



S U M M E R 2 0 0 9

Doctor Perspectives

Transparency of President's HIT Bill

Well, it is official, President Obama has signed the American Recovery and Reimbursement Act of 2009, which includes \$20 billion for Healthcare IT. What this means for physicians is the purchase of an EMR through a conditional "IOU."

Here are some of the details of the legislation and its potential impact to physicians.

First off, it is voluntary and the government is not requiring a physician to purchase an EMR. You are free to select a digital solution that best meets your needs. The incentive is a maximum of \$44,000 per physician, depending on when you implement the EMR, and is paid out over five years.

It is necessary to weigh the value of these payments against the costs of purchasing an EMR, especially one

you might otherwise not select due to capital costs, implementation challenges, and negative impact on physician productivity and practice efficiency.

Next, if you qualify, you are required to adopt specific standards of EHR technology – calling it "meaningful use." Meaningful use requires that you demonstrate to the satisfaction of the Secretary of Health and Human Services these certain capabilities, which include ePrescribing, interoperability and reporting. The standards will be developed by the government by year end; however, they will likely be in line with the current CCHIT criteria.

What you may not know is the law states that meaningful use become more stringent each year, but it

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RACs Are Rolling Again

The brief moratorium in further expansion of CMS's Recovery Audit Contractors into additional states was lifted on February 4, 2009, and most Mid-South states will become subject to RAC scrutiny in *August 2009.

Region C, which includes Alabama, Arkansas, Georgia, Louisiana, Mississippi, North Carolina, *Tennessee, Virginia, and West Virginia, will be audited by Connolly Consulting Associates, Inc. of Wilton, Connecticut. Connolly is currently active in Colorado, Florida, New Mexico, and South Carolina.

RACs gained notoriety early in their testing phase for certain anti-provider behaviors which have been curtailed in the nationwide roll-out due before January 1, 2010. RACs must now employ certified coders to conduct their audits and must pay

providers underpayments as well as collect overpayments. The dreaded "extrapolation" and alleged ruthlessness of the RACs are, alas very much still part of the new regime.

The extrapolation works like this:

A provider is notified by the RAC to submit chart documentation which will substantiate the charges of specified claims, representing a random sample of a certain set of claims. The provider does so and the audit occurs. In the resultant report the RAC identifies a fault with the documentation or claims (miscoding E&M level, questionable medical necessity, etc.). The portion of the sample found to be in error is then "extrapolated" to all claims in that set paid over a certain period, up to

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New Tennessee Taxes on Rental of Commercial Property

Family-owned limited liability entities, such as LLCs, LPs, and Family Partnerships, have until now escaped the 6.5% Tennessee excise tax on profits and franchise taxes due to a family-owned non-corporate exemption (FONCE). In addition to ownership requirements, most of the gross income had to be earned from passive sources (such as rent, dividends, interest, etc.). A new law effective July 1, 2009 changes the rules so that most rents are no longer considered passive. **Many rental entities will now be subject to these Tennessee taxes.**

Example: Smith & Jones Clinic rents its facility from Smith Heirs LLC, owned by you (the only physician amongst the heirs) and your siblings. The LLC earned a profit of \$200,000 on the rental of its new \$2,000,000 building. In 2008, it was not subject to Tennessee excise or franchise taxes, due to the FONCE exemption. After



July 1, 2009, it no longer qualifies for the FONCE exemption and will owe annually \$13,000 in excise taxes and \$5,000 in franchise taxes. A total of \$18,000, or 9% of the rental profit, is now payable to the Tennessee Department of Revenue.

Ownership of real estate in an LLC or LP has been very popular due to liability protection for the owners and favorable federal tax rules.

Rents from residential property are still passive if you are renting less than five residential units. Most farm property rentals are also still considered passive. The options un-

der these new rules are still evolving, and taxpayers need to consider all alternatives prior to taking action.

What should you do if you are affected?

It is time to be creative and plan for these taxes. One solution does *not* fit all and some LLCs will simply need to pay the tax. The amount of rents paid might require changes. On the other hand, you could elect to forego limited liability status by either filing as such with the Secretary of State or converting to a general partnership. Alternatively, the real estate may need to be contributed back to the lessor. There are a number of possibilities and all require thorough analysis.

Most importantly, you should have a good tax advisor and brainstorm ideas to protect you from a surprise next April. The time to plan is now!

