com). As a certified medical planner, she is responsible for leading the platform to the top of the B2B educational marketplace, while continuing to nurture a rapidly expanding list of clients. She is on private assignment for Resurrection Healthcare in Chicago.

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By Stacy Harper, JD, MHSA, CPC

HIPAA: Your Practice Is Accountable for Access

New regulations divide patients' rights into accounting of disclosures and access reports.

Recently proposed changes to the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule place additional emphasis on HIPAA compliance and the capability of systems containing electronic protected health information (ePHI). Specifically, the Department of Health & Human Services (HHS) Office of Civil Rights (OCR) is proposing changes to the accounting of disclosures, as required by the Health Information Technology for Economic and Clinical Health (HITECH) Act. The HIPAA Security Rule already requires covered entities (practices) to track all disclosures (subject to certain exceptions) during the previous six year period, but does not require entities to disclose this information to patients. New proposed Privacy Rule regulations would create two patient rights intended to enhance transparency in disclosures and to improve the overall process of disclosures.

1. Accounting of Disclosures

The first patient right under the proposed rule would modify the existing policy for accounting of disclosures. In place of the previous regulations that only listed exceptions to the accounting requirement, the new regulation will list the disclosures that must be included. The proposed categories are:

Included	Excluded
Impermissible disclosures that do not amount to a breach	Disclosures required by law
Public health activities (except for reporting child abuse)	For facility directory or to persons involved in the individual's care
Judicial and administrative proceedings	To the individual him or herself
Law enforcement activities	Pursuant to an authorization
To avert serious threat to health or safety	Incident-to a permitted disclosure
Military and veterans activities	For national security and intelligence
Department of State's medical suitability determinations	To correctional institutions
Government programs providing health benefits	In a limited data set
Workers' compensation	Prior to April 14, 2003

Upon patient request, the covered entity must provide the accounting of disclosures for the previous three-year period. The accounting must be provided within 30 days of the patient's request and must include the approximate disclosure date, name and address of the recipient, brief description of the PHI involved, and a brief description of the disclosure's purpose. The effective date of the new accounting requirement is 180 days from the final rule's effective date, which will be 240 days from the final rule's publication.

2. Access Report

The second patient right under the proposed rule involves the provision of an access report. Although the accounting of disclosures applies to all PHI (whether in paper or electronic form), the access report applies only to ePHI. This report must include all access to the requesting individual's PHI maintained in the covered entity's electronic designated record set during the previous three-year period.

Because this is an access report, it should include both access by the covered entity's work force, as well as access related to a disclosure. The access report should be compiled based on audit logs pulled from the various electronic systems containing PHI and must include:

- The date and time of the access
- Identity of the individual or entity accessing the record
- A description of the types of information accessed, if available
- A description of the action taken by the user, if available

The proposed rule applies this access report requirement to the entire electronic designated record set, including both electronic health records (EHRs) and electronic billing, scheduling, or practice management records. The compliance date for the audit report depends on the date in which the specific software system is implemented. Records systems implemented after Jan. 1, 2009 must be compliant by Jan. 1, 2013. Systems implemented before Jan. 1, 2009 must be compliant by Jan. 1, 2014.

Don't Forget Associates

Both the accounting of disclosures and the access report must be conducted by both the covered entity and its business associates. The proposed rule no longer allows covered entities to simply provide the individual with a list of business associates. The covered entity must instead integrate the disclosures and access of its business associates into the report or accounting that it provides to the requesting individual.

Update Notice of Privacy Practices

To comply with these new regulations, covered entities will need to update their Notice of Privacy Practices to inform patients of their rights. The revised documents must be implemented by the applicable compliance date. This change to the Notice of Privacy Practices is considered a material change that requires redistribution to all patients.

Covered Entities' Responsibility

Covered entities will need to implement policies and pro-

cedures related to the requesting and accounting provision of disclosures and access reports. Policies and procedures regarding disclosure tracking (included on the accounting) should already be in place, but may need to be revised to clarify the types of disclosures for inclusion or exclusion.

Perhaps most importantly, covered entities will need to contact software vendors to determine whether systems can provide the information required for the access reports. Although the compliance dates for these reports are in 2013 and 2014, the disclosures included in these reports could have occurred as early as Jan. 1, 2010.

