Anesthesiology Groups Can Customize Practice Management Solutions for Improved Revenue Cycle Management and Long-Term Growth

By Andrew Bolles

In order to sustain a successful independent anesthesiology practice, physician leaders must look at the health of the business overall, in addition to simply running an efficient revenue cycle management (RCM) program. Managing an anesthesiology practice to achieve increased effectiveness and improved productivity is essential not only for survival, but also to maintain positive cash flow in today’s health care environment. Incorporating practice management services into RCM programs can augment anesthesiology billing and support future growth and sustainability.

With declining reimbursement rates and new bundled payment initiatives taking hold, many practices are stepping up their RCM programs to more closely monitor revenue, follow up on denials, and develop better self-pay and high deductible payment protocols in an effort to increase collections. RCM strategies ideally utilize business analytics and financial modeling to identify trends and predict future revenues based on historical data and utilization. While focusing on RCM is critical, there are other complimentary practice management services that will bolster the long-term success of an anesthesiology practice. Running a successful practice truly requires a business mindset and focus on all areas, in addition to traditional revenue management.

Seeing the Strategy

Practice management today requires a strategy that addresses an increasingly complex environment, which means groups must have more sophisticated management expertise than ever before. In the past, successful practice management was measured by the quantity of monthly deposits and...
(possibly) measurements of surgeon satisfaction. Today a successful practice is measured by the strength of its relationships, its ability to compete, the financial strength of the organization, and service quality, among other elements. It is critical that a group’s physician leadership and administrators locate helpful resources to evaluate and strengthen business operations, make informed business decisions, and allow more time to focus on patient care.

Today groups have the option to utilize outside resources to bolster internal practice management capabilities. In fact, the group’s current RCM partner might offer additional services beyond basic billing and collections. Practice management support services should offer flexible consultative or staffing support needed to provide strategic advice, whether it is for general business services, mergers and acquisitions, or hospital or carrier contract negotiations. These solutions can be customized to fit the needs of each individual practice, and service providers can and should work directly with the group administration, or even serve as the administration if need be, to map out areas of need within the practice.

If, for instance, the group employs a full-time practice administrator, that individual might work in tandem with a consultant to supplement his/her strengths. In the event that a group loses an employee who is a major asset, such as a CEO or CFO, established practice management partners may have an experienced professional on staff who can serve in this role in the interim while new permanent candidates are researched. In this regard, practice management support serves as a fail-safe and insurance policy.

RCM analytics also carry over into the strategic elements of practice management. It is critical to benchmark progress against your own group, but it’s also extremely helpful to see how other groups operate. Ideally, RCM analytics will provide performance feedback across a host of relevant RCM attributes allowing practices to identify problem areas in real time and resolve issues as they appear.

In addition to RCM data, benchmarking is possible across a broad range of practice attributes. For example: What are other groups paying shareholders versus non-shareholders? How much vacation do other practices offer? With the use of practice management survey data, anesthesiology groups can benchmark their practice data against similar practices across the country or their own region.

**Best Practices in All Areas**

In addition to outsourcing RCM functions, many anesthesiology practices outsource general business services as it can be cost prohibitive to staff many of these functions in-house. While basic functions such as human resources, payroll, bookkeeping, and accounting may be fairly easy to hire or replace, other business operations may require more sophisticated expertise usually held by more experienced and higher-salaried professionals. Groups may benefit by working with a solutions provider that has the experience of working with many similar practices, offering both basic service outsourcing and higher level expertise - and a thorough understanding of industry specifics. With this model, groups can access highly experienced and degreed professionals, essentially paying for the level and amount of support needed, and no more.

Areas including bylaws, benefit plans or retirement planning can be especially complex. For instance, an anesthesiology practice may be considering creating new bylaws or amendments and creating retirement plans whereby all anesthesiologists in the group feel their needs are being met; both the
physicians contemplating retirement and those just coming in to the practice. Another area might include renegotiating medical malpractice coverage. Consulting with an expert who has developed models that were successful in previous engagements may offer a practice an alternative that may be successful for them.

Ultimately, an experienced practice management partner will give an anesthesiology group exposure to a full range of best practices. A solid understanding of how other practices are strategically investing in mobile and communication infrastructures, for example, or investing in decision support tools or structuring their practice models can help formulate a practice management strategy and support long-term growth and sustainability.

**Hospitals as Partners**

Consolidation in any industry is an effort to bring together different groups with the desired effect of increasing market share and perhaps more importantly, strengthening one’s position at the bargaining table. A larger practice offers more physicians and opens up scheduling availability and cases. Being bigger equates to more power in contract negotiations and in attracting the most talented physicians. However, consolidation is no longer the only answer to meet the increasing demands and expectations of health systems.

Practices today must strive to maintain (or reestablish) their positions as service leaders; to become information providers that can help referring physicians and patients become better medical decision makers. Practice management services must support this effort. For instance, Zotec Partners works with its practice management clients to ensure they are consistently engaged with hospital administration - not just during a contract renewal period - ensuring that both party’s goals are understood and aligned. This type of collaboration helps to demonstrate the practice’s value to all stakeholders. To ensure sustainability and profitability, anesthesiology practices must be able to continuously evidence their contribution to hospital care initiatives through collaborative and demonstrable analytics.

**Opportunities for Growth**

The environment for anesthesiology practices interested in protecting their current business and ensuring future growth is especially challenging. There are many different paths to maintain practice independence and achieve growth, but groups must ask the right questions along the way. Should the group consider strategic growth through a merger or acquisition? Mergers and acquisitions should be pursued only with ideal partners, with opportunities that are both appropriate and strategic. Evaluating potential partners is a complex process, and merging cultures presents a number of potential hurdles.

Should the group move beyond its traditional hospital service agreement and annual stipend, and take steps toward a coordination of care model and true gain-sharing opportunities with the hospital? If so, does the group have the expertise and data it needs to negotiate this type of agreement successfully? Does the group fully understand the competitive landscape? Of course, these are just a few of the questions the group must ask as it moves forward.

In today’s complex environment, effective practice management services that complement a group’s RCM system must fully leverage information, data and experience. Whether an anesthesiology
practice is determining the best way to compile and use its data for benchmarking, manage its business operations or develop the most sound business model for its long-term growth and sustainability, it would be best served to consider a practice management strategy and service provider that aligns with a group's billing and RCM system.

