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The Business of Medicine Newsletter

"Leave the Business of Medicine to Us"

Inside DoctorsManagement: Message from the President

The Affordable Care Act and Decreased Reimbursement for Providers

Healthcare providers are often faced with making serious decisions, but how to deal with The Affordable Care Act presents as one of the most serious and complex decisions many practices have ever had to make. The questions surrounding this legislation are numerous and not as easy to answer as many on both sides of the argument would have you believe.

Regardless of your political affiliation, if you work in health care, you have to come to terms with the fact that your reimbursement may go down because of the federally run insurance exchanges and the Sustainable Growth Rate (SGR). The cause of this downturn in reimbursement could be contributed to rates for insurance premiums being set too low and a significant increase in the number of baby boomers eligible for Medicare.

Many providers may face a big challenge in understanding that the insurance companies participating in the exchanges negotiated rates for premiums with the government before negotiating reimbursement rates with providers. This may lead to rates for the new plans being set at levels less than the current Medicare rates.

Nearly one-third of all health systems are not profitable. Many of the most efficient systems are realizing a 4-5% profit margin.

Now is the time to start your strategic planning for 2014 to help ensure that your budgets are in place and compensation structures can be sustained, and to identify technology, employee and other resources needed to ensure your operations remain consistent. Don't wait until it is too late; there is nothing worse than having to play catch up! We are here to help.

Yours in Success,

Paul L. King
President
DoctorsManagement, LLC

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"Pay or Play" Mandate Delay Did Not Give Employers the Day Off

As many undoubtedly know by now, the Obama administration announced a one-year delay, until January 1, 2015, of the Patient Protection and Affordable Care Act (ACA) mandate that employers with 50 or more full-time equivalent employees provide health care coverage to their full-time employees or pay steep penalties.

The announcement by the U.S. Treasury Department said that the mandate's delay is intended to "provide time to adapt health coverage and reporting systems while employers are moving toward making health coverage affordable and accessible for their employees."

As a refresher, the ACA requires a "large employer" (i.e., an employer with at least 50 full-time equivalent employees) to comply with two mandates:

1. **Make Healthcare Coverage Available.** First, a "large employer" is required to offer healthcare coverage to their "full-time employees" and their dependents. A "full-time employee" for the purpose of this mandate is any employee who averages at least 30 hours per week in a given month. If a "large employer" fails to offer coverage to at least 95% of its full-time employees in any given month, the employer is potentially subject to penalty.
2. **Offer Healthcare Coverage that is "Affordable" and Provides "Minimum Value."** Second, if a "large employer" does offer coverage to its "full-time employees," that coverage must be "affordable" and it must provide a "minimum value." To provide a "minimum value," the coverage must be expected to pay at least 60% of the total allowable cost of

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Special Features

- "Pay or Play" Mandate Delay Did Not Give Employers the Day Off
- 1995 or 1997 Guidelines—Which Should We Use?

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

Inside this issue:

Attention COLA-Accredited Laboratories

COLA released a new Accreditation Manual in June 2013. The manual may be downloaded from a COLA Central account at no additional charge. COLA did not mail the manuals to their labs but rather sent notification of the new manual through its e-mail alert system.

COLA labs that do not have a COLA Central account are missing out now and will miss out more in the future as COLA goes paperless. Contact COLA to set up an account using your COLA ID number.

Meanwhile, we will summarize the changes for you. Basically, COLA now requires COLA –accredited laboratories to treat waived tests the same as nonwaived ones.

COLA now requires procedure manuals for waived tests, with the same information as for nonwaived tests. Manuals produced by AAPOL/ DoctorsManagement have always included waived tests.

COLA will now include in its survey (and has been for some time) documentation that the laboratory is following the manufacturer's instructions for quality control, specimen collection and handling, environmental requirements and expiration dates, and result reporting for waived tests.

COLA is putting even more emphasis on personnel competencies, modeling their criteria to comply with CLIA requirements but adding competencies for personnel performing waived testing.

CLIA and COLA require an evaluation using at least these six procedures for testing personnel who run nonwaived tests.

1. Direct observations of routine patient test performance, including patient preparation (if applicable), specimen handling, processing and testing;

2. Monitoring the recording and reporting of test results;

3. Review of intermediate test results or worksheets, quality control records, proficiency testing;

4. Direct observations of performance of instrument maintenance and function;

5. Assessment of test performance through testing previously analyzed specimens, internal blind testing samples or external proficiency testing samples; and

6. Assessment of problem solving skills.

At this point, COLA has not promulgated competency methods for personnel performing waived tests but suggests that the above six procedures will not be required. Perhaps a review of paperwork, checking expiration dates and quality control documentation, will suffice.