Although the accounting of disclosures applies to all PHI (whether in paper or electronic form), the access report applies only to ePHI. Perhaps most importantly, covered entities need to contact software vendors to determine whether systems can provide the information required for the access reports.

Automation Makes Tracking Easier

Although this seems like a lot to accomplish, the OCR says it considered the burden to health care providers in preparing these proposed regulations. The current meaningful use requirements for EHR make tracking information for accounting of disclosures an optional feature. As a result, most EHRs—and certainly most practice management systems—lack this functionality, which makes the accounting of disclosures a manual process. By dividing patients' rights into accounting of disclosures and access reports, the new tracking of treatment, payment, and health care operations disclosures is restricted to the automated process of

access reports, rather than the burdensome accounting of disclosures. ^{MPD}



Stacy Harper, JD, MHSA, CPC, is a partner with Forbes Law Group, LLC. Her practice focuses on health care regulatory compliance and reimbursement. As a former medical practice manager, she has first-hand knowledge of the day-to-day challenges of medical practices. Stacy also offers her clients an in-depth understanding of the federal regulatory environment affecting health care.

Concierge Medicine: Personalized, Cost Effective Care



Concierge medicine, also known as boutique or private medicine, is growing beyond just a trend. Paid almost entirely by patients rather than health insurance companies, “concierge” physicians offer more personalized health care to reduced patient bases.

More and more consumers are seeking out this model, once thought to be an insignificant niche in health care delivery. Just five years ago, there were only a few hundred of these practices in the country, according to “Concierge Medicine ... Another Option for Frustrated Doctors” (*Tennessee Medicine*, November 2006, Vol. 99, No. 11). Today, the American Academy of Private Physicians (AAPPP) says that number is well over 1,000.

In the current health care environment, physicians feel as though they cannot deliver quality care based on the number of patients they see per day. To compensate, physicians and their staff must either spend less time with each patient or devote more of their day to patient visits—by coming in earlier, staying later, or shortening their lunch breaks. Despite the extra effort, practice revenues are stagnant, at best. As reimbursements shrink and the demands from insurers increase, physicians and staff—who are already over-extended—are feeling the pressure. Furthermore, smaller practices have limited resources to meet the requirements of health care reform, such as electronic health record (EHR) systems.

Some physicians are responding by joining forces with larger practices or hospital groups, merging with other practices, or even retiring. According to a 2010 study by the Association of American Medical Colleges (AAMC), between now and 2015 (after health care reforms), physician shortages are expected to increase across all specialties. Estimates indicate a shortage of 63,000 physicians by 2015. The downward trend is expected to continue with worsening shortages through 2025.

By Doug Graham and Karen Petrillo

In addition to the physician having the freedom to deliver the level of care he or she sees fit, the primary advantage of a classic concierge practice is reduced administrative costs by cutting out third-party payers.

The Return of Personalized Care

With shortages looming and the U.S. population aging, the need for timely access to quality health care will be greater than ever. As this reality filters to the consumer through the media and personal experience, patients interested in the peace of mind that comes with flexible scheduling, immediate access to their physician, and more personalized attention may drive an increased demand for concierge physicians. Baby boomers (those born during the demographic birth boom between 1946 and 1964) are projected to have enough disposable income to take advantage of this more tailored delivery of health care. Boomers will be the wealthiest group of elderly in history, *USA Today* reports. Although they make up only 20 percent of the population, baby boomers will control 40 percent of the nation's disposable income.

As the trends converge and the landscape of health care morphs, savvy physicians are developing models to meet the needs of their patients, deliver health care as they see fit for the patient, and create a more palatable lifestyle for themselves. Physicians who set out to design a concierge practice have creative license to design a practice that best suits their professional and personal goals, and should keep in mind the needs of their patient base and market demographics.

How Concierge Medicine Works

In the classic concierge medical practice, a physician accepts a monthly or annual fee in exchange for granting the patient special access. Services may include priority appointments (same day, in some cases), 24/7 access via email and cell phone, house calls, ample time with the physician during visits, and escort service to hospital emergency room visits. Depending on the services they deliver, concierge physicians charge up to \$10,000 a year, with most charging \$1,500 to \$2,000, according to the *New York Times*.