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Be on the Lookout for the ASA's Annual Commercial Conversion Factor 2014 Survey Results

The American Society of Anesthesiologists (ASA) presented the annual commercial conversion factor survey for 2013 last October, and announced a new survey this past June. For comparative purposes, this article will highlight the ASA's 2013 findings.

Each summer, the ASA anonymously surveys anesthesiology practices across the country asking them to report up to five of their largest managed care (commercial) contract conversion factors (CFs) and the percentage each contract represents of their commercial population, along with some demographic information. The ASA cited its objectives on the survey was to report to its members the average contractual amounts for the top five contracts and to present a regional survey of trends in commercial contracting.

Based on the 2013 ASA commercial CF survey results, the national average CF factor was $71.69, ranging between $70.33 and $73.82 for the five contracts. The national median was $67.61, ranging between $66 and $69 for the five contracts. In the 2012 survey, the mean CF ranged between $64.80 and $71.44, and the median ranged between $61.70 and $68. In contrast, the current national Medicare CF for anesthesia services is $21.92, or just 30.6 percent of the 2013 overall mean commercial CF.

The survey reflects valid responses from 223 practices in 44 states plus the District of Columbia, an increase from last year’s survey. The 2012 survey results included 175 practices from 40 states and the District of Columbia. It was disseminated in June 2013. To comply with the principles established by the Department of Justice and the Federal Trade Commission in their 1996 Statements of Antitrust Enforcement Policy in Health Care, the survey requested data from respondents that were at least three months old. To comply with the statements, the ASA was only able to provide aggregated data. Since some states did not respond and other states had insufficient response rates, the ASA was unable to provide data on a state level.

The responses to the survey represented 325 unique practices. However, 102 respondents indicated they had at least one commercial contract (non-governmental payer) but then failed to provide any data. Therefore, the ASA excluded these responses in its overall analysis.

Based on the ASA’s review of the analysis, the most interesting findings it cited are as follows:

- The national average CF increased from a range of $64.80 - $71.44 in 2012 to a range of $70.33 - $73.82. In addition, the median CF increased from a range of $66.70 - $68 in 2012 to $66 and $69.
- CFs across the country are similar, with the Eastern region still having the highest.
- Every region and nearly every contract category had a reported conversion factor high of at least $148. The highest CF reported was $250.40.

The ASA concluded its findings by stating that this year’s survey represented the largest sample size
of all ASA CF surveys. The survey median increased from 2012, with a national median of $67.61 (mean $71.69). The ranges of rates, shown in the ASA survey results document, show less variance of CFs. The increased median CF is likely due to a narrowing of the range of CFs trending slightly upward.

The ASA continues to monitor the trend in the commercial CF survey results and launched the survey again this past June. Anesthesiologists should expect to see survey results in October 2014.

To view the full survey results, visit https://www.asahq.org/For-Members/Publications-and-Research/Newsletter-Articles/2013/October-2013/practice-management.aspx

References


ICD-10 Deadline Set for October 1, 2015

The U.S. Department of Health and Human Services (HHS) issued a rule on Thursday, July 31, 2014 finalizing October 1, 2015 as the new compliance date for health care providers, health plans, and health care clearinghouses to transition to ICD-10, the tenth revision of the International Classification of Diseases. This deadline allows providers, insurance companies and others in the health care industry time to ramp up their operations to ensure their systems and business processes are ready to go on October 1, 2015.

Zotec Partners remains ready for the ICD-10 adoption and will continue to work closely with its provider clients on planned ICD-10 efforts. Now that CMS has finalized the deadline, Zotec will update its transition timelines accordingly, to ensure its clients are fully prepared for the transition.

Additional references:


(3) http://www.modernhealthcare.com/article/20140731/NEWS/307319823?AllowView=VDl3UXk1TytDZldCbkJiYkY0M3hlMFNxamtVY0NPVT0=&utm_source=link-20140731-NEWS-307319823&utm_medium=email&utm_campaign=hits-alert
Anesthesia Highlights and Summary: 2015 MPFS Proposed Rule
By Missy Lovell, BSN, RN, MBA and Daniel W. Simile, Jr., CPA

The following article contains Anesthesia-specific highlights and summary on CMS’ Proposed Final Rule for the Medicare Physician Fee Schedule (MPFS) that was originally published on July 11, 2014. CMS will accept comments on the proposed rule until September 2, 2014, and will respond to them in a final rule to be published in early November 2014.

1. **2015 Reduction in the Conversion Factor**
   There is a zero percent update mandated from January 1, 2015 to March 31, 2015 leaving the current anesthesia national conversion factor (CF) of $22.6765 essentially unchanged during that time. Unless Congress intervenes prior to April 1, 2015, then CMS estimates a -20.9% update will be applied.

2. **2015 Proposed Fee Schedule Calculation Provisions and Estimated Impacts**
   Based on proposed provisions of the 2015 fee schedule, CMS estimates a 0% impact for anesthesiology, essentially no impact based on the current provisions of the proposed rule. Interventional pain management is estimated to be impacted to a slightly more positive degree at +1%. All estimated specialty impacts are exclusive of any change to the current CF.

3. **Review of Potentially Misvalued Codes, RVU PE and Input Proposals**
   CMS identified 65 codes as being potentially misvalued based on their high level of Medicare expenditures. Other proposals relate to the gradual phase out of ten (10) and 90-day global packages into zero (0)-day global packages, over 2017 and 2018 respectively, which would allow separate billing for medically necessary pre-op and post-op services as applicable. There are Malpractice (MP) RVU revisions among other provisions that may directly or indirectly affect anesthesiology.

4. **Geographic Practice Cost Indices (GPCIs)**
   GPCIs are used in the RBRVS formula to measure resource cost differences among localities compared to the national average for each of the three RVU components. 2015 holds the second year of a phase-in of revised GPCIs and the work GPCI floor of 1.0 is currently in place through the end of March 2015; this “floor” is set to expire again at that time and the 2015 proposed rule holds GPCI addenda that include January - March 2015 GPCIs and April – December 2015.