The Region 10 Medicare Part B transition from CIGNA Government Services to Cahaba has been moved up from September 1, 2009 to August 29, 2009.



**If you live in the river,
you should make
friends
with the crocodile.
~ Indian Proverb**

Transparency of President's HIT Bill

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does not make clear how measurements will be defined, evaluated, and enforced.

The earliest payment year is 2011. Payment schedule is as follows:

Year 1: \$15,000 or \$18,000

Year 2: \$12,000

Year 3: \$8,000

Year 4: \$4,000

Year 5: \$2,000 (average of \$8,800 per year)

To receive the full amount, the EMR must be implemented by 2012. To receive any incentive payments, the EMR must be implemented by 2014. No payments are made after 2016. Also, in 2015, a one percent reduction in Medicare Reimbursement will affect non-participants, which increases to two percent in 2016 and three percent in 2017.

As you would imagine anything offered by the federal government is not always physician friendly. The incentive to participate in this "IOU" has significant risk which falls entirely on the phy-

sicians and medical practices. Purchasing one of these does not guarantee any incentive payment. If you cannot prove that you are actually using the Electronic Medical Record in the way, and to the full extent, that the government is "looking" for, and to the full extent that the government requires, you will not qualify for the government payments. In fact, it is quite possible you could prove that you meant meaningful use in the beginning, but as the law changes to become more stringent, you could be forfeiting any future payments.

If there is one lesson that we should have learned with any federal programs for healthcare, be prepared for the government's proverbial "carrot and stick."



“Men do not care how nobly they live, but only how long, although it is within reach of every man to live nobly, but within no man’s power to live long.” Seneca

Effective 7/1/2009 the following became effective in CMS’s National Correct Coding Initiative database:

3565 new edit pairs, most of which cannot be bypassed by using a modifier; and 6090 terminated edit pairs, 5002 of which are retroactive to last quarter (which means if these got denied or if you didn't bill them because they failed your claims scrubber, you can now re-file & likely be paid). On the Outpatient Code Editor database, there are 22 terminations and 17 modifier changes which combine into a whopping 303,954 new edit pairs. *[If you want more information or detail on these (oh, surely not!), contact WUHCG’s Mary Ann Lucas.]* Kind of makes you want to go back to when doctors drove Buicks, accepted bushels of potatoes in payment for services, and occasionally actually got to care for patients.

RACs Are Rolling Again

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three years. The provider must then rebate the amount allegedly paid in error from all such claims.

For example, a RAC audit of 100 randomly-selected claims for office consults reveals that the records of 19 of them did not document a request from another practitioner or a report back to that practitioner. Therefore, these patient services should have only been reimbursed as office visits, and the provider must rebate the difference in payments. However, the RAC may assess, not the rebate of payment differences in those 19 claims, but in 19% of all payments for office consults back to 2007.



What can a practitioner do to protect his practice from such a scenario up front?

Not much, beyond documenting and claiming absolutely perfectly.

One possible preventative measure is to review (and update, if necessary) your compliance manual. If you're behind on the chart audit schedule it specifies, take steps to get caught up. In the conduct of the audits, deficits in documentation or coding habits may be identified. Schedule in-service training to prevent any such identified problems from continuing. You will, in particular, want to research any services which may have been claimed in error due to these problems. Self-disclosure and voluntary rebate of overpayments is the safest path to follow in this circumstance. RACs are constrained from taking actions on claims which are in steps of self-disclosure.

*[*A blackout period around the beginning of a new Part A MAC (what we're calling Medicare carriers and FIs these days) may postpone the RAC program past 8/1/09, however. Such a blackout applies to Tennessee because of the Part B crossover from CIGNA Government Services to Cahaba on September 1; RAC is therefore pushed back to December 2009.]*

MRSA Diagnosis Code Update

In response to the near-epidemic upsurge in methicillin-resistant *Staphylococcus aureus* (MRSA) cases and “a sudden, unrelenting rise of community-acquired infections” over the last 10 years, the ICD-9 CM has been updated to provide specific diagnosis codes just for MRSA. 041.12 should be “used as an additional code to identify the bacterial agent in diseases classified elsewhere.” MRSA septicemia has its own code, 038.12, and is specifically excluded from 041.12. For methicillin-resistant pneumonia due to staph aureus, use 482.42. There are parallel MSSA codes for those cases susceptible to methicillins. Lacking a Boolean “not” operator to affix to the E870 – E876 external codes, there is, alas, no code to distinguish community-acquired cases from the more expected hospital-related.