Some high-end concierge practices are all inclusive, while

others charge a modest annual fee with additional fees required for services and tests as they are rendered. It is common for a concierge physician to set a price schedule that offers several tiered options. For example, one option might include ample visits per year, along with various tests and maybe even a couple of visits for out-of-town guests (should the need arise). A different option, with a lower annual fee, might offer two visits per year, one round of standard blood work with additional visits, and tests available at pricing spelled out in the patient contract. The variations are endless, and it is up to the physician to decide the structure based on the needs of the patient base and vision for the concierge practice.

In the classic model, the physician does not accept any form of health insurance. In addition to the physician having the freedom to deliver the level of care he or she sees fit, the primary advantage of a classic concierge practice is reduced administrative costs by cutting out third-party payers. Patients participating in a concierge arrangement usually maintain medical insurance; to cover catastrophic events, hospital bills, lab services, specialist care, and other medical services that the practice cannot provide.

Hybrid Practices Are an Option

The "hybrid" concierge practice is an alternative that is becoming more popular. In this model, the physician accepts a limited number of patients from the current practice who choose to join the concierge option. Patients who do not want to participate in the concierge model continue to see their physician as they always have. The concierge patients get a direct line of communication with the physician. In these practices, doctors and staff juggle the task of managing two levels of patients, and still retain a large patient base.

Most physicians who embark on the path of private or concierge medicine don't look back. Dr. Charles Marable,

Most physicians who embark on the path of private or concierge medicine don't look back.

the first physician in Tennessee to convert to concierge medicine, said, "I can't imagine practicing in today's managed care environment; that system gets in the way of quality patient care. This decision has allowed me to focus more time on my patients, caring for them as I was trained to, without sacrificing my personal health and family."

Practicing concierge medicine is not for every physician. Physicians must be willing to be available to patients 24/7. And, the physician must do it for the right reasons. Converting to a concierge practice purely to rebel against a system that is no longer tolerable probably is not the best motive.

How to Get Started

After the decision has been made, converting to a concierge practice requires considerable planning and execution because there are countless ways a practice can be structured. Even those simply pondering the possibilities of concierge medicine will find the following tips helpful:

- 1. Survey your current patients.** It is imperative to look carefully at your patient base, get to know the demographics, run statistics on the average number of visits per year, and even break down the numbers based on age ranges. This will help determine a fee schedule that is fair to both you and your overall patient base.
- 2. Make a timetable.** There are many steps involved in a practice conversion. A timetable will help identify each step and determine and maintain a realistic target conversion date.
- 3. Address legal issues.** It is paramount that a competent health care attorney be identified. Although there are several online resources for attorneys (such as lawyers.com and findlaw.com), it is crucial to ask if the firm has experience structuring a retainer-style medical practice.
- 4. Notify third-party payers.** In some cases, insurance companies will not contract with physicians that charge a retainer. Others are perfectly fine with reimbursing physicians for covered services, with the understanding that they will not reimburse the patient's retainer. It is best to identify these issues early in the process.
- 5. Determine the pricing model.** Will the practice be a classic concierge model, or a hybrid practice that continues

to accept and file insurance claims for some patients? The existing patient base will tell a great deal about what type and how many pricing options should be offered.

6. Create marketing materials. The tone and message of the marketing materials will depend somewhat on whether the practice will target the existing patient base or solicit new patients.

7. Communicate the transition to the existing patient base. Keep in mind that patients may not be familiar with concierge medicine. Carefully explain why the practice is making the transition, what this means to the patient, and what they need to do next. Offer assistance finding a new provider to those who elect not to participate. Most concierge physicians set a limit to the number of patients they will accept, and accept patients on a first-come, first-serve basis.

8. Schedule follow-up meetings. Some patients may require a detailed explanation. A great way to deliver this is to invite patients to a presentation about the transition at the practice or other convenient location. Offer individual meetings, as required.

9. Hire a consultant. Running a practice while converting to another can be arduous. A consultant can short-circuit many of the steps involved, and can pay attention to important details that may otherwise be overlooked.

The impact of health care reform and the aging baby boomer population remains to be seen. The growing number of concierge practices is testimony that concierge medicine will continue to find its place in the U.S. health care market. **MPD**



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Letter to the Editor



Correction to PQRS Incentive Percentage

There was an error in “Is Claims or Registry-based PQRS Reporting Right for You?” in July’s issue. On page 12, the article states:

“Eligible providers (EPs) who successfully participate in PQRS may receive a 1 percent incentive payment in 2011, with 0.05 percent available from 2012 to 2014,” and “An additional 0.05 percent incentive payment

is available from 2011 through 2014 for EPs who provide data on quality measures through a maintenance of certification program (MOCP) operated by a specialized body of the America Board of Medical Specialties (ABMS).”