5. **Off-Campus Provider Based Departments and Physician Services**
   CMS proposes to collect data to analyze the frequency, type and payment for services furnished in off-campus provider based departments through the use of a HCPCS modifier. CMS is proposing that a modifier be reported for “off-campus services,” (e.g., physician’s offices, provider based departments of hospitals where the billing of these off-campus sites of service include both professional and facility fees). This modifier is to be reported with every code for physician and hospital services furnished in an off-campus provider based department of a hospital, both on the 1500 and UB-04, and seek input on the use of a modifier for that purpose.

6. **Colorectal Cancer Screening Tests**
   CMS is revising the definition of “screening colonoscopy” to bring anesthesia furnished in conjunction with the service within the scope of the provision that Part B waives the beneficiary’s deductible and co-pay and pays 100% for the anesthesia associated with the screening service.

7. **Solicitation of Comment on the Payment Policy for Substitute Physician Billing Arrangements**
In general there is an allowance for two types of substitute physician billing arrangements: (1) reciprocal billing and (2) locum tenens billing. Based on various concerns mentioned in the proposed rule, they seek provider comment on specific substitute physician questions to analyze the need for any changes to existing regulation.

8. **2015 Physician Quality Reporting System**

The 2015 PQRS program moving forward will no longer provide incentive payments for successful participation and concurrently lack of participation and/or successful reporting can earn the providers an adjustment in 2017 and forward. The 2015 PQRS reporting will determine whether or not the EP or group gets assessed a -2% PQRS adjustment in 2017; therefore if a provider does not meet the criteria CMS sets in place for successful reporting and participation in 2015, the EP will see their services paid at 98.0% of the allowable in 2017. CMS proposes some changes to the existing reporting criteria as outlined in the proposed rule; of particular importance to anesthesiologists is the proposal to delete 73 measures, one of which is PQRS Measure30 - Perioperative Care: Timing of Prophylactic Antibiotic—Administering Physician.

9. **Value Based Payment Modifier (VBM)**

The VBM originated in the Patient Protection and Affordable Care Act (PPACA), and will lead to potential payment adjustments based on a comparison of physicians’ cost and quality. The 2017 VBM adjustment will be based on 2015 PQRS reporting criterion and is proposed to be assessed on groups with two (2) or more EPs and solo practitioners, which would now meet the mandate that all physicians be applicable to the VBM by 2017. Other proposed changes will apply the VBM adjustment in 2017 to all physician and non-physicians practitioners (NPPs) in an eligible group and to double the VBM adjustment potential from 2016. They propose a -4% VBM adjustment potential for those groups who do not qualify for quality tiering.

10. **Reports of Payments or Other Transfers of Value to Covered Recipients (Open Payments - Sunshine Act)**

The Open Payments program was developed in response to the Sunshine Act, and according to CMS promotes transparency by publishing data on the financial relationships between the healthcare industry and healthcare providers on a website for public inspection, essentially it requires drug and device companies to disclose payments to physicians.

Physicians currently have a small window of opportunity (through August 27, 2014) to review industry supplied data and dispute it prior to being publicly available on September 30, 2014 (as described in the detail section below) and physicians are advised to review the website for their information if applicable so they have ample time for dispute as necessary. The recently released rule also proposed some changes to the Open Payments program.

**Anesthesia Summary**

**2015 Reduction in the Conversion Factor**

The Protecting Access to Medicare Act of 2014 (PAMA) provides for a 0% update from January 1, 2015 to March 31, 2015. The 0% update and adjustments necessary to maintain budget neutrality from policies proposed in this rule result in a minimally adjusted CF for the first three months of 2015. If Congress fails to act to avert mandated SGR-related cuts prior to April 1, 2015, then a -20.9% update will be applied.

**2015 Proposed Fee Schedule Calculation Provisions and Estimated Impacts**
The following tables illustrates CMS estimates regarding the following impacts per selected specialties of all of the provisions included within the 2015 proposed fee schedule and the individual RVU component impacts.

Note: This does not include the impact of the negative CF change/SGR per current law.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Allowed Charges (mill)</th>
<th>Impact of Work RVU Changes</th>
<th>Impact of PE RVU Changes</th>
<th>Impact of MP RVU Changes</th>
<th>Combined Impact**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anesthesiology</td>
<td>$1979</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Interventional Pain Mgmt.</td>
<td>$572</td>
<td>0%</td>
<td>1%</td>
<td>0%</td>
<td>1%</td>
</tr>
</tbody>
</table>

**Shows the payment impact on PFS services and does not include the effects of the change in the CF scheduled to occur on April 1, 2015 under current law.

Review of Potentially Misvalued Codes, RVU PE and Input Proposals

Potentially Misvalued Codes

Attached is the list of “potentially misvalued” codes that were identified through the high expenditure specialty screen and CMS would ask for provider input; they would assess changes in physician work and direct PE inputs for the services identified on the list and revalue as applicable. Additionally there were other services as noted below that they are also adding to the potentially misvalued list and would ask for provider comments.

Epidural Injection and fluoro guidance – 62310, 62311, 62318 - 19 and 77001, 77002 - 03

In 2014, CMS applied interim RVU values for the epidural injection codes and received many comments on the decreases for those services. CMS is now proposing to reinstate the 2013 RVU values for those codes in 2015 and will reassess the inputs for those services. It also noted that fluoro was typically billed along with those services and several “similar” services had the fluoro bundled. So concurrently along with positive reinstatement of the 2013 RVU’s it is also proposing that fluoro now be “bundled” into these services and propose to disallow separate billing for the fluoro.

Valuation and Coding of the Global Package

CMS reiterates that there are three categories of global packages labeled based on the number of post-op days included in the global period: zero (0), ten (10) and 90-day. CMS then essentially “bundles” the pre-op, intra-op, and post-op visits, postsurgical pain management by the physician, and supplies (except for those excluded) into the global surgical package. CMS has not reassessed these packages since this “global” package was first established 1992, and realizes that there are some apparent fundamental flaws with this current packaging of services to include the following:

- They were established several years ago when FU care was more homogenous;
- There is much more diversity in the kind of procedures covered by global periods, setting and the
FU care that is provided;
- The care needs of beneficiaries has evolved; and
- Payment, for most bundled services, relies on valuing the combined services together; and there are no separate MPFS values for the procedures or the FU care, making it difficult to estimate the amount of each.

