Part B News

COLLECT EVERY DOLLAR YOUR PRACTICE DESERVES

www.partbnews.com

April 11, 2016 | Vol. 30, Issue 15

IN THIS ISSUE

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

Practice management

Rehearse plans, plug leaks to prepare for press calls after an EHR hack

A recent hack at a health care chain shows how easy it is for news about your practice to spread — and the importance of a solid communications protocol to maintain some control over the coverage you get.

On March 29, news outlets started reporting that MedStar Health, a non-profit health system of clinics and hospitals in the Baltimore and Washington, D.C., area, had been hit with some sort of electronic health records (EHR) outage.

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

Coding

Heed size, local coverage policies to reduce denials for debridement coding

Pay close attention to the size of wound-related surgical procedures and get a handle on your local payer policies to cut debridement denials down to size.

Practices that perform debridement beyond the skin struggle to get their claims through, leaving millions of dollars on the table as an unfortunate side effect, according to the most recent Medicare claims data.

While the lost reimbursement is tough to swallow, the solution may be an easier pill to take. Your first step to improved

*(see **Debridement**, p. 7)*

Practice management

Change policies and culture to discourage providers, others from working while sick

Reduce the likelihood clinicians will spread pathogens to patients by setting clear policies on working while sick and establishing a culture that discourages the practice.

Health care providers are routinely exposed to and contract infections like influenza and norovirus. Such illnesses are unpleasant but nonthreatening for healthy people. However, they can be dangerous to immunocompromised patients.

A study published by the American Medical Association in *JAMA Pediatrics* last July reported that 83.1% of physicians who responded to a survey said they worked sick at least once in the previous year. While 95.3% of respondents reported they believed working while sick posed a risk to patients, 9.3% admitted they did so at least five times in the same time frame.

Attempting to persevere through an illness rather than calling out sick is a prevalent practice across the workforce. In health care, physicians say that mindset is particularly ingrained.

"I think it extends all the way back to training," says Dr. Kimberly Becher, a family physician who practices in Clay County, W.V. "In most medical schools, you can't miss more than two days on any rotation or you have to repeat it."

There also is a desire not to leave patients and fellow clinicians in the lurch. The *JAMA Pediatrics* study found that fear of letting down colleagues and patients, respectively, were the top two reasons for working while sick.

Culture must change

Additionally, nearly half of the study's respondents cited fear of ostracism as another reason. That speaks to a need to change organizational culture so that calling in sick is an accepted, even desired, action when circumstances justify it.

"People call it the culture of the hero," explains Kelley Boston, MPH, regulatory and accreditation director at Infection Prevention and Management Associates Inc., a Texas-based medical consultancy, and a member of the communications committee of the Association for Professionals in Infection Control and Epidemiology (APIC), a national professional organization.

"You always want to help … But leaders need to articulate that there are no social repercussions for calling in sick. You're staying home to protect patients. You can think about it in positive ways instead of negative ways. You're doing what you needed to do."

Managers from the front line to the C-suite must lead by example, calling in sick themselves when infections are present and offering respect to subordinates who do the same. Moreover, encouraging or even compelling sick employees to go home or stay home is an important managerial task.

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, 2016, 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. 502, Gaithersburg, MD 20878. ISSN 0893-8121. *pbncustomer@decisionhealth.com* Price: $597/year.

"Leading by example is huge," Becher asserts. "You can't tell everyone else to go home when you don't yourself … Call people out and make them go home."

Offering to help pick up the slack left by absent colleagues also can help, as can taking concerted personal responsibility for your own health.

"If I'm working and don't feel 100%, I'll have another doctor see patients that are especially immunocompromised," Becher says. "When others call out, I volunteer to help do their work for them. Step up for others and offer to help."

Get policies in line

Culture change can help, but putting the right policies in place may be the key to preventing this risky behavior.

"Staff need clear guidance," Boston asserts. "What do you do when you're sick? What is too sick to come to work? Is it a fever? Allergy attack? Vomiting? What are our rules?"

There is no definitive set of standards to determine whether a sick clinician is "safe" to come to work, although typical signs of symptoms of being particularly contagious — fever, diarrhea, vomiting — can be useful bellwethers.