The PQRS incentive for 2012-2014 is 0.5 percent of total allowable Medicare payments, not 0.05 percent. Likewise, the incentive for providing data through an MOCP is 0.5 percent, rather than 0.05 percent.



SEPTEMBER WEBINAR

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September 22, 2011 | 11 a.m. MST

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By Christopher A. Parrella, J.D., CHC, CPC, CPCO

Primer on the Anti-kickback Statute and Stark Law

Understanding government fraud and abuse laws is your best defense.

As the Obama administration further reinforces its federal and state health care fraud and abuse enforcement budgets, it is essential for practice managers to have a basic understanding of two of the biggest fraud and abuse tools within the government's arsenal: the anti-kickback statute (AKS) and the Stark law.

The Federal Anti-kickback Statute

The AKS (42 U.S.C. § 1320a-7b(b) (1-3)) prohibits the offer, solicitation, payment, or receipt of any remuneration, in cash or in kind, in return for, or to introduce, the referral of a patient for any service that is covered by a federal health care program (most notably, Medicare and Medicaid). Reward in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item reimbursed under a federal health care program is also prohibited.

Examples of potential kickback violations include:

- A physician who offers a patient recruiter \$100 per patient
- A manufacturer of medical

devices offering gifts and educational programs in exotic locales to physicians who prescribe its products

- A pharmacy that pays for a patient's groceries and cleaning service in return for the patient's continued loyalty

Whether the remuneration actually results in a referral is immaterial because it's sufficient that the reward may induce someone to refer or recommend. Under *Greber* (United States v. Greber, 760 F.2d 68, 71 (3rd Cir.), cert. denied, 474 U.S. 988 (1985)), it is also irrelevant if there are other legitimate reasons for the remuneration. If one purpose is to induce referrals, then the AKS may be violated.

The AKS contains exceptions protecting parties from criminal liability for conduct that would otherwise violate the statute. Similarly, the AKS permits the Department of Health & Human Services (HHS) secretary to promulgate "safe harbors," which identify referral arrangements that do not violate the AKS (see 42 CFR 1001.952). If the requirements of the Safe Harbor are strictly complied with, individuals and entities can insulate themselves from prosecution under the AKS for conduct that would otherwise violate the statute. There are 25 exceptions and nine safe harbors.

A violation of the AKS constitutes a felony criminal offense. Sanctions include imprisonment of up to five years, criminal fines of up to \$25,000,

civil money penalties of \$50,000 per act, and/or exclusion from all federal and/or state health care programs. Sanctions apply to all parties to the transaction—he who "offers/pays" and "solicits/receives."

The Patient Protection and Affordable Care Act (PPACA) is a federal statute that was signed into law on March 23, 2010. The statute, among its many provisions, clarifies the intent standard of the AKS by requiring there be a "knowing" and "willful" intent element to sustain a conviction. The law provides that a person need not have actual knowledge that the alleged activity violates the AKS itself, or that there be a specific intent to commit a violation of the AKS, so long as the defendant committed the act (knowingly) with the knowledge that such conduct was unlawful.

The PPACA also makes a violation of AKS a basis for a False Claims Act (FCA) violation.

Patient Referral Act Ethics

Stark law (42 U.S.C. § 1395nn), effective for referrals made after Dec. 31, 1994, states that if a physician (or an immediate family member of such physician) has a "financial relationship" with an entity, the physician may not make a referral to that entity for the furnishing of "designated health services" for which payment is sought under Medicare or Medicaid. Nor may the entity present a claim or bill to any individual, third-party payer, or other entity for designated health services. The following services/items are

defined as designated health services (enumerated by CPT® codes):

- Clinical laboratory services
- Physical therapy services, speech-language pathology services
- Occupational therapy services
- Radiology or other diagnostic services, including magnetic resonance imaging (MRI), computed tomography (CT) scans and ultrasound services
- Radiation therapy services and supplies
- Durable medical equipment and supplies
- Parenteral and enteral nutrients, equipment and supplies
- Prosthetics, orthotics, and prosthetic devices and supplies
- Home health services
- Outpatient prescription drugs
- Inpatient and outpatient hospital services
- Nuclear medicine services and supplies

All six elements of Stark must be present to implicate the statute. If all six elements are present, the referral will be protected only if an applicable exception applies. There are four general exceptions, two ownership/investment exceptions, and seven compensation exceptions.