It also notes throughout its discussion that providers may furnish a wide range of post-op services depending on patient need, changes to medical practice, and the number of visits may vary greatly per case. CMS also cited two OIG reviews in which it noted that based on each sample there was not as many E/M services provided as were included within the bundled global package(s).

According to the Part B News, July 14, 2014, there are 3,799 codes with the 90-day global period and 473 codes with the ten (10)-day global. Experts believe that CMS will also request future comments on how the surgical codes should be re-valued, assuming no global period concept applies.

To address these issues and disparities, CMS is proposing to currently retain global packages for surgical services, but to refine them by transitioning over several years all ten (10) and 90-day global codes to zero (0)-day global codes. Medically reasonable and necessary visits would be billed separately outside of the day of the surgical procedure. The proposal includes making the transition for current ten (10)-day global codes in 2017 and 90-day global codes in 2018 pending the availability of data.

Valuing Services that include moderate sedation as inherent in the Procedure

CMS notes that the CPT manual includes more than 300 diagnostic and therapeutic procedures for which CPT has determined that moderate sedation is an inherent part of furnishing the service and therefore only the procedural service is billed. Due to changing medical practice, many of those “categories of services” now have a separate anesthesia charge billed in addition to the procedures. CMS is asking for comments on approaches to valuing those 300+ codes that would allow them to pay accurately for moderate sedation when furnished and avoid duplicate payments when a separate anesthesia service is furnished and billed.

Malpractice RVUs (MP)

CMS is required to review, and if necessary adjust RVUs no less than every five years. CY 2015 will hold the third review and update to the MP RVUs. Keeping in mind that on average, the work RVU comprises 50.9% of payment for a service under the MPFS, the PE RVU about 44.8%, and the MP about 4.3%, most revisions to this RVU category will be minimally felt in comparison to other RVU changes.

Geographic Practice Cost Indices (GPCIs)

“Section 1848 (e)(1)(C) of the Act requires CMS to review and, if necessary, adjust the GPCIs at least every 3 years; if more than one (1)-year has elapsed since the date of the last previous GPCI adjustment, the adjustment to be applied in the first year of the next adjustment shall be half of the adjustment that otherwise would be made. Therefore, since the previous GPCI update was implemented in CY 2011 and CY 2012.” CMS phased in half of the latest GPCI adjustment in CY 2014 and the 2015 GPCIs will hold the completed GPCI adjustments.
GPCIs are used in the fee formula to measure resource cost differences among localities compared to the national average for each of the three RVU components. As a reminder, there is a permanent 1.5 work GPCI floor in place for Alaska which was initiated on January 1, 2009 and on January 1, 2011 a permanent 1.0 PE GPCI floor for frontier states was effected (Montana, Wyoming, North Dakota, Nevada and South Dakota). There was also a work GPCI floor of 1.0 in place for all localities, which was set to expire in 2009 and ultimately got extended through the end of March 2015. This “floor” is set to expire again at that time and the GPCI addenda include January – March 2015 GPCIs and April – December 2015 GPCIs. This 1.0 work floor would have to be extended with congressional action.

**Off-Campus Provider Based Departments and Physician Services**

CMS notes that they would like to better understand the growing trend toward hospital acquisition of physician offices and treatment of those locations as off-campus provider based departments and how those affect payments under the MPFS and beneficiary cost-sharing. Assumedly this trend may be fueled from a desire to purchase physician offices and designate them as “provider-based” which allows the hospital to bill a facility fee in addition to the claims submitted by the physician providers to Part B. The industry and others have noted that in these situations, although the same professional services are supplied at the same locations, the payments can differ significantly in provider based departments versus physician office designations. CMS also notes concerns of increased beneficiary cost-sharing when physician offices become hospital OP departments and MedPAC (the non-partisan think tank that advises Congress on Medicare policies) has recommended that Medicare pay selected HOPPS services at MPFS rates. CMS opines that as more physician offices become hospital based, it becomes difficult to determine which PE costs typically are incurred by the physician, hospital or whether their “site of service” differential accounts for the typical resource costs. Based on these concerns, CMS feels that they should collect data that would allow them to analyze the frequency, type and payment for service furnished in off-campus provider based departments. They propose the use of a HCPCS modifier to be reported with every code for physician and hospital services furnished in an off-campus provider based department of a hospital, to be used on the 1500 and the UB-04 and seek comment on the modifier usage.

**Colorectal Cancer Screening Tests**

CMS notes that until recently the standard of care for screening colonoscopies has been moderate sedation provided by the endoscopist, without separate anesthesia. Because of that moderate sedation was bundling into the payment for the screening tests, (G0104 and 05). In a recent study though, an increase was noted in the amount of colonoscopies and upper endoscopy procedures furnished using an anesthesia provider; from 13.5% in 2003 to 30.2% in 2009 in just the Medicare population alone. Medicare looked at their own claims data and found that 53% of screening colonoscopies had separate anesthesia claims reported in conjunction with the screening service. An unintended consequence of this was that many beneficiaries had their screening colonoscopies paid at 100% due to the preventive services provisions in the PPACA, but then would have to pay the co-pay and deductible for the anesthesia provided with the screening service. Therefore CMS is proposing to revise the definition of “colorectal cancer screening tests” to include anesthesia delivered in conjunction with them, therefore extending the waiver of cost-sharing to the anesthesia services provided with the screening tests. Anesthesiologists can expect to be paid at 100% from
Medicare for those services if the definition revision is finalized.

**Solicitation of Comment on the Payment Policy for Substitute Physician Billing Arrangements**

CMS notes that in general it allows for two types of substitute physician billing arrangements, reciprocal billing and locum tenens billing. CMS noted various concerns with the current billing policies to include:

- Operational and program integrity issues that result from the use of substitute physicians to fill staffing needs:
  - Or to replace a physician who has permanently left a group and misunderstandings of who would alert the carrier when the physician left a group, which would mean the departed physician is left “open” with the group for an extended time.
  - This means the departed physicians NPI may be used on claims concurrently with his/her new group and the departed group.
- Without acknowledgement of the substitute physician on the claim form for these services, Medicare lacks the knowledge of whether or not the substitute physician is enrolled in Medicare or holds the credentials necessary to provide services to Medicare beneficiaries.

