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The Business of Medicine Newsletter

"Leave the Business of Medicine to Us"

DOCTORS® MANAGEMENT
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Special Features

Let Us Show You How to Get Back to Being a Doctor

Inside DoctorsManagement: Message From the President

Welcome to the launch of *The Business of Medicine Newsletter*. This is a free service to clients and customers of DoctorsManagement and NAMAS. This newsletter is purely for informational purposes and not a way of selling services. You are already our clients and customers. With the volume of work we deal with each day, there is not a lot of time left to be able to research and keep current on news and other critical happenings. It is our goal to provide you with the most important news each month as well as a detailed analysis of how it will impact you and the guidance you need to ensure that when you act, you do so in an effective and efficient way. This newsletter will arrive in your inbox on or about the 20th of each month.

This is only January, yet there are already so many major things taking place within the healthcare industry. The Centers for Medicare & Medicaid Services (CMS) announced the impact of the implementation of the American Taxpayer Relief Act of 2012. The law provides relief to physicians in the way of elevating the scheduled 26.5 percent sustainable growth rate (SGR) formula cut for 2013. This means, according to The CMS, that the 2013 conversion factor will be $34.0230.

The Department of Justice announced that False Claims Act recoveries in 2012 set records, including for healthcare recoveries, which topped $3 billion. The Justice Department recovered $4.9 billion in settlements and judgments in civil cases for the fiscal year ending Sept. 30, 2012, surpassing last year's record by $1.7 billion. A record number (647) of those cases were filed under qui tam, or whistle-blower, provisions. Of the $4.9 billion recovered under the False Claims Act in 2012, $3.3 billion was recovered in whistle-blower suits. While there are definite risks, practices need to be forward thinking and proactive to ensure your ability to thrive in economic uncertainty and an age of stepped up enforcement. The remaining articles within this newsletter are written by internal faculty whom are considered to be among the best and brightest in the industry, within their respective area(s) of specialty. I sincerely hope you enjoy this edition of *The Business of Medicine*.

Yours in Success,

Paul King,
President
DoctorsManagement

Increasing Collections Through the Reductions of Bad Patient Behavior

Collections is both an art and a science that, when performed in conjunction, leads to positive outcomes. Practices without doubt continue to struggle both in dealing with payors and with their patients. However, there are steps to be considered and implemented to ensure successful collections moving forward.

Let's begin with the structure of your office policy surrounding patients. What's that? You say you don't have a real policy… Well, don't feel bad because most practices, outside of a plaque on the wall that says, "Payment is expected at the time services are rendered", don't have a policy either.

You need to have a policy that is firm but flexible. However, for a policy to work, everyone in the office must support it- this includes the physicians. I recommend sending statements only to those patients with a balance large enough to outweigh the costs associated with sending up to threee statements. The average cost of sending a statement is $10.00. If you send three statements to a patient that owes $10, then your cost of collecting exceeded the amount you were trying to collect. For patients who owe less than $40, send one statement and then follow up with two to three phone calls over a 90 day period. If they ignore the calls and the statement, flag their account so when they call to make their next appointment the scheduler will know to place them on hold and transfer the call to either the office manager or the person in charge of collections. Once the patient has paid their outstanding balance, they can be scheduled. Of course if you have a patient that owes hundreds or even thousands of dollars, you will have to work with them to create a financial payment plan that makes sense and they can keep up with. (cont. on p. 2)

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Increasing Collections Through the Reductions of Bad Patient Behavior cont.

Let them specify the amount they want to pay. That way if they indicate down the road it is an unreasonable amount, you can remind them they chose that amount to pay. Use a Federal Truth in Lending form to outline the repayment terms and get the patient to sign it. Make sure that when you set the repayment terms they are at an amount significant enough to actually make a dent in the balance, and make sure it is an amount that will allow their balance to be paid off in a reasonable timeframe.

Most practices suffer due to the entitlement mentality of a small but disruptive group of patients. These patients each month cause your staff to have to make dozens of costly referrals of severely delinquent accounts to collection agencies, which lead to a loss of money for your business. Stop sending statements every month because no matter how many you send, they are not going to pay. If you spend staff time calling them and they have caller ID, they know who is calling, thus allowing them to dodge your calls. This results in your employees feeling powerless and deflated.