The flu also is one of, if not the, most problematic of the common infectious diseases. As a result, APIC developed a position paper recommending influenza vaccination as a condition of employment for health care personnel, unless the vaccination is medically contraindicated.

"If you work in health care, you're going to get the flu," Boston says. "Get the flu vaccine."

How to rework your policies

Components of an effective policy to prevent clinicians from working sick, according to Boston and Becher, include:

- **Revisit the number of leave days allotted to employees**, particularly front-line providers, Boston says. There is no consensus on an appropriate number of days, but more leave days can directly reduce incidents of working sick and indirectly signal support for staying home when sickness calls for it.
- **Group vacation and sick leave days together** so employees have more flexibility in how they use the leave they've accrued.
- **Plan ahead.** For example, build cushions into staff margins or set up relationships with staffing agencies during seasons when flu or other illnesses are more prevalent.
- **Create an extra layer of physician backups.** "Have someone on call to be on call," Becher explains. "Which partner will be available for whom and when?"
- **Set up tools within an electronic health records system so that clinicians can easily communicate remotely with colleagues.** "Our EHR has real-time communication in the system, so there are ways to keep working without direct patient contact," Becher says.
- **Identify non-clinical tasks for clinicians willing or able to work off site while sick.** "You can get caught up on things like messages and refills at home," Becher says.
- **Apply policies across the board**. Environmental services staff, lab clinicians and customer service staff are an integral part of the health care team and come into contact with patients and with doctors, nurses and others who are providing more direct, hands-on care.

Bring policy and culture together by communicating expectations and options to employees before they get sick.

"Tell everyone, 'here's what happens when you're sick, and what we will do to take care of your colleagues and patients,'" Boston advises. — *Scott Harris (pbnfeedback@decisionhealth.com)*

Resources:

- APIC Position Paper: Influenza Vaccination Should Be Condition of Employment (PDF) *www.apic.org/Resource_/TinyMceFileManager/Advocacy-PDFs/APIC_Influenza_Immunization_of_HCP_12711.PDF*

Revenue audit findings

The Stark Reality: Unassigned codes, delayed Medicaid payments and more

The following revenue audit findings are the latest from Stark Medical Auditing and Consulting.

Audit No. 1: Unassigned codes affect annual bonus

Problem: A hospital-employed group has a clause in its contract that grants the group a bonus each year if the physicians meet a certain relative-value unit (RVU) threshold. However, the physicians were informed they narrowly missed the threshold in both 2014 and 2015 despite believing they had met their goal.

Process: As part of a contract with the group, Stark tracks the RVU threshold on a monthly basis. While examining data in the reporting from their third-party biller

back down to the CPT code level, we identified four codes that were not assigned an RVU in 2015 and therefore were not being counted toward the goal. The error was uncovered when the group's client manager reviewed a monthly report that showed zero work RVUs calculated for the codes in question. The manager verified that the codes have work RVUs by using Medicare's "Fee Lookup" tool.

After following up to ensure the missing codes were retroactively assigned with RVUs, we expect the group will meet its bonus threshold for 2015. The CPT detail for 2014 also is under review in case similar errors were made.

Recommendations:

- **Perform quarterly audits** to ensure the integrity of data reporting from your biller.
- **Consider a third-party auditor to verify results.** If a group relies on reporting from its biller to submit data for bonuses similar to this, it has only the biller's assurances that the data is correct. A third-party auditor can track this data regularly to discover reporting issues before they begin affecting your revenue.

Audit No. 2: Delayed start for state managed Medicaid causes payment gaps

Problem: A behavioral health provider in Iowa was not receiving Medicaid payments because of the delayed start of the state's managed care program.

Process: The transition from traditional Medicaid to a managed Medicaid product is causing headaches for many health care providers, as the Iowa provider undergoing this transition can attest. Although CMS planned to launch Iowa's managed care program in January after terminating the previous managed care organization's (MCO) Medicaid contract in December, multiple start-date delays from CMS have led to a months-long payment gap.

The Iowa provider is part of an association that's working aggressively to develop contracts with the new MCOs. However, the delay in the start date for the new MCOs created issues because the state program itself (Iowa Medicaid Enterprise) did not create a contingency plan. Because of that lack of foresight, IME is now handling all of the behavioral health care claims processing on an outdated technology platform with limited staffing. On top of that, IME has been providing different directions for claims filing for each provider, which has required the providers to restructure internal systems to get claims processed efficiently and out the door.