Because of these concerns they are seeking provider input on a series of questions for possible changes to existing regulation concerning substitute physicians.

**2015 Physician Quality Reporting System (PQRS)**

The PQRS has been in existence since 2007 and currently providers can participate as an individual eligible professional (EP) or as a group practice through the Group Practice Reporting Option (GPRO). The 2015 PQRS program moving forward will no longer provide incentive payments for successful participation and concurrently lack of participation and/or successful reporting can earn the providers an adjustment in 2017 and forward. The 2016 PQRS adjustment increased to -2.0% (based on 2014 participation) and 2015 PQRS reporting will determine whether or not the EP gets assessed a -2% PQRS adjustment in 2017. If an EP does not meet the criteria CMS sets in place for successful reporting and participation in 2015, the EP will see their services paid at 98.0% of the allowable in 2017.

For 2015, CMS proposes to add 28 new individual measures and two measures groups to PQRS reporting. Additionally, they propose to remove 73 measures, including PQRS Measure 30-Perioperative Care: Timing of Prophylactic Antibiotic—Administering Physician, one of the few measures anesthesiologists previously reported.

The 2015 reporting mechanisms are: claims-based reporting, qualified registry, EHR, the GPRO web interface, certified survey vendors and the Qualified Clinical Data Registry (QCDR). Some notable proposed changes include:

- If an EP chooses to report via a qualified registry or through the claims-based method, in addition to requiring that an EP or group practice report on at least nine (9) measures covering three (3) NQS domains, any EP or practice who sees at least one (1) Medicare patient in a face-to-face encounter must report on at least two (2) cross-cutting measures as specified in the cross cutting
measure list. Examples of those cross cutting measures listed include (18 measures total):

1. Tobacco Use - Screening and Cessation Intervention Screening and Cessation Intervention: Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counselling intervention if identified as a tobacco user.

2. Documentation of Current Medications in the Medical Record - Percentage of visits for patients aged 18-years and older for which the eligible professional attests to documenting a list of current medications using all immediate resources available on the date of the encounter. The list must include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications name, dosage, frequency and route of administration.

3. Care Plan - Percentage of patients aged 65-years and older who have a care plan or surrogate decision maker documented in the medical record or documentation in the medical record that a care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide a care plan.

4. Pain Assessment and Follow-Up - Percentage of visits for patients aged 18 years and older with documentation of a pain assessment using a standardized tool(s) on each visit AND documentation of a follow-up plan when pain is present.

○ If an EP reports through a QCDR, they have proposed to require that EPs report on nine (9) measures (covering at least three [3] NQS domains) of which three (3) of those (or less if applicable) are outcome measures. The QCDR can now list 30 non-PQRS measures instead of the 20 they were held to in 2014.

In summary, the criterion for EPs who choose to report individual measures via claims or a qualified registry are (for the 12 month reporting period of January 1, 2015 – December 31, 2015):

○ The EP would report at least nine (9) measures covering at least three (3) NQS domains and report each measure for at least 50% of the eligible instances.

○ Of the measures reported, if the EP sees at least one (1) Medicare patient in a face-to-face encounter, the EP would report on at least two (2) measures contained in the proposed cross cutting measure set.

○ A face-to-face encounter will be determined by submitted codes, such as office visits, outpatient visits, surgical procedures, etc., telehealth visits would not be included in this definition.

○ If less than nine (9) are applicable, they would report on up to eight (8) measures and be applicable to the MAV process.

If an EP chooses to report measures groups through a qualified registry, the EP would report during the 12 month period:

○ At least one (1) measures group and report each measure group for at least 20 patients, (11 or more of which should be Medicare patients).

*Note: For 2015, there is no incentive as in prior years for success participation in a Maintenance of Certification (MOC) program.*
**Value Based Payment Modifier (VBM)**

The VBM originated in the PPACA, and will lead to potential payment adjustments based on a comparison of physicians' cost and quality. The proposal is budget-neutral, so increases in Medicare payment rates for some physicians will be offset by reductions for others. The VBM will be applied to groups with 100 or more EPs in 2015, groups of 10 or more EPs in 2016 and to all physicians in 2017. The 2017 VBM adjustment will be based on 2015 criterion.

The VBM program contains two primary components:

- The Physician Quality and Resource Use Reports (QRURs)
- Development and implementation of a Value-based Payment Modifier (VBM)

Historically the VBM adjustments that will be made per group are based on prior year’s PQRS participation, and indirectly utilizes the EP’s QRURs. The EP’s successful participation in PQRS for 2015 significantly affects the VBM adjustment that may ultimately be seen in 2017, and their QRURs will play a central role in the quality tiering adjustment that will ultimately be determined.

In late summer 2014, CMS will make QRURs available based on care provided in 2013 to all groups and solo practitioners. The 2013 QRURs will display a group practice’s quality and cost composite scores which are used to calculate the VBM. For group practices of 100 or more EPs that elected quality tiering, the 2013 QRUR will display the groups 2015 VBM adjustment.

The 2017 proposed process is much the same but CMS outlined the following proposals regarding the VBM policies that will determine the 2017 VBM payment adjustment for EPs and groups:

- To apply the VBM to all physicians and non-physician EPs in groups with two (2) or more EPs and to solo practitioners in 2017,
- Mandatory quality tiering for groups that meet the criteria for satisfactory reporting of PQRS data via GPRO or if reporting individually have at least 50% of the group’s EPs meet the criteria, or those who satisfactorily participate in a QCDR.
  - The one distinction is that groups with two – nine (2-9) EPs would be subject only to a neutral or upward quality tiering adjustment and groups with ten (10) or more would be subject to a downward adjustment also.
  - As this is the first year that groups with two – nine (2-9) are applicable to the VBM, this continues the gradual transition into the program.
- To increase the amount of payment at risk from -2% to -4% in 2017,
- To align the quality measures/reporting mechanisms for the VBM with those available under PQRS during the CY2015 performance period.