COLA also now requires its laboratories to enroll waived tests in proficiency testing and to treat proficiency testing for waived tests identical to proficiency testing for nonwaived tests. And of course—keep all records for a minimum of 24 months.

There have been some rumblings that CLIA may also start requiring proficiency testing for waived tests. It is simply the right thing to do!

Laboratory Procedure Manual

Both CLIA and COLA have always required procedure manuals for nonwaived tests. Very often these books come off the shelf once or twice per year—for the director to sign and for the surveyor to evaluate. Sometimes the lab staff members have trouble even locating them.

These manuals are invaluable tools that must be readily available to the staff and actually used by the staff. To ensure that this happens, each person in the laboratory should be required to review and sign the manual every year. In fact, this should be included in the competency evaluation. How can anyone be sure they are following the manufacturer's instructions and their own procedures if they have never even read it?

Ann Bachman
Partner, Director of OSHA Department
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Job Performance

In today's society, there are many of us that are worried about job security or even having a job. For those of us that are lucky enough to have a job, are we living up to out potential? Do we like coming into work or just going home? There has been a link between job performance and job satisfaction since the dawn of time—whether it was the caveman who, when inventing the wheel, could not wait until sunset to go home to his cave or the modern doctor that can't wait to leave the office to go home to his or her modern conveniences.

That person who says that they have no stress in their life is living in a monastery on top of some mountain. In an article by R. Shahu and S. Gole (2008), job stress relates to how satisfied we are with our job and how we perform at that job. The quality of work life goes down when the stress goes up. Several things are attributed to the reduction of stress. One was that being micromanaged caused stress. Once the employee was allowed to make more decisions on their own and not have to report to someone all the time, job satisfaction and performance was raised and job stress was lessened. Another stress reducer was teamwork. If people were allowed to gather ideas and problem solve in a group, production went up and tasks were completed quicker. This also reduced cost spent on time. These reductions in turn reduced the stress for management. It is often that performance can lead to job satisfaction instead of the other way around. When goals are set and achieved, performing well can lead to being happier on the job. This mostly happens in management or professional job settings.

How can you determine if employees are satisfied with their jobs? And if they are not, why aren't they? Ruth Mayhew of Demand Media (2013) recommends performance appraisals. You can conduct these with surveys of focus groups, opinion surveys and performance reviews of current employees, and exit interviews with employees voluntarily leaving the business. All of these methods can direct management to current situations that need to be addressed. For example, in a survey kept confidential or even anonymous, an employee may actually say "sometimes I call in sick because I don't enjoy working here." Working conditions can also be a focal point of the questions.

If you feel like you are inventing the wheel, there are ways to confront this stress head-on and determine what is causing other stress without moving to that monastery. Determine what your goals are and don't face problems alone. Draw upon the talent that you have surrounded yourself with and use it to your advantage to alleviate some stress.

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1995 or 1997 Guidelines—Which Should We Use?

Many physician offices struggle to determine which set of E/M guidelines will best support their practice. There are several things that can factor into this decision. Let us review them in detail.

History

We often forget there are key differences in the history section of these two guidelines; it is not only the exam that differs. The 1997 E/M guidelines instruct us to document the status of 3 or more chronic conditions to meet the requirement of an 'Extended' HPI. This can be extremely helpful, particularly when seeing patients in follow-up for multiple chronic conditions. These patients routinely do not have acute complaints, but they are coming in for maintenance. The history element in the 1997 guidelines can help push your history score higher.

It is critical to remember that if you choose the 1997 guidelines to access the history element, you must continue to use the 1997 guidelines for the entire audit (e.g., exam).

Specialty Exam

The specialty exams located in the 1997 guidelines are not limited to only specialists. Any provider can use a specialty exam if it helps address the work done for a given patient. For example, Family Practice physicians may perform their exam focusing on the skin. They may then benefit from using the 1997 Integumentary exam for the patient.

The opposite is also true; specialists are not required to use the specialty exams and may benefit from using the 1995 general exam.

So Which One?

The first step to determine which exam you should use would be to evaluate a sample of your physician's documentation. They will have a 'style' that typically helps you decide. If they tend to do a general head-to-toe exam, they may fit better into the 1995 exam. If they have a detailed exam of a given organ system, the 1997 specialty exam may help them get proper credit for that detail.