"It's been a huge issue and many providers are just now starting to see payments here in March," says Jessica Jankowski, executive client administrator for Stark. "However, several of their services still aren't being paid for various reasons that IME has yet to explain."

Recommendations:

- **Start preparing for change now** if you know an MCO is coming in. Most of the population in states following this route will have to choose a managed Medicaid product.
- **Learn how this transition could affect your payer mix, how the networks are structured and if you will need additional contracts**, among other important details.

Audit No. 3: Revenue lost in translation

Problem: A Midwest pathology group potentially lost $758,000 because of an unusual glitch in their third-party biller's system interface that caused a particular code to disappear on 4% of accessions when sent out for payment.

Process: The affected code was being transmitted properly for payment in the majority of cases, but the practice risked losing revenue because of timely filing denials.

Because the error was discovered on accessions being sent to two insurers, the problem was determined to be an IT issue on the billing agency's end. This audit uncovered hard proof from recent dates of service that the issue has yet to be resolved.

Recommendations:

- **Work with the billing agency's IT department.** Bring the hard proof to its attention.
- **Have the biller complete a 100% charge capture comparison** of the actual hard copy report to what they have on file to make sure that all of the charges are making it over from the file and getting billed.
- **Ensure IT puts a fix in place** when the source of the error is determined.

Stark Medical Auditing and Consulting (www.starkmedicalauditing.com) is a national auditing and management firm that provides revenue audits for private practices and hospital-owned physician practices as well as billing services. Contact Mick Raich at mraich@starkmedicalauditing.com or call us at 517-486-4262. Audit assistance is provided by Billie Morawski, audit

(continued on p. 6)

Benchmark of the week

Surgical debridement code denials improve — but they're still awful

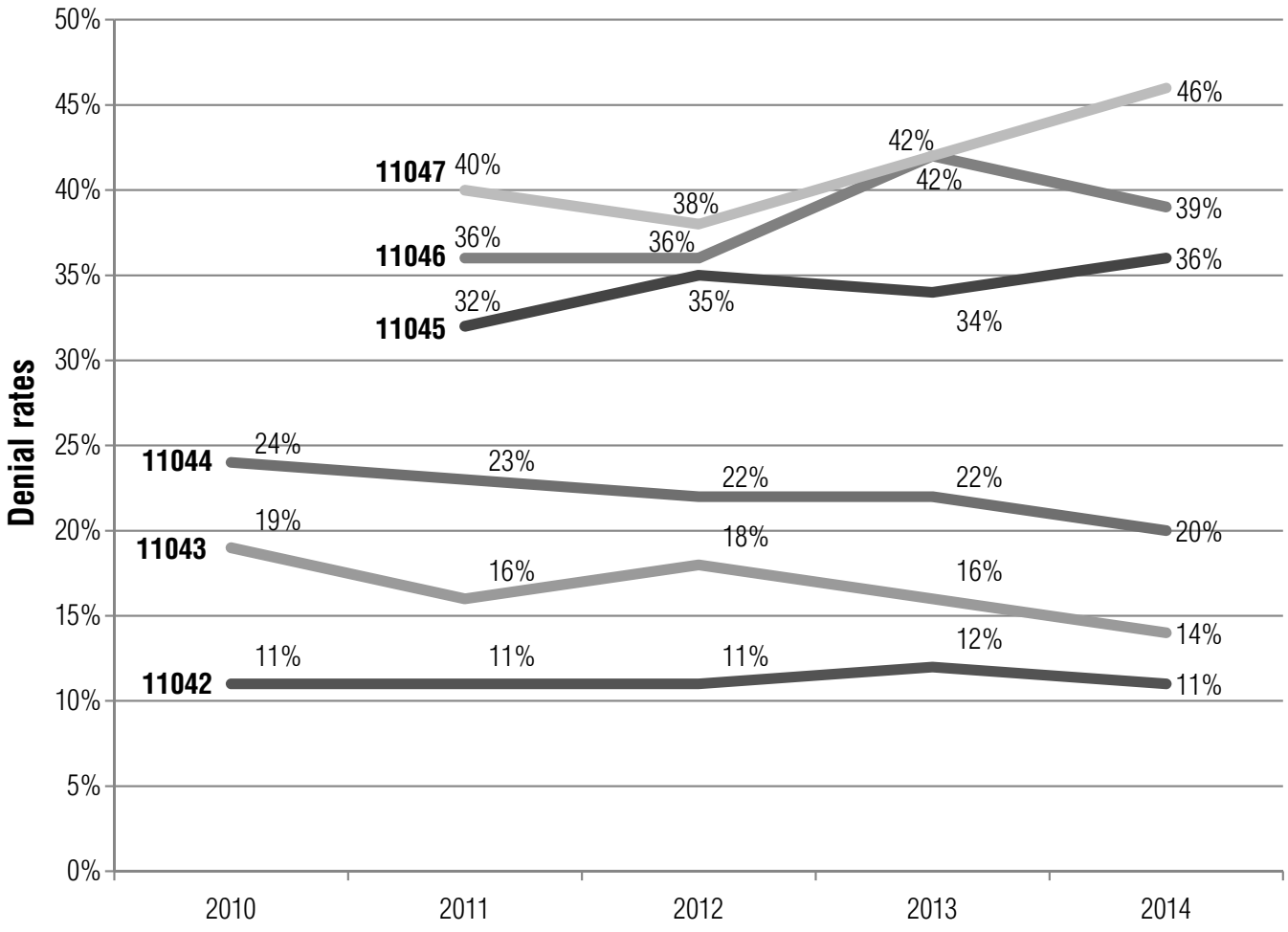
The surgical debridement codes referenced in the coding story on p. 1 — **11042-11044**, which report the service for up to 20 square centimeters and **11045-11047**, which report the service for more than 20 square centimeters — all have bad denial rates. While some of the rates have dropped between 2010 to 2014 (the most recent year for which we have Medicare data), all remain in double-digit territory. In 2013, one practice even told *PBN* that it had stopped billing debridement codes because it wasn't worth the denials management (*PBN 11/21/13*).