Groups are increasingly becoming applicable to the quality tiering and are subject to an upward, neutral or downward adjustment and according to CMS have been provided, “...sufficient lead time to understand how the VM work and how to participate in PQRS.” In late summer of 2014, CMS will distribute QRURs based on CY 2013 data to all groups of physicians and solo practitioners. This will contain performance information on the quality and cost measures used to calculate the quality and cost composites of the VBM and will show how all TINs would fare under the policies established for the VBM. Additionally it will provide information about the individually reported PQRS measures and the specialty-adjusted cost measures. In the summer of 2015, they will distribute the 2014 data and
their hopes is that will provide adequate lead time for groups to better their understanding of the VBM adjustment potential and how to improve quality and costs as applicable.

It is important to note that for 2015 and 2016, any VBM adjustment made will only be applied to physicians, but CMS is proposing (as this is at their discretion) to apply the adjustment in 2017 to all physician and non-physicians practitioners (NPPs) in an eligible group and the NPPs would be subject to the same VBM policies. Those NPPs under the TIN could include: CRNA’s, physician assistants, and nurse practitioners.

CMS is proposing that groups who elect to continue to report individual measures via the claims based or registry method and who do not have 50% of their EPs successfully participate in PQRS and avoid the PQRS adjustment, will additionally get a -4% VBM adjustment for the group in 2017 (both physicians and NPPs). If more than 50% of their EPs successfully participate in PQRS and avoid the PQRS adjustment then they will move into quality tiering, which could afford them an upward increase, neutral adjustment or a downward adjustment although groups with two – nine (2 – 9) EPs will be exempt from any downward quality tiering adjustment.

CMS estimates that based on the quality tiering data from 2012 claims, approximately 6% of all EPs would earn an upward quality tiering adjustment, 83% would earn a neutral adjustment and 11% would earn a downward quality tiering adjustment.

CMS did announce they are considering including or allowing groups that have hospital-based physicians to elect the inclusion of the hospital Value-Based Purchasing (VBP) program performance in the VBM calculation in future years of the program. This may better align incentives for quality improvement and cost control across CMS programs according to CMS. They would also then have to assess and analyze under what methodology to determine which hospital or hospitals performance would apply to any given TIN. They discuss three (3) options for including Hospital VBP program performance in the VBM and seek provider input.

Reports of Payments or Other Transfers of Value to Covered Recipients (Open Payments - Sunshine Act)

The Affordable Care Act held a provision (now commonly known as the Sunshine Act) that mandated the creation of a program that would require “(1) reporting payments and other transfers of value made to covered recipients and physician owners or investors, by manufacturers of drugs, devices, biologicals, or medical supplies for which payment is available under Medicare, Medicaid, or the Children’s Health Insurance Program (CHIP); and (2) reporting ownership or investment interests held by physicians or their immediate family members in applicable manufacturers and applicable Group Purchasing Organizations (GPOs), as well as reporting payments or transfers of value made by these applicable manufacturers and applicable GPOs to these physicians.” The Open Payments program was developed in response to the Sunshine Act, and according to CMS promotes transparency by publishing data on the financial relationships between the healthcare industry (applicable manufacturers and applicable GPOs; together referred to as reporting entities) and healthcare providers (physicians and teaching hospitals) on a website that can be accessed by the public for evaluation and inspection. Essentially it requires drug and device companies to disclose payments to physicians.
The applicable vendors and manufactures have reported their 2013 data and physicians have an opportunity to review and dispute the data that has been reported; they can register in CMS’s Enterprise portal and review and potentially dispute the data prior to being released to the public on September 30 of 2014. The review period is in progress; it runs from July 14, 2014 through August 27th, 2014. Physicians are encouraged to review the data and register as soon as possible to ensure adequate dispute time if necessary. Physicians can access the link below to access registration instructions, and once registered can review the reported data and they will have a variety of options available to either; affirm their payment, dispute it with an explanation, or withdraw a dispute.


Through the 2015 rule, CMS proposes some changes to the Open Payments Program as; removing the exclusion for payments to physicians for speaking at certain accredited continuing education programs, requiring manufacturers to report the marketed name of all products, associated with reported payments or transfers of value (if any), separating out form descriptors used in reporting ownership interests, and removing the definition of “covered device.”

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Health Care Reform Timeline: Critical Elements of HC Reform Implementation
By Sarah Mountford, CPC, RCC

The Patient Protection and Affordable Care Act (ACA) was enacted in 2010 with a few primary goals: Improve the quality and affordability of health insurance, lower the uninsured rate through the expansion of public and private insurance coverage, and reduce the cost of health care for individuals and the government while improving the quality of that care. Through expansion of state Medicaid programs and the use of state based Health Insurance Exchanges (HIEs), the administration expects to insure 50 million previously uninsured individuals by 2019. Zotec’s timeline of health care reform can help you understand changes, impacts and critical elements of implementation.

2010
- States establish and implement process for reviewing premium increases.
- Insurance companies must report medical loss ratios.
- For tax years 2010-2013, employer tax credit Phase I.
- 10 percent tax on indoor tanning services.
- Insurance reform implemented: coverage for children with pre-existing conditions, children can remain on parents’ policies until age 26, prohibits lifetime limits on dollar value of coverage (within 6 months).
- $250 rebate to Medicare beneficiaries reaching Part D coverage gap in 2010.

2011
- Changes to HSAs MSAs: OTC drugs not eligible for reimbursement. Increase tax on distributions from HSA or Archer MSA not used for qualified medical expenses to 20 percent.
- Insurance companies must provide rebates related to medical loss ratios.
- $2.5 billion fee on pharmaceutical companies.
- Increase funding to community health centers by $11B over five years.

2012
- Electronic funds transfers and health care payment and remittance rules adopted by July 1.
- Reduce Medicare payments for preventative hospital readmissions.
- Big Pharma fee goes to $3.0 billion through 2016.