Potential self-referral violations include:

- A physician refers all blood specimens to a clinical laboratory in which he has an ownership interest.
- A physician has a compensation arrangement (without a written agreement) with a diagnostic facility to which he or she refers radiation therapy patients.

In cases where the physician or a group practice has billed and collected for designated health services in violation of the Stark law, the physician or group is required to refund such amounts on

a timely basis. The Office of Inspector General (OIG) also may impose upon any person a civil penalty of up to \$15,000 for each improper service provided by the person who knew, or should have known, the service was rendered in violation of the Stark law; and up to \$100,000 for each scheme to circumvent the Stark law.

Any physician or entity entering into an arrangement or scheme in violation of the self-referral ban may also be subject to an assessment of not more than twice the amount claimed for each designated health service rendered in violation of the ban, and may also be excluded from participation in all state and federal health care programs.

Section 6409 of PPACA requires self-disclosure protocols to be developed by the Centers for Medicare & Medicaid Services (CMS). CMS' instructions must include the procedures for self-disclosures, the affect of self-disclosure on Corporate Integrity Agreements, and information regarding possible reductions in penalties for self-disclosure of Stark law violations.

Because there is an increased likelihood that an enforcement agency may request records or perform a site visit at your practice, your practice will benefit greatly if you can identify these potential issues in advance and bring such conduct into compliance with the law. ^{MPD}



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A violation of the AKS constitutes a felony criminal offense. Sanctions include imprisonment of up to five years, criminal fines of up to \$25,000, civil money penalties of \$50,000 per act, and/or exclusion from all federal and/or state health care programs.

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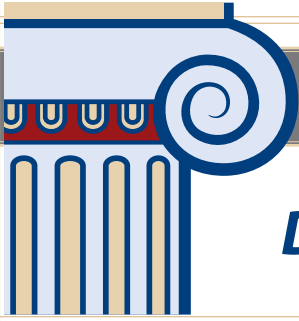
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Legal Forum

Do's and Don'ts when Collecting Debt

Question:

Both federal and state laws govern debt collection. Is there anything I should know regarding what collectors may say or do when dealing with patients with past-due balances?

Response:

The Fair Debt Collection Practices Act (15 U.S.C. § 1601) requires that debt collectors treat consumers fairly by prohibiting abusive, deceptive, and unfair practices in the course of collecting outstanding debt on behalf of others. Under the act, debt collector means any person who, through the use of any instrumentality of interstate commerce or the mail, engages in the collection of any debts owed or due to another.

This law may not apply to physician offices unless they hire a collection agency. Nevertheless, medical debt and the aggressive practices of health care providers regarding bad debt collection has been the focus of public scrutiny. If your medical practice currently uses or is considering using a collection agency, you should consider the following practices covered by the act when developing debt collection policies or deciding on which agency to use (see section 808 of the act):

- A. Harassment:** Debt collectors may not harass, oppress, or abuse a person in connection with the collection of a debt:
- Using threats of harm or violence against the person, their property, or reputation
 - Publishing a list of consumers who refuse to pay their debt (except to a credit bureau)

- Using obscene or profane language when communicating with a person regarding their debts
- Repeatedly using the telephone to annoy a person
- Calling persons without identifying themselves
- Advertising the person's debt for purposes of coercing payment

B. False Statements: Debt collectors are prohibited from using any false statements when collecting a debt. For example, debt collectors should not:

- Falsely imply that they are attorneys or government representatives
- Falsely imply that the person owing the debt has committed a crime
- Falsely represent that they operate or work for a credit bureau
- Misrepresent the amount of the debt
- Misrepresent the involvement of an attorney in collecting a debt
- Indicate that papers being sent to the person are legal forms when they are not
- Indicate that papers being sent to the person are not legal forms when they are
- Falsely imply that the person will be arrested for not paying the debt
- Falsely imply that the creditor will seize, garnish, attach, or sell a person's property or wages unless the creditor intends to do so, and it is legal to do so

Legal questions?
We've got answers.