Documentation is often an issue for these claims. Sometime alternative codes are more appropriate — for example, if the provider is surgically preparing the patient for a skin graft to address a traumatic or acute injury, then **15002-15005** may be more appropriate and more likely to be paid (*PBN 1/18/13*).

The denial rates for the codes for debridement of more than 20 square centimeters are much worse than those for the first-20-square-centimeters codes. Note that they're also used far less often — while in 2014 11042-11044 averaged 704,511 claims, 11045-11047 averaged 236,435. Since 11045-11047 were added in 2011, it may be that providers haven't gotten the hang of them yet (*PBN 12/20/10*). Also, these are add-on codes and can't be paid unless they appear with one or more of the first-20 codes, which providers may forget.

(For tips on using debridement codes properly, see story, p. 1.) — Roy Edroso (redroso@decisionhealth.com)

Denial rates on debridement codes 11042-11047 from 2010-2014



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

(continued from p. 4)

coordinator for Vachette Business Services and Stark Medical Auditing.

EHR

(continued from p. 1)

MedStar Health announced to the press that it was experiencing "downtime" because of "malware" and laid out its steps for getting back online.

While MedStar reported diligently through press releases and social media updates, stories appeared in the press that the FBI was investigating the crash, and *The Washington Post* reported that "one woman who works at MedStar Southern Maryland Hospital Center sent *The Washington Post* an image of the ransom note" sent by the hackers. The *Post* also anonymously quoted nurses and a doctor who worked at MedStar Health facilities as to the state of service under the crash; their characterizations were not entirely flattering.

Questions from *Part B News* about the outage and the anonymous employees' reports went unanswered by MedStar Health at press time.

"MedStar Health appears to have acted relatively quickly to address the situation," says Warren Cooper, senior communications specialist at Warren, N.J., PR firm Evergreen Partners. But he didn't like the anonymous quotes — they "put the healthcare system on the defensive and suggest that its leaders weren't really in control of the situation."