Patients seek out your services when they are not feeling well or something appears to be off. They have to meet the financial obligations they accepted when they sought medical care from your practice.

Begin by taking a deep dive into your A/R and what you will quickly find is that the majority of accounts you're sending to collections is somewhere between 10-20% of repeat offenders – people who have been sent to collections multiple times yet they continue to present to your office for care.

Why continue to see people who have no concern for your financial well being? They don't respect the fact that they have financial obligations and this leads to significant problems for your business. Break the cycle and regain control of your practice. For too long practices have allowed patients to dictate how you run your practice.

You have to establish rules from the start and ensure **your customers** are abiding by them. If you live in a small town I know it feels like it is more difficult because of the likelihood of outside interaction between the physicians and patients. However, when you go to Macy's or your local supermarket, do you take the items you need and want and simply walk to a cashier and tell them to send you a bill? Of course not, they would look at you like you had four heads. So, the question becomes; why do you allow that in your practice? STOP the insanity and start treating your practice like the for profit money making business it is intended to be. You shouldn't feel awkward running into patients who don't pay their bills; they should feel awkward for scamming the system.

Don't forget that when you address your collection policy you have to also address your collection agency to ensure they are doing what they claimed they could and would do. Typically when an agency collects, you tend to get a very small share. Look for an agency with a commission rate less than 35% (typically rates run between 35-50%) but who can show they are collecting at a rate higher than the national average, which is around 30%.

Making changes will improve not only your bottom line but also staff morale. Making the change will greatly reduce the number of delinquent accounts and keep more of your money in-house. Collecting at the time of service is your best opportunity to capture the monies you're entitled to. At the end of the day, you and your patients will take the business side of medicine more seriously by making these changes. You have worked hard to create the optimal care center for your patients; now with the introduction and enforcement of a solid collection policy you will realize more of your patients doing their part to make the doctor-patient relationship successful.

Sean M. Weiss
Vice President and
Chief Compliance Officer
DoctorsManagement, LLC

DM University has launched new courses. For more information log on to www.dmuniversity.net

Managed Care: Provide teeth to your managed care negotiations

So many times providers tell me that the Payors just will not listen to their requests for more money. Almost every time I ask what they said to the Payor, they tell me "We told them we were a good quality provider" or "We are credentialed or certified in that area" or "Our patients love us", or that "We just deserve more money". All very noble attributes, but to really put some teeth in your negotiations, you need to negotiate with data. Managed Care Organizations are data driven organizations and that's the language they speak.

What data sets do you need? There are basically three data sets that must be compiled:

- First, you need to know the cost of your services. The cost can be determined by using the Medicare RBRVs units for each CPT code. Use a weighted average of the codes instead of a straight average to help determine the true impact a rate increase has on how much you actually get paid. It's possible to get a very large straight average increase that produces very little revenue. The weighed average reveals this ploy.
- Second, you need to know your frequency distribution (how many times you do a particular CPT code). This is used in the calculation of the weighted average. The codes you use the most are your most (cont. p. 4)

Accounting: 2012 American Taxpayer Relief Act—Individuals

On New Year's Day 2013, Congress passed a far-reaching new law intended to avert the so-called fiscal cliff. The American Taxpayer Relief Act, signed into law by President Obama on January 2, 2013, impacts every taxpayer. Not only does the new law make reduced income tax rates permanent for most taxpayers, it extends either permanently or temporarily a host of other tax incentives. At the same time, the new law creates valuable tax planning opportunities. Not all provisions, however, are good for all taxpayers. Those individuals with income above $400,000 ($450,000 for families) are now subject to a new top income tax rate of 39.6 percent and a new capital gains maximum rate of 20 percent. All taxpayers will be taxed two percent more in 2013 than in 2012 on wages and self-employment income up to the Social Security employment tax wage base ($113,700).