2013
- Limits to contributions to FSAs for medical expenses from 7.5 percent of adjusted gross income to 10 percent. Waives increase for individuals 65 and older for tax years 2013-2016.
- 2.9 percent excise tax on the sale of any taxable medical device.
- Medicare Part A tax rate on wages goes up by 0.9 percent on earnings over $200,000 for individuals and $250,000 for married couples filing jointly. Imposes a 3.8 percent tax on unearned income for higher-income taxpayers.
- Medicare pilot program to test bundled payments.
2014
- Medicaid expansion: Participating states receive 100 percent federal financing for increased payment rates through 2016, after which the payment will phase-down. Only 24 states participate in expansion.
- Individual mandate phased-in with premium and cost-sharing subsidies for qualified individuals.
- Employer mandate begins.
- All health plans except grandfathered individual and employer-sponsored plans, required to offer at least a standardized mandatory health benefits package.
- Grandfathered group plans may only impose annual limits as determined by HHS. Elimination of pre-existing condition exclusions for adults.
- $8 billion fee on insurance sector.

2015
- $11.3 billion fee on insurance sector through 2016.
- Small businesses with up to 100 employees can send their employees to the exchanges to purchase insurance.

2016
- Rules impacting enrollment and disenrollment in a health plan, plan premium payments and referral certification and authorization effective Jan. 1.

2017
- States may allow businesses with more than 100 employees to purchase coverage in the SHOP exchange.
- Big Pharma fee goes up to $3.5 billion.
- Insurance sector fee goes up to $13.9 billion.

2018
- IPAB recommendations automatically implemented if Medicare spending exceeds GDP per capita plus 1 percent, unless congress takes equivalent cost-cutting measures.
- Tax on so called Cadillac plans valued at more than $10,300 for individual coverage and $27,500 for family coverage.
- Big Pharma fee goes to $4.2 billion.
- Insurance sector fee goes to $14.3 billion.

Sarah Mountford, CPC, RCC is a client services manager for Zotec Partners.
AQI is the Definition of Quality

Quality, as defined by the Merriam Webster dictionary is “a high level of value or excellence.” The Anesthesia Quality Institute (AQI) is dedicated to providing anesthesiologists with the resources needed to improve their patients’ care, and as a partner to the AQI, Zotec Partners shares this level of quality excellence in its anesthesia billing process.

AQI’s registries provide regular reports on patient outcomes and business efficiency, showing both trends over time and comparisons to national benchmarks. AQI data provides the measuring stick for continuous quality improvement in the field of anesthesiology.

AQI was developed in 2009 as a non-profit affiliated organization of the American Society of Anesthesiologists (ASA). AQI’s work complements and enhances the efforts of ASA and other organizations such as the Anesthesia Patient Safety Foundation, the Foundation for Anesthesia Education and Research, the National Surgical Quality Improvement Project and the Surgical Alliance.

As the largest registry in the country, AQI’s vision is “to be the primary source of information for quality improvement in the clinical practice of anesthesiology,” through the maintenance of its 9 registries. More registries are in the works including the Maternal Quality Improvement Project and the Global Outcomes Registry.

AQI’s registries are organized to help physician anesthesiologists and their groups easily submit case information and receive reports that identify existing gaps in knowledge or clinical application. Data are presented so as to demonstrate changes over time and group performance in the context of national and peer-group comparators. The reports help physician anesthesiologists and their groups understand how their clinical outcomes compare to others in similar practice environments. Aggregate data from AQI registries is also available to researchers and professional societies interested in documenting trends in the national practice of anesthesia.

The National Anesthesia Clinical Outcomes Registry (NACOR) was launched on the first of January in 2010 with only 6 practices. Today, NACOR includes over 20 million cases from more than 220 contributing providers. There are 2,000 facilities and over 15,000 anesthesiologists participating in the registry; between 25 to 30% of the clinically active anesthesiologists nationwide. There are currently 44 states that have practices participating. These numbers are constantly growing as more facilities and practices recognize the need for registry data and external benchmarks. With the current changes in regulatory requirements and the demands of non-federal payers, registry participation is becoming less of an option and more of a need. The Center for Medicare and Medicaid Services (CMS) has recently changed requirements for the Physician Quality Reporting System (PQRS) giving providers penalties for not reporting beginning in 2016. Due to this reform, registry participation is going to become increasingly desired by most anesthesiologists.

AQI just recently became a Qualified Clinical Data Registry (QCDR). This opens up more reporting options for anesthesiologists, with up to 19 measures now eligible for reporting. For successful participation in PQRS for incentive purposes using a QCDR, an individual eligible professional must report on 9 measures across 3 National Quality Strategy domains, including (one outcome measure)
for 50% of all patient cases related to the measure. Measures reported can be a combination of PQRS and non-PQRS measures. AQI and ASA worked collaboratively to create the current non-PQRS measures. For more information on PQRS reporting visit the AQI website https://www.aqihq.org/PQRSoverview.aspx.

In early 2013, AQI released the Participant User File (PUF): An aggregate, de-identified, clean version of selected NACOR data fields. This data is being studied by more than a dozen researchers from institutions including Harvard, Vanderbilt, Yale, the Mayo Clinic and Weill Cornell Medical College. Data has been published in several peer-reviewed journals. The latest publications appeared in the Journal of American Geriatrics Society “Patterns of Surgical Care and Complications in Elderly Adults” by Stacie Deiner and in Anesthesiology News “Anesthetic Choice for TKA Cases Tied to Board Certification” by Peter M. Fleischut. The AQI is using this information internally to provide high-level dashboards of summary data for ASA and state society leaders, important ASA committees and anesthesia subspecialty societies. Information and instructions for accessing AQI data can be found on the AQI website http://aqihq.org/puf_inquiry.aspx.

The Anesthesia Incident Reporting System (AIRS) has been consistently growing. Currently it has more than 1200 serious adverse events, unsafe conditions, and near misses; more than 60% were designated by the submitters as potentially preventable. The AQI is seeking ideas on how to grow the AIRS registry further. AIRS has currently submitted over 40 written items for the ASA NEWSLETTER highlighting opportunities for improving care. These case reports are available online at http://www.aqihq.org/casereportsandcommittee.aspx. A mobile app for reporting these events was recently released and is available through Apple and Google Play by searching “AQI AIRS”.