8 tips for crisis communications

Here's how communications experts advise you to prepare for an incident like this:

1. Have a plan — and practice. You don't have to be experiencing a hacking incident to have at least some boilerplate ready for when one comes up. "A cyberattack must be considered like all potential crises and be included as part of a communications program," says Thomas Graham, president and CEO of Crosswind Media & Public Relations in Austin, Texas. Work with IT or the cybersecurity team if you have one on a "communications risk assessment" and potential crisis scenarios, such as if your EHR goes down, patient data is hacked or a ransomware threat occurs.

And don't just write it down — game it out, says Scott Sobel, senior strategy and communications executive with PR firm kglobal in Washington, D.C. He advises regular desktop or roleplay exercises to make sure everyone is clear on their jobs and how to perform them when the crisis hits. This comes with a dividend: Because the plan will be interdisciplinary — involving not just IT and communications but all the other departments that will be affected — rehearsing it "increases all kinds of coordination capabilities; it's catalyst for better communications and business practices in general," says Sobel.

2. Establish a clear chain of communications command. Practices should have a designated crisis spokesperson before there's a crisis, and his or her name should be common knowledge. **"**Everyone has to know when they're approached by the media who the reporter

should be sent to," says Cooper. From the start, every employee should have the spokesperson's name and "an easy number to pass along" so they can refer press contacts to them.

This applies to clinical and senior staff as well — everyone from the janitor to the CEO has to know who handles the calls and refrain from trying to do that person's job themselves.

3. Have a no-talking policy that's clear and explicit. Susan M. Tellem, RN, partner at Tellem Grody PR Inc. in Los Angeles, once worked on crisis communication for a hospital and "as an experiment, I called into the nurses' station, saying I was just curious about a situation — and I got an earful from every employee I talked with."

Employees like to share, particularly if they're dissatisfied. So make it clear that won't be tolerated. "It has to be clearly spelled out in the employee manual and repeated in staff meetings," says Tellem.

4. Prepare employees for stealth enquiries. Reporters don't always identify themselves, says Cooper. And sometimes people who are not reporters will ask about sensitive issues and transmit the answers to people who shouldn't have them. So employees should also be trained to give special handling to calls that come in about those sensitive issues.

Use response protocols to make this easier. For example, "let me know what you need and someone will get back to you." "If you're good about your training, responses will be automatic," says Cooper.

5. Loop in legal and public relations staff if you have it. "Make sure you have your legal counsel and PR counsel prepare or at least review your prepared statements or press releases," says Nina Dietrich, founder of an eponymous public relations and strategic marketing communications firm in Glen Rock, N.J. Legal will make sure you don't inadvertently suggest or reveal something for which you could be sued or prosecuted; PR will make sure you aren't in conflict with your practice's wider communications strategy.

6. Be proactive. It's conventional PR wisdom to "get out in front of your story," and press outreach is a logical way to do it. Prepare with a proactive strategy by having a list of key media contacts appropriate to your business, cross-indexed by topic — some publications are the kind you approach when you have an EHR outage, while others might be more appropriate to contact when one of your nurses wins an award.

Note: If things get busy, you may have to "triage" your media outreach. "You have to determine where you can be efficient and effective," says Randy E. Pruett, programs and events manager for Pierpont Communications Inc. in Dallas. "I once responded to 36 media inquiries, and left 20 more for the next day, in one day for a large retailer financial crisis. It wasn't physically possible to get to all 56 in one day."

7. Never say "no comment." "That's the equivalent of saying 'guilty as charged,'" says Cooper. It's better to say something like, "This is what we know right now, but as the situation evolves and we can share more, I absolutely will." And do get back to them, says Cooper. "You want to have the journalist on your side as a partner."

"Report what you know and reiterate that you are investigating the matter," says Dietrich.

8. Be careful of your tone. You can convey potentially unwelcome information in ways that make it easier to take, says Tellem. For example, "we would really like to help you do your story but all the answers are not in yet" sounds better than "I don't have an answer for you." — *Roy Edroso (redroso@decisionhealth.com)*

Debridement

(continued from p. 1)

coding is to acquaint yourself with the specific policies of your local payers, including your Medicare administrative contractor (MAC) — something that, while routine, practices appear to be overlooking.

"The staff in the provider's offices [that struggle with coding] don't know that there are guidelines for them," explains Sandie Moore, CMC, coding and billing specialist with the Santa Clara Medical Association in San Jose, Calif.