- Falsely state that a lawsuit will be taken against the person which may not be taken, or which the creditor does not intend to take
- C. Other prohibited actions:** Debt collectors also are prohibited from engaging in the following activities:
- Providing false credit information about the person to anyone
 - Sending the person anything that looks like an official document from a court or government agency when it is not
 - Using a false name
- D. Unfair practices:** Debt collectors may not engage in unfair practices when they try to collect a debt. For example, debt collectors may not:
- Collect any amount greater than the debt, unless allowed by law
 - Deposit a post-dated check prematurely
 - Make the person accept collect calls or pay for telegrams
 - Take or threaten to take a person's property unless this can be done legally
 - Contact a person by postcard

Debt collectors may not harass, oppress, or abuse a person in connection with the collection of a debt.

My suggestion is that practices embrace these principles to set ground rules for the billing and collection staff. If the practice hires a third-party debt collector, they should make sure the collector does not engage in abusive practices as outlined above because this can damage the practice's reputation. [MPD](#)



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Have a Legal Question? Ask Our Experts.
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Medical Practice News

Continued from page 7

Seven of the 10 physician groups in the study achieved benchmark performance on all 32 performance measures. The remaining three achieved 30 of the performance measures. This is an increase since the first year of the demonstration, when only two physician groups achieved the benchmarks.

Under the PGP Transition Demonstration, physician groups must have lower growth in Medicare costs relative to a national benchmark to share in savings. The PGP Transition Demonstration design includes a retrospective assignment algorithm based on services provided by primary care providers—rather than all specialties, as was done under the initial PGP Demonstration. This methodology underscores the important role primary care providers play in coordinating care to achieve better quality and cost outcomes. Quality performance continues to be a key aspect of the demonstration's design; and the PGP Transition Demonstration includes new measures and areas of focus, including claims and chart-based measures, composite measures,

and patient experience measures.

See the PGP Transition Demonstration fact sheet for more information: www.cms.gov/DemoProjectsEvalRpts/downloads/PGP_Fact_Sheet.pdf.

MAC Demand Letters Replace RAC Demand Letters

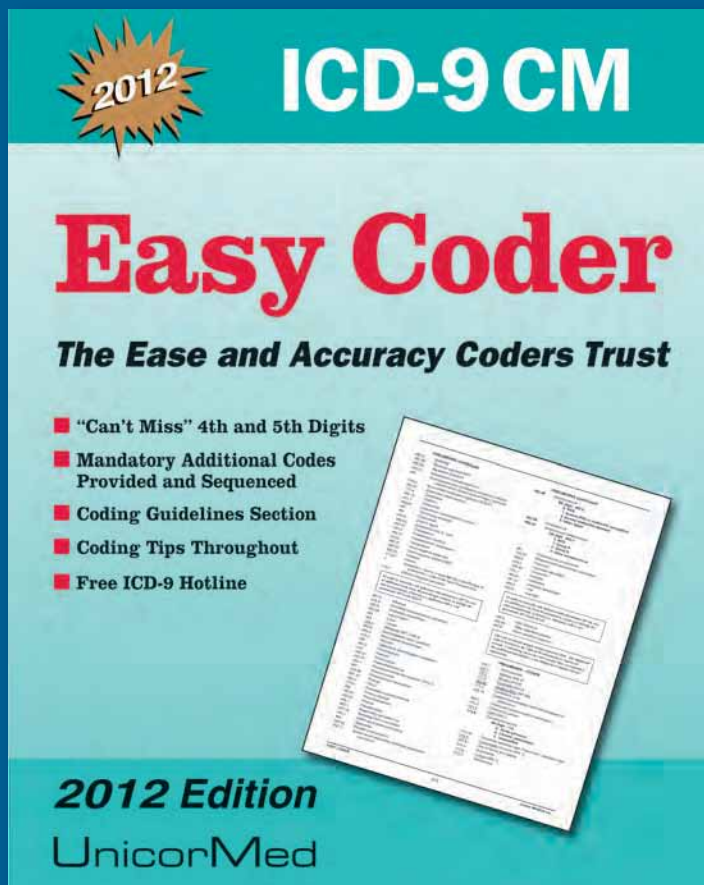
As of Jan. 3, 2012 you no longer have to worry about receiving demand letters from recovery audit contractors (RACs). Instead, if a RAC—now referred to simply as a “recovery auditor”—identifies an instance of improper payment, it will submit a claim adjustment to the appropriate Medicare administrative contractor (MAC). The MAC will then issue an automated demand letter for any overpayment, and will follow the same process as is used to recover any other overpayment. The decision to shift responsibility for issuing demand letters from RACs to MACs was made “to increase consistency and efficiency through automation,” according to the Centers for Medicare & Medicaid Services (CMS).