Tax rates
The American Taxpayer Relief Act preserves and permanently extends the Bush-era income tax cuts except for single individuals with taxable income above $400,000; married couples filing joint returns with taxable income above $450,000; and heads of household with taxable income above $425,000. Income above these thresholds will be taxed at a 39.6 percent rate, effective January 1, 2013. The $400,000/$450,000/$425,000 thresholds will be adjusted for inflation after 2013.

The new law, however, does not extend the payroll tax holiday. Effective January 1, 2013, the employee-share of Social Security increased from 4.2 percent to 6.2 percent (its rate before enactment of the payroll tax holiday). The net result is that all individuals who receive wages (and self-employed individuals) will see less take-home pay in 2013.

Capital gains
Effective January 1, 2013, the maximum tax rate on qualified capital gains and dividends rose from 15 to 20 percent for taxpayers whose incomes exceed the thresholds set for the 39.6 percent rate (the $400,000/$450,000/$425,000 thresholds discussed above). The maximum tax rate for all other taxpayers remains at 15 percent; and moreover, a zero-percent rate will continue to apply to qualified capital gains and dividends to the extent income falls below the top of the 15 percent tax bracket.

Alternative Minimum Tax
The American Taxpayer Relief Act permanently patches the AMT by increasing the exemption amounts and indexing them for inflation.

Retirement savings
The American Taxpayer Relief Act makes a valuable change to the treatment of retirement savings and opens up an important planning opportunity. The American Taxpayer Relief Act lifts most restrictions and now allows participants in 401(k) plans with in-plan Roth conversion features to make transfers to a Roth account at anytime. Congress made this change because conversion is a taxable event and will raise revenue.

Estate tax
The American Taxpayer Relief Act aims to provide some certainty. Effective January 1, 2013, the maximum estate, gift and GST tax rate is generally 40 percent, which reflects an increase from 35 percent for 2012. The exclusion amount for estate and gift taxes is unchanged for 2013 and subsequent years at $5 million (adjusted for inflation). The new law also makes permanent portability and some enhancements made in previous tax laws.

Tax credits and deductions
The American Taxpayer Relief Act makes some of these incentives permanent and extends others. One of the most widely used tax credits, the $1,000 child tax credit, is made permanent.

Other popular tax credits and deductions for individuals made permanent or extended by the new law include:

- Enhanced adoption credit/exclusion (permanent); Enhanced child and dependent care credit (permanent); Enhanced student loan interest deduction (permanent); American Opportunity Tax Credit (through 2017); Higher education tuition deduction (through 2013); IRA distributions to charitable organizations (through 2013); Transit benefits parity (through 2013); Cancellation of indebtedness on principal residence (through 2013); Code Sec. 25C residential energy efficient property credit (through 2013); Teachers' classroom expense deduction (through 2013)

The American Taxpayer Relief Act also revives the Pease limitation and personal exemption phase out (PEP) for higher-income taxpayers after 2012. Generally, individuals with incomes over $250,000 and married couples with incomes over $300,000 will see both their exemptions and itemized deductions limited.

Planning opportunities
The American Taxpayer Relief Act opens tax planning opportunities because it impacts so many tax rules - everything from income rates to retirement planning. Congress intended to make permanent many of the changes, which creates a climate for tax planning unlike the recent past where uncertainty was the rule and not the exception.

T. Blake King , CPA, MAcc, CVA
Partner DoctorsManagement, LLC

DoctorsManagement is pleased to announce that our Group Purchasing Organization can assist small and medium sized practices in saving thousands of dollars each month. There are no upfront costs or long-term commitments. Call Craig King at 800-635-4040 ext 113.

HIPAA Tip of The Week

Passwords are paramount to HIPAA Privacy and Security compliance. Each user in the practice must have a unique logon password that allows him or her to access the portion of the practice management software and/or electronic medical record necessary to perform the job responsibilities assigned. The password should also prevent the individual from accessing parts that he or she does not need.

The American Medical Association recently published a study done by Verizon on the role of passwords in computer system security. It covered some statistics pertinent to healthcare and password security. We have summarized the information here.