For example, Noridian, the Part B MAC in Moore's home state of California, requires that the provider capture specific information, including "the indications for the debridement (the presence of necrotic or devitalized tissue) and the size, location, observed depth of the ulcer(s), and the specific depth/level of debridement performed."

Yet providers in jurisdiction J5 (Iowa, Kansas, Missouri and Nebraska) may need to expand on the details because the MAC for those states, WPS Medicare, states that "the patient's medical record must contain

clearly documented evidence of the progress of the wound's response to treatment at each visit."

Get a handle on what you're required to include in the patient's notes by referring to your MAC's local coverage determination (LCD) on the topic. You'll likely find the relevant LCD under a variation of "wound care," as WPS Medicare classifies it, or "treatment of ulcers and symptomatic hyperkeratoses," as Noridian does.

3 more tips to shore up your coding

Among all specialties, providers saw an aggregate 11.4% denial rate on wound-debridement code **11042** (Debridement, subcutaneous tissue [includes epidermis and dermis, if performed]; first 20 sq cm or less) and a significantly higher 33.9% denial rate for add-on code **11045** (… each additional 20 sq cm).

All told, providers were denied more than $59 million for the two codes in 2014, according to Medicare claims data. Get your wound-care coding up to speed with the following tips:

1. Watch your code bundles. "The problem with 11042 is that it bundles into many other codes," notes Margie Scalley Vaught, CPC, a consultant based in Chehalis, Wash. CMS' Correct Coding Initiative (CCI) bundles 11042 into dozens of other CPT codes, some that are restrictive and others that require a modifier to unbundle them. For example, CCI edits restrict you from billing 11042 with **G0245-G0247**, procedure codes related to the evaluation and management of diabetic patients.

Yet you're allowed to bill 11042 with similar debridement codes 11004-11006, provided you evince medical necessity and submit the claim with the appropriate modifier — in this case, use modifier **59** (Distinct procedural service).

2. Pinpoint the exact size of the debridement, advises Maxine Lewis, president of Medical Coding and Reimbursement in Cincinnati. When Lewis administers chart audits to her provider clients, she often notices that "size is not documented," she says. Or the provider may not get specific enough. "He may say '20,' but I don't know if it's centimeters or inches," she sighs.

Example: A patient presents with two wounds of the same depth, one on each hand. The provider performs debridement of the wound on the right hand, which has a surface area of 18 centimeters. The provider also performs debridement of the left-hand wound, which is 17 square centimeters. Report 11042 for the first 20 centimeters and also 11045 to capture the remaining 15 centimeters.

ICD-10

Check your lesion-removal claims with melanoma diagnoses

Providers in North Carolina, South Carolina, Virginia and West Virginia should double check their lesion-removal claims, as their Medicare administrative contractor (MAC) Palmetto GBA is adding melanoma-related diagnosis codes to its list of accepted ICD-10 codes for lesion-removal services.

"I don't know why they weren't put in there originally," says Maxine Lewis, president of Medical Coding and Reimbursement in Cincinnati. The revised local coverage determination (LCD), affecting lesion-removal codes in the **11300**, **11400** and **11600** series, among others, takes effect April 8, 2016. In it, Palmetto is adding 14 ICD-10 codes in the melanoma series, ranging from **D03.0** (Melanoma in situ of lip) to **D03.8** (Melanoma in situ of other sites).

Since the launch of ICD-10, payers have intermittently updated their LCDs to reflect correct coverage terms (*PBN 2/22/16*). While *Part B News* is not aware of any claims rejections related to the previously missing melanoma codes, you may want to confirm that you didn't receive a rejection unjustly. — *Richard Scott (rscott@decisionhealth.com)*

3. Be depth-specific. Depth is one of the tricky elements of debridement coding, warns Vaught. That's because coding guidelines state that you shouldn't add together the wound size from wounds of different depths. For instance, if your patient has two wounds, one that reaches the subcutaneous tissue and another that reaches the muscle or fascia (**11043**), you should code the two services separately.

For example, you'll go with two separate codes, each with their own measurements: 11042 for the wound that has a depth to the subcutaneous tissue and 11043 for the wound that descends to the muscle or fascia. — *Richard Scott (rscott@decisionhealth.com)*

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.