Your MAC also “will be responsible for fielding any administrative con-

cerns you may have, such as time frames for payment recovery and the appeals process,” per *MLN Matters* article 7436 (www.cms.gov/MLN MattersArticles/Downloads/MM7436.pdf). Although MACs will be responsible for issuing demand letters and collecting overpayment, if you wish to challenge the recovery auditor's findings, you must appeal to the recovery auditor. *MLN Matters* article 7436 states that the Medicare contractor will include the name of the initiating recovery auditor and his or her contact information in the related demand letter, and you “should contact that Recovery Auditor for any audit specific questions, such as their rationale for identifying the potential improper payment.”

The bottom line: Come 2012, MACs will automatically issue demand letters and recover alleged overpayments—even those based on unsubstantiated recovery auditor findings. If the recovery auditor makes a mistake, providers will have to work with the recovery auditor to clarify the problem, and then appeal to their MAC to have payments returned to them. [MPD](#)

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Will Your Documentation Be Ready for ICD-10?

Documentation dissection highlighting the increased specificity required to code for ICD-10-CM:

7th Character

Injury codes require a 7th character extender that identifies the encounter. Documentation must be clear so that the correct extender can be applied.

Applied Specificity: Concussion

For a concussion documentation needs to include if the patient suffered loss of consciousness.

Acute vs. Chronic

Documentation of the patient's condition must include acute or chronic to assign the most appropriate ICD-10 code.

S: Mrs. Finley presents today after having a new cabinet fall on her last week, suffering a concussion, as well as some cervicgia. She was cooking dinner at the home she shares with her husband. She did not seek treatment at that time. She states that the people that put in the cabinet in her kitchen missed the stud by about two inches. Her husband, who was home with her at the time, told her she was "out cold" for about two minutes. The patient continues to have cephalgias since it happened, primarily occipital, extending up into the bilateral occipital and parietal regions. The headaches come on suddenly, last for long periods of time, and occur every day. They are not relieved by Advil. She denies any vision changes, any taste changes, any smell changes. The patient has a marked amount of tenderness across the superior trapezius.

O: Her weight is 188 which is up 5 pounds from last time, blood pressure 144/82, pulse rate 70, respirations are 18. She has full strength in her upper extremities. DTRs in the biceps and triceps are adequate. Grip strength is adequate. Heart rate is regular and lungs are clear.

A: 1. Status post concussion with acute persistent headaches
2. Cervicgia
3. Dorsal somatic dysfunction

P: The plan at this time is to send her for physical therapy, three times a week for four weeks for cervical soft tissue muscle massage, as well as upper dorsal. We'll recheck her in one month, sooner if needed.

External Cause

The falling cabinet is what caused the injuries. Description of the cause is required.

Activity

In ICD-10 the activity of the patient needs to be documented. An activity code is only used once at the initial encounter.

Location

Documentation needs to include the location of the patient at the time of injury or other condition. In ICD-10 the details include the actual room of the house the patient was in when the injury occurred.

Relief or No Relief

Intractable vs. non-intractable are an inherent part of the ICD-10 code for headaches and documentation needs to be clear for the appropriate code to be assigned.

	ICD-10 Coding	
S06.0x1A	Concussion with loss of consciousness of 30 minutes or less	initial encounter
G44.311	Acute post traumatic headache	intractable
M54.2	Cervicgia	
M99.01	Segmental and somatic dysfunction of cervical region	
W20.8xxA	Struck by falling object (accidentally)	initial encounter
Y93.g3	Activity, cooking and baking	
Y92.010	Place of occurrence, house, single family, kitchen	

One of the largest problems following the October 1, 2013 implementation date for ICD-10 will be documentation insufficient to support the specificity required for the new ICD-10 code sets. We believe a behavioral change in documentation habits for most providers will be necessary—and now is the time to start preparing.



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