The study, published in October 2012, revealed that 72% of cyber attacks on healthcare organizations resulted from hackers guessing or using an automated system to guess passwords and other logon credentials. Small practices, defined for this purpose as those with fewer than 100 employees, are particularly vulnerable due to a lack of basic security systems, firewalls, and "strong" or "hard-to-guess" passwords.

The lack of these measures allows savvy hackers to access protected health information and use it to steal the identities of the patients. The average cost per breached record was $194 in 2011. HHS is now fining covered entities for security breaches affecting fewer than 500 individuals.

Strong passwords are recommended as one measure to prevent breaches. A strong password has the following characteristics:
* At least eight characters
* A combination of letters and symbols.

The article suggested several ways to create and remember passwords:
* Use a short phrase with underscore spaces, such as "have_your_cake."
* Choose an easy-to-remember phrase and use the first letter of each word; substitute symbols or numbers where possible. For example, use "?HM! TD!TW_" for "How much is that doggie in the window?" The "?" at the beginning rather than the end would be stronger than one at the end, which could be a clue.
* Use the keyboard to create a shape. For example, "vgy7ujmnbv" creates a triangle.

Each person must have his or her own password that is not shared with anyone. Sharing passwords creates a risk and also makes it difficult to know who did what when an access report is pulled.

Cloud-based password managers, such as SplashID Safe, help individuals find forgotten passwords but should be used only if the master password is extremely strong. It is acceptable to write passwords down as long as they are not kept near the machines. "Tip sheets" with clues are also acceptable if they do not include the actual characters of the passwords.

Experts recommend changing passwords every 60-90 days. Some software systems require frequent changes and may even generate the passwords automatically. When an individual leaves the practice, that person's logon should be inactivated or blocked.

Ann Bachman
Partner
Regulatory Compliance Director
DoctorsManagement

Tips of the Month: Auditing

A few important tips for delivering your audit report:

- Face your fear of conflict.
- Be confident yet respectful.
- Be conscious of your demeanor.
- Speak persuasively not abrasively.
- Prepare a script and rehearse.
- Stay focused on what you want to communicate.
- Offer positive feedback first - what does the provider do well?
- Provide supporting documentation.

Remember that the most important role for an auditor is to be an educator. If your provider senses you lack confidence, or perhaps you come across as abrasive and judgmental, you may lose their attention very quickly and lose your opportunity to educate.

NAMAS Member Services

NAMAS will be visiting cities across the U.S. with their Certified Professional Medical Auditor (CPMA®) training. Visit www.namas-auditing.com for a full schedule of the classes and more information.

Managed Care, continued from page 2:

valuable codes. Guard against any decrease to your highly-used codes.

- Third, you need to be able to compare each Payor's reimbursement to both your cost to provide that service and to the reimbursement levels of the other payors. It's also a good idea to compare the reimbursement levels to your current charges, as many times your charges will be set less than the highest amount you could be paid. Be careful with this data as it is proprietary and cannot be shared outside the practice, with your peers, or with other payers.

When you have all of these data sets, you are ready to approach the boss for a raise. And you can talk with him, in terms that he will understand.

Bob Rotar
Sr. Management Consultant
DoctorsManagement

Reimbursement: Medicare Reimbursement Changes for 2013 and beyond

If the anxiety of the never-ending battle over the SGR Medicare cuts or PQRS, eRx, and Meaningful Use bonuses are not enough, there a few notable Medicare reimbursement changes to be aware of for the coming year and, most likely, beyond.

2013 Medicare reimbursement changes impacts several areas and specialties. Unless Congress and the Obama administration act, many localities are receiving a decrease in their Geographic Adjust Factor (GAF) resulting from the expiration of 1.0 Work Geographic Practice Cost Indices (GPCI) floor. As it stands, 53 out of 89 localities will be affected. The localities with the top decreases are Puerto Rico, Montana, South Dakota, Oklahoma, Rural Missouri, and Iowa. Each provider or practice should inquire with their local Medicare Administrative Contractor to see if they are in an affected locality.