URGENT: Tennessee Identity Theft Alert

Due to the critical nature of the following, we are including it in its entirety. Please also note that the communiqué mentions both the CMS 588 form and the CMS 855 form, each of which could easily be mistaken for the other.

April 24, 2009

CIGNA Government Services (CGS) in cooperation with the Tennessee Medical Association has determined that the upcoming transition of services to Cahaba GBA, the Jurisdiction 10 Medicare Administrative Contractor (MAC), may provide an opportunity for identity theft.

During the transition you will be asked to complete the CMS form 588 Electronic Funds Transfer Authorization Agreement (EFT). You will receive a written request for this form via the mail system.

CMS contractors will not request items be faxed unless you have recently submitted an application and are updating information for that application. **If you have any question as to the authenticity of a request you should validate the request by calling CIGNA Government Services as noted below.** Do NOT call any phone number that may be listed on the request.

If you receive a fax, mailing or other communication that requests you to complete a partial CMS 855 enrollment application or other CMS form, please verify the request by calling the Tennessee Provider Enrollment call center at CIGNA Government Services until 9/1/2009. That telephone number is 1-866-824-8572 and is staffed between the hours of 8:30 AM to 4:30 PM Monday through Friday.

The CIGNA Government Services Provider Enrollment web site is located at:

<http://www.cignagovernmentservices.com/partb/enrollment/>.

For more information regarding the Jurisdiction 10 Implementation, please visit the Cahaba GBA Implementation website at: <http://www.cahabagba.com/j10/index.htm>.

Tips for Protecting Your Identity:

- * Know who you are providing your personal information to.
- * Educate your entire office staff on the importance of protecting this information.
- * Monitor correspondence between your office, Medicare and other insurance companies.
- * Shred all sensitive documents that do not require retention.
- * If you suspect your identity has been compromised, contact CIGNA Government Services immediately. Retain any documents that may be useful to law enforcement.
- * Protect your information in the same manner as you protect the patient's information.



In Tennessee as of July 1, 2009 the tamper-resistant features previously required of paper prescriptions for Medicaid beneficiaries are now required for all patients.

Roth IRA Conversions – Available to All

The Roth Individual Retirement Account (IRA) has existed since 1998. Roth IRAs are an excellent tool for wealth accumulation because the earnings accumulate tax-free. Withdrawals are tax-free as long as certain requirements are met. In addition, the Roth can be a useful instrument in estate planning. Unfortunately, many physicians have been barred from both contributing to a Roth IRA and converting other retirement accounts to Roths due to low adjusted gross income (AGI) limitations. Although there are no pending changes regarding income limits for contributions, many high income taxpayers may benefit from an upcoming change to the rules for conversions.

Beginning in 2010, there are no AGI limitations – anyone can convert a retirement plan to a Roth IRA. You will owe tax on amounts attributed to pre-tax contributions and earnings when you execute the conversion. For 2010 conversions only, there is a special tax rule that applies, unless you elect out of it – you are taxed on the income in 2011 and 2012. Because tax rates in 2011 and beyond are scheduled to be higher than

current rates, you should consider electing out of the two-year spread. Also keep in mind that the repeal of AGI limits is permanent – you don't have to do it all in 2010. You can convert portions of your eligible retirement plan accounts over several years.

If you are thinking of converting to a Roth IRA, planning is essential. There are some traps and opportunities to be aware of. Owners of multiple traditional IRA accounts require careful analysis because a withdrawal from one account is deemed to be pro-rata from all accounts. In addition, there is a strategy you can use when you convert – setting up separate Roth IRA accounts for asset classes that are expected to perform differently. This protects your funds and may result in tax savings in the event of an unanticipated decline in one class.

Your strategy also needs to consider asset protection. Before converting, look at state law and exposure to creditors. Now is the time to begin to look at your options. If you are thinking of converting, contact us. We can help you develop a customized strategy. Please contact Renee Goetzka, rgoetzka@wucpas.com.



e-Prescription Help at Hand

If your investigation and consideration of an e-prescribing system has you bogged down worse than a turtle in a tar pit, there is good news: help may be close at hand. In collaboration with the American Medical Association, the American Academy of Family Physicians, the American College of Physicians, the Medical Group Management Association, and the Center for Improving Medication Management, an organization called eHealth Initiative (sub-titled “Real Solutions, Better Health”) offers for free download “A Clinician’s Guide to Electronic Prescribing”, a 43-page fairly comprehensive primer on the subject, including a buyer’s guide. Find it at www.ehealthinitiative.org/eRx/ and click on the Clinician’s Guide.