Last year, AQI began to participate in new ASA quality initiatives. The first was the Anesthesia Quality Meeting (AQM), which has proven to be enormously popular. The first of these meetings took place in Chicago in November of 2013 and the most recent in Dallas in April. This meeting is a weekend course that is intended for anesthesia department quality management officers and is designed to teach the basis of quality management in anesthesia practice. This meeting sells out quickly and the next is set to take place this coming November 2014. Another continuing initiative is the partnership with ASA’s Quality Management and Departmental Administration (QMDA) Committee’s “Quality Consultation” program to provide high-functioning anesthesia practices with national benchmarking of their efforts, documentation of clinical performance, and suggestions for further improvement. The consultation is based on a review of practice structure, NACOR data, personal interviews, and a one-day site visit by a team of experienced, practicing anesthesiologists.

For more information on quality consultations with AQI, physicians and staff may contact Dr. Richard Dutton, M.D., MBA, at R.Dutton@asahq.org.
CMS is increasing its scrutiny in the payment of post operative pain blocks. This has been most relevant with Wisconsin Physician Services (WPS), the Medicare payer for Iowa, Kansas, Missouri, Nebraska, Indiana and Michigan, and with Noridian, the Medicare payer for Washington, Oregon, Idaho, Montana, Wyoming, North Dakota, South Dakota, Utah, Colorado, Alaska, Hawaii, California and Nevada. Per the CMS National Correct Coding Initiative (NCCI) policy manual, post operative pain management is considered to be the surgeon’s responsibility and payment for this is bundled into the surgeon’s fee for the surgical procedure. In instances where additional post operative pain management is required, CMS allows the surgeon to transfer this care to another provider (ie, the anesthesiologist) provided certain criteria are met. These include the following:

- There is a written request from the surgeon
- The adequacy of the intraoperative anesthesia is not dependent on the pain block

These rules haven’t changed; it seems that only the enforcement of the documentation requirements has changed.

In November 2013, Noridian implemented an Local Coverage Determination (LCD) for nerve blocks that contain the following:

*Reimbursement for the control or management of acute pain in the immediate postoperative period is generally packaged into the payment for the surgical procedure. However, if a need for transfer of pain management is documented and ordered by the surgeon and the accepting provider documents the need for and acceptance of transfer of care, separate reimbursement may be made for the service.*

During the WPS Anesthesia Services Teleconference on April 17, 2014, participants were informed of their intent to deny all claims in relation to post-operative pain blocks. WPS stated that when appealing a claim that has been denied, the surgeon’s written request for the post operative pain blocks and why it was necessary to be performed by another provider should also be submitted. They stated this edit cannot be automatically overridden with the -59 modifier, and their plan is to review every post operative pain service for both the surgeon and anesthesiologist documentation. Providers from Florida who attended this teleconference stated that CIGNA has implemented this increased scrutiny as well.

It has become increasingly prevalent that payers are examining the documentation associated with these post operative pain blocks, and more specifically, they are looking for the order from the surgeon containing the request for the pain management services. Many groups are changing to a block form that includes the order for the transfer of care for these services along with the rationale.
for the transfer with a place for the surgeon to date and sign the form. Regardless of the methodology used to capture the necessary documentation, providers will have to incorporate this required information somewhere within the medical record in order to be reimbursed for pain blocks. It will be only a matter of time before the list of payers requiring this information grows.

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Zotec Partners Hires Medical Billing Veteran Mark Scruggs as Partner of Corporate Strategy

Zotec Partners (Zotec) is pleased to announce that it has hired esteemed industry veteran Mark Scruggs, as a partner of corporate strategy.

Scruggs, a co-founder and partner of former EmPhysis Medical Management, has more than 25 years of experience in health care billing. Zotec acquired EmPhysis Medical Management in 2007. Mark worked to successfully transition the business to Zotec and then left in 2011 to pursue other opportunities. Since that time, Mark has maintained close ties with Zotec, and being aware of the exciting accomplishments Zotec has achieved these past few years, recently made the decision to rejoin its team.

Zotec is now one of the largest revenue cycle management (RCM) firms in the U.S. The company provides billing and practice management services to hospital-based physicians in the specialties of radiology, anesthesia, pathology and emergency medicine.

According to Mark Scruggs, “Zotec is a revolutionary company that has grown within the medical billing industry by leaps and bounds in the last decade. The technology it has developed is unmatched, and the level of expertise and client service it provides continues to give it a stronghold across the specialties it serves. I look forward to being a part of this innovative company again and helping it solidify its presence across the hospital-based markets.”

“Mark is a respected and well-known professional in the medical billing industry, and I am excited he is reuniting with the Zotec family. He will be a significant asset to Zotec’s team not only because of the knowledge and expertise he brings, but also because he shares the same passion we have for our clients’ success,” adds Zotec’s CEO and Founder, T. Scott Law. “Hiring Mark further demonstrates that Zotec is the leading authority in billing and practice management for hospital-based physicians, because it means we are attracting the highest caliber of people who can provide the expertise and service that cannot be found elsewhere in the industry.”

Zotec is the industry leader in specialized medical billing and practice management services for the hospital-based specialty market. The company is committed to the continuous pursuit of excellence in the physician revenue cycle and practice management industry by delivering effective solutions through its innovative software, personalized service and measurable client results. Zotec proprietary processes and technology manage in excess of 70 million medical encounters across all 50 states.

For more information about Zotec Partners, visit http://www.zotecpartners.com.
Join Zotec Partners' Anesthesiology Book Club

Join Zotec Partners' Anesthesiology Book Club and Get Your Free Copy of "ePatient 2015: 15 Surprising Trends Changing Health Care" today! The book explains how digital technologies, history, legislation, and culture are combining to rapidly transform how consumers manage their care and interact with each other and their providers.

Zotec would like to extend a special invitation to our anesthesiology book club for an insightful discussion about "ePatient 2015: 15 Surprising Trends Changing Health Care" by Rohit Bhargava and Fard Johnmar.

Participation is simple:

Step 1: Complete the electronic form found here. Once completed, we will send you a copy of this intriguing and informative book.

Step 2: We will provide you with a reading schedule and points to consider as you read the book.

Step 3: At the end of the allotted reading time (October 14, 2014) and as a refresher on those points most critical to our discussions, we will provide a summary about the book.

We look forward to receiving your information and discussing this book with you during the next few weeks!