Multiple Procedure Payment Reduction (MPPR)

Medicare has a longstanding policy to reduce payment by 50% for second and subsequent procedures furnished to the same patient by the same physician on the same day (e.g., surgical procedures, practice expense of therapy services, etc.). For 2013 we will see (MPPR) for:

1. Professional and technical components of advanced imaging, if furnished by physicians in the same group practice, same patient, same session, and same day.
2. A 25% reduction for the technical component for cardiovascular diagnostic tests for the same patient, same physician or physicians in the same group practice, on the same day.
3. A 20% reduction for the technical components for ophthalmology tests for the same patient, same physician or physicians in the same group practice, on the same day.
4. A reduction of 20% for subsequent therapy services will end on April 1, 2013, and rise to 50%.

Outpatient therapy caps that apply per beneficiary will increase from $1,880 to $1,900 for 2013. Be aware that CMS's authority to issue exceptions to the therapy cap expired December 31, 2012.

Medicare claims-based data collection will be implemented for therapy services in 2013. This program requires the use of a set of non-payable G-codes (G8978-G8999 and G9158-G9186) and modifiers (CH-CN) to report functionality and severity. Claims that do not have these codes reported will be denied effective July 1, 2013.

A three day payment window related to services prior to a hospital admission has been established by the Preservation of Access to Care for Medicare Beneficiaries and Pension Act. The act states that services furnished to a Medicare beneficiary in the three days prior to an inpatient admission in a facility wholly owned or wholly operated by the hospital are considered "operating costs of the inpatient hospital services" and included in the hospital's payment under the Inpatient Prospective Payment System (IPPS). In other words, if you are a provider employed by a hospital-owned practice, your diagnostic services provided three days prior to a patient's hospital admission are now bundled into the admission service, unless the hospital attests that the services are clinically unrelated to the later admission. Furthermore, the "related" non-diagnostic services will be paid at the facility rate. Physicians should append the new PD modifier to codes that indicate the services are subject to the three-day payment window.

Many physician practices may be unaware, but with the Affordable Care Act (ACA) comes a requirement of CMS (Medicare) to examine "potentially misvalued" codes in seven categories:

1. Codes and families of codes for which there has been the fastest growth;
2. Codes and families of codes that have experienced substantial changes in practice expenses;
3. Codes that are recently established for new technologies or services;
4. Multiple codes that are frequently billed in conjunction with furnishing a single service;
5. Codes with low relative values, especially those that are billed multiple times for a single service;
6. Codes which have been reviewed since the implementation of the RBRVS (the so-called "Harvard-valued codes");
7. Other codes to be determined by the Secretary of Health and Human Services.

In addition to identifying and reviewing potentially misvalued codes, the statue also requires them to establish a formal process to validate RVUs under the Physician Fee Schedule:

1. The validation process may include validation of work elements (such as time, mental effort and professional judgement, technical skill and physical effort, and stress due to risk) involved with the furnishing of a service and may also include validation of the pre-, post-, and intra-service time components of work.
2. The HHS Secretary is directed, as part of the validation, to validate a sampling of the work RVUs of codes identified through any of the seven categories of potentially misvalued codes specified in the ACA.
3. The HHS Secretary may conduct the validation using methods similar to those used to review potentially misvalued codes, including conduction surveys, other data collection activities, studies, or other analysis as the Secretary determines to be appropriate to facilitate the validation of RVUs of services.

These new requirements of CMS dictated by the ACA will no doubt bring many changes to multiple codes sets and reimbursements bursements for years to come; some good, some not so good. CMS understands there may be significant controversy over Medicare's adjustments, especially those parts of the ACA debate, and has requested the organizations such as the Institute of Medicine (IOM) and others to study the effects.

R. Kevin Townsend, CMPE, CPC, CPMA
Director of Coding, Auditing, and Reimbursement Services
DoctorsManagement, LLC

Special Announcements

DoctorsManagement would like to welcome a few new associates to the DM team.

Sean Weiss

Sean has taken on the role of vice president and chief compliance officer for DoctorsManagement. Mr. Weiss is recognized as an expert in compliance and has a proven history of helping large and small healthcare organizations maintain compliance and profitability—despite today's binding regulations. He has held executive level positions with some of the industry's largest and most respected organizations. He has also served on the Ethics and Compliance Steering Committee at Columbia/HCA that developed policies and procedures to help decipher complex regulatory issues.