For another bright spot in an otherwise murky and perilous sphere, check out www.nationalerx.com/index.htm. Their particular offering is a free, online, stand-alone e-prescribing system. Wait, now, before you dismiss this as a hoax hands-down, check out their “Sponsors” and “Supporters”.

We explicitly do not endorse any of the products or opinions on either of these websites, but the more you know, the better decision you’ll make when (not if) you select an e-prescription system. Contact WUHCG President Bill Appling for help getting to that point.

Vendor Contracts: *Caveat Emptor!*

In today's medical practices, it is critical to discuss business issues, future strategy, and which vendors on whom to rely. This is especially true when dealing with electronic medical records/e-Prescribe (EMR/e-Rx) vendors, outsourced IT contractors, and off-site data backup companies. You will want to obtain insight from your staff and consultants while considering any contract that could ultimately have a negative impact on the entire organization or potentially place patient care or information at risk. Point 1: read the contracts carefully before signing.



Many vendors describe the benefits of their systems and services, but few take the time to review their contracts with you. Remember, their interest is not the same as yours. Most vendor agreements are heavily weighted in their favor and provide little or no recourse for the physician. When reading contracts, assume the worst scenario can happen. Are all the gaps filled? Point 2: negotiate items not mentioned in the contract or which would be onerous and expensive for the practice.

Look at alternative vendors to determine who has the best services, the best terms and conditions. Confidentiality, integrity, availability, and mobility of patient data are critical areas you need to review thoroughly. Take the time to make an informed decision. Point 3: when contract provisions are not clear or if important considerations are left out, have a third party review the contract to help you determine where you are at risk or to uncover future ramifications.

Below are some critical questions to ask about contracts related to EMR/e-Rx vendors, outsourced IT contractors, and off-site data backup companies:

Under what terms can I terminate the agreement?

Can I move my data (patient data, business data, etc.) when the contract is terminated, or does the vendor retain my data?

If my practice merges with another that has an EMR in place, can I take my data to the newly formed group?

What service level guarantees (database uptime, performance guarantees, mean time to repair, technical support response times, third-party obligations, data integrity, etc.) does the vendor offer?

Does the disclaimer of warranties only protect the vendor, and if so, what is the risk to my practice?

What are the limitations of liability, and will these limitations put my practice at risk in the event a patient suffers injury due to vendor negligence, incorrect data-set input, or other unforeseen errors (know as "hold harmless" clauses)?

Does the vendor offer redundant data centers whereby I can redirect or access my data or patient data requests to/from an alternate site if the primary site were "dark" or inaccessible?

It is in your best interest to scrutinize every word in the contract. Seek the advice of an attorney as well as someone in the technology industry to determine what language is acceptable, what needs clarification, and what further changes need to be made to protect your practice. It is your ultimate decision, but take the necessary steps to protect your patients, your business, and your staff. The list of questions above are just a few you need to ask....there are many more. Take the initiative, take the time, communicate well, do the research, and make an informed decision.

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Watkins Uiberall Healthcare Consulting Group, LLC
1661 Aaron Brenner Drive, Suite 300
Memphis, Tennessee 38120

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GROUP, LLC

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Experience.
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Memphis Office

Mary Ann Lucas
1661 Aaron Brenner Drive
Suite 300
Memphis, TN 38120
(901) 761-2720
mlucas@wucpas.com

Tupelo Office

Randy Gammill
499 Gloster Creek Village
Suite F-9
Tupelo, MS 38801
(662) 269-4014
rgammill@wucpas.com

www.wucpas.com

FTC's Red Flag Rules – is your practice in compliance?

November 1st is the commencement date of the FTC's Red Flag Rules – is your practice in compliance? These regulations govern how creditors (including medical practices which bill patients) safeguard against identity theft of those to whom credit is offered. They also have the rare distinction of making good business sense. Contact WUHCG's Virginia Pierce for a complimentary compliance kit.