David Miller

David joins DM as a Senior Management Consultant. Mr. Miller spent six years as the president of a large, physician-owned insurance company. With a proven history of guiding struggling healthcare organizations into profitability, Miller helps new clients regain control of practice procedures to improve profits. With a finger on the pulse of local, regional and national healthcare issues, Miller helps ease the stress providers and their managers feel as a result of the current healthcare climate.

DoctorsManagement is honored to add Sean Weiss and David Miller to its team of healthcare experts.

New DoctorsManagement Clients

Multi-Specialty Practice—Phoenix, AZ
Primary Care Practice—Tucson, AZ
Podiatry Practice—Brunswick, GA
Ophthalmology Practice—Brunswick, GA
Family Practice—Jesup, GA
Hospitalist Practice—Statesboro, GA
Women's Health Practice—Huntsville, AL
Cardiovascular Practice—Ft. Pierce, FL
Orthopaedic Practice—Crestview, FL
Chiropractic Practice—Jacksonville, FL
Wound Care Practice—Naples, FL
Audiology Practice—Ocala, FL
Podiatry Practice—Ocala, FL
Orthopaedic Practice— South FL
Internal Medicine Practice—Duluth, GA
OBGYN Practice—Leesville, LA
Multi-Specialty Hospital System—Hagerstown, MD
Neurology Practice—Hastings, NE
General Surgery Practice—Hastings, NE
Neurosurgery Practice—Hamilton, NJ
OBGYN Practice—Queens, NY
Pediatric Practice—Asheville, NC
Orthopaedic Practice—Kingsport, TN
Cardiology Practice—Knoxville, TN
Dermatology Practice—Danville, VA
Pathology Lab—Richmond, VA
Family Practice—Beckley, WV
Physical Therapy Practice—Amarillo, TX
Internal Medicine Practice—Ennis, TX

Focus on the Top Line

Like most of you, I have learned as much or more from my mistakes as I have from my successes. One of the biggest mistakes I made as a former business owner as well as an executive of a large healthcare company was giving more time and resources to the top bottom line instead of the top line.

In today's healthcare practice, decreasing revenue and increasing expenses are driving practice managers and providers to focus on reducing operational expenses.

Some examples of mistakes made around operations reductions that I see in the field include staff reductions at the front desk. Less staff to service patients at a critical moment in their experience with your practice can reduce the level of customer service your practice delivers and quickly lead to a lower patient volume.

I see many physicians and practice managers placing their focus on expense reduction instead of developing and implementing a strategic plan to grow their business. Many physician offices are multi-million dollar businesses that require a plan and forethought and not overnight austerity program. With a simple, strategic business plan that contains measurable goals and objectives for the practice and providers, you can be off to a great start toward financial and career success. You don't have to be an MBA and you don't need a ten-page document.

Here are some points to include in your plan to increase revenue:

- Increase your fees – Be prepared for your collection percentage to go down, however collections should increase.
- Do a coding assessment – Are you getting paid the optimal amount for your work? The investment in an assessment typically yields results that far exceed the expenditure for a coding professional to do an assessment. And you receive the added benefit of reducing your risk by reviewing your practice's coding and documentation practices.
- Renegotiate your Managed Care contracts – Everyone knows this, but very few practices make the effort. If you put off reviewing your contracts because you think you have to wait until your contract renewal date, think again. You can request an audit anytime and 90% of the time you will be granted the opportunity to review.

Here are some ways to grow your business:

- Network with other physicians that can give you referrals
- Have someone in your office focus on marketing, primarily electronic marketing.
- Focus on better customer service – If you are like most physicians, you think you have great customer service. To be quite frank, most physician offices aren't even close to meeting customer expectations, especially when it comes to serving patients under 40.
- Get on the chicken dinner circuit – speak to any group that will let you regardless of audience demographics, even if it is just for public speaking practice.

David Miller
Senior Management Consultant
DoctorsManagement