Your compliance plan may also address the use of one exam or another. There is no rule or statute that says you have to use the same set of guidelines for every patient, but internally your team may want some protocol for which set you will utilize. Bottom line, you will need to be able to support your level of service with whichever set of guidelines you choose.

Personally, when I am auditing, I do a quick review of the total documentation to see which guideline will fit best.

- Is there an HPI or, instead, the status of three or more chronic conditions?
- If I used the 1997 guidelines for the history (chronic conditions), will that negatively affect my exam outcome?
- Which better supports the level of service reported? The 1997 guidelines to get a higher history or the 1995 guidelines to get a higher exam?

Carrier Rules

Carriers do not have specific rules on which set of guidelines you should follow, but some (Novitas, for example) may have created their own set of audit rules that change the basic 1995 and 1997 guidelines. You will need to review these carrier-specific rules to see if your carrier may have these in place.

Summary

Do not be afraid to utilize the entire arsenal of guidelines available. Between the 1995 and 1997 guidelines, we have 14 different sets of elements we can use.

1995 guidelines
Body areas
Organ systems

1997 guidelines
General Multisystem
Cardiovascular
Ear, Nose, Mouth and Throat
Eyes
Genitourinary (female)
Genitourinary (male)
Hematologic/Lymphatic/Immunologic
Musculoskeletal
Neurological
Psychiatric
Respiratory
Skin

As auditors, we need to be familiar with each set of these guidelines and use them to support the work we are reviewing to ensure credit is given appropriately.

Regan Tyler
Senior Consultant
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Article Section 179—Equipment Deduction

Planning to purchase new equipment in 2013? Buy before year-end to deduct up to $500,000 from this year's taxes!

Section 179 of the IRS tax code had been scheduled to shrink the equipment tax deduction from the 2012 level of $139,000 to only $25,000 in 2013. The Fiscal Cliff Bill that passed January 1st of 2013, however, INCREASED Section 179 to $500,000 of value that a small business can deduct this year.

Section 179 encourages small business owners to invest in equipment or technology by allowing them to deduct the asset's full value the first year. When you acquire new equipment, including machinery, furniture, fixtures and off-the-shelf software, you may deduct up to $500,000 of the value during the first year of ownership. A fifty-percent Bonus Deduction applies to purchases up to $2,000,000 (see your professional tax advisor for more details).

Example using a hypothetical $150,000 capital equipment purchase this year:

Equipment Up to $2mm Value

A. Equipment Price: $150,000

B. Section 179 Deduction this year: $150,000

C. 50% bonus deduction (A-B x .50): $0

D. First Year Tax Deduction (A+B+C) : $150,000

E. Combined Federal & State Tax Bracket: 38%

F. Total 2013 tax savings as a result of deduction (E x F) : $57,000

In the above analysis, the practice purchased equipment valued at $150,000. The practice may deduct $57,000 based on its prevailing 38% tax rate, making the NET equipment cost $93,000! There are also special deductions available for lease-financed equipment, but check with your tax advisor for more information.

Act now, as this increased deduction applies to 2013 purchases only until further action by Congress!

Valora Gurganious
Senior Consultant

"*Pay or Play*" Mandate Delay – *continued from page 1*

claims. To be "affordable," the amount a "full-time employee" is required to pay in order to become covered under the plan cannot exceed 9.5% of the employee's wages from the employer (i.e., W2/Box 1). If a "large employer" fails to offer coverage that is "affordable" or fails to offer coverage that provides "minimum value," the employer is potentially subject to a penalty.

Employers should take time now to review any benefit-program changes they were contemplating for next year and use this one-year reprieve wisely.

Here are some important takeaways from the one-year delay:

1. **No Requirement to Offer Healthcare Coverage in 2014.** You don't have to offer coverage at all to your employees in 2014 if you don't want to do so. You can if you want, but there are no penalties if you don't. Of course, many employers already do and will continue to do so.
2. **The Rest of the ACA Remains in Effect.** If you plan to start or continue to offer coverage in 2014, you need to do it the "right way." There is a long laundry list of required plan changes. For example, you will not be permitted to have a waiting period that is longer than 90 calendar days. That means those who begin coverage on the first day of the month following a 90-day waiting period will now have to change the coverage effective date to be within the 90-day window.
3. **Employers Can Still Utilize the Healthcare Market Place.** Come October 1, 2013, individuals, including employees, striving to comply with the individual mandate to have coverage can research and enroll in healthcare coverage through the Healthcare Market Place (i.e., Exchanges). Such plans will become effective for enrollees on January 1, 2014. This will require employers to address employee confusion about their need to have health coverage and their options for coverage.
4. **Beware of the ACA Excise Tax.** If you offer coverage that does not comply with certain ACA mandates, including requirements that will take effect for the first time in 2014, you could be hit with a daily excise tax of $100 per day per affected individual.
5. **Counting Employees to Determine If an Employer is a "Large Employer."** For 2014, there was a special transition rule for determining if an employer was a "large employer." Instead of counting its employees during all twelve months of 2013, an employer could elect to count its employees during any six consecutive months in 2013. This rule will not apply for 2015; so, if an employer needs to determine if it is a "large employer" for 2015, it will need to count its employees during all twelve months of 2014.
6. **Special Transition Rule for "Standard Measurement Periods."** If you are not clearly a large employer (with hundreds of employees), or you maintain a fluctuating number of employees or are uncertain of your employee count (part-time staff), then it is important to determine your status as "small" or "large" employer. For 2014, there was a special transition rule for "standard measurement periods." Under this special rule, a "large employer" could elect its first "standard measurement period" to be as short as six months, even if the employer had otherwise elected to have both a "standard measurement period" and a "stability period" that were twelve months long. Again, unless further guidance is forthcoming, that transition rule will not apply for 2015. Consequently, if your first "standard measurement period" will be 12 months long—and that's what most employers are expected to elect—that "standard measurement period" will need to start before the end of 2013 in order to provide time for an "administrative period" before January 1, 2015. For example, if you want to have a two-month "administrative period" at the end of 2014, your "standard measurement period" will need to start by November 1, 2013. Some employers may want more time, so employers may want to start the first "standard measurement period" on October 15, 2013. ***This means that most "large employers" will need to start counting hours before the end of this year.***
7. **"Large Employers" with Fiscal Year Plans.** For 2014, there was a special transition rule for "large employers" with fiscal year plans — that is, with plans that begin on a date other than January 1st. Under this transition rule, these employers could wait until the first day of their 2014 plan year to comply with the ACA employer mandates. Currently, and unless further guidance is forthcoming, there will no longer be a transition rule allowing "large employers" with fiscal year plans to wait until the first day of their *2015* plan year to comply with the ACA's employer mandates. This means that these employers will need to comply as of January 1, 2015. To do this, they will either need to offer coverage to all of their "full-time employees" as of the first day of their 2014 plan year, so that coverage has already been offered as of January 1, 2015, or they will need to allow those full-time employees to enroll at some time in 2014 so that their enrollment takes effect as of January 1, 2015, even if that is in the middle of their plan year.

It is not an overstatement to say that healthcare reform is one of the most complicated laws to come about and while the additional time to prepare is welcome—this is not the time to stop preparing!

Philip Dickey, MPH, PHR
HR Services Director, Partner
DoctorsManagement

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Most Common Coding and Billing Errors—Part 2

This is the second of a two-part series to tackle the most common coding and billing errors for medical practices. With this month's newsletter, we will explore such errors as non-covered services, medical necessity denials, and inappropriate modifiers.

Non-covered services
The Medicare program contains many exclusions that providers should be aware of to avoid unnecessary denied claims and unnecessary work for accounts receivable staff. These exclusions include the following: Personal comfort items; self-administered drugs and biological (is paid by Part D); cosmetic surgery (unless done to repair an accidental injury or improvement of malformed body member); eye exams for the purpose of fitting or changing eyeglasses or contact lenses in the absence of disease or injury to the eye; routine immunizations (with the exception of a limited few); routine physicals (with the exception of new annual wellness visits); diagnostics performed for screening purposes (with the exception of a small number of preventive screenings); hearing aids; routine dental (care, treatment, filling, removal or replacement of teeth); custodial care, services furnished or paid by government institutions; services resulting from acts of war; and charges to Medicare for services furnished by a physician to immediate relatives or members of the same household.

Stay current on exclusion policies by checking your Medicare administrator's website for changes. Most will post changes to policies and their effective date. If not, go directly to Medicare's website at www.cms.gov and find them there.

Lack of established medical necessity
When claims deny because the payer does not deem the procedure to be a "medical necessity," check the Medicare National or Local Coverage Determination (NCD or LCD) or commercial payer medical policies. Check the NCD or LCD on the respective carrier's or CMS website for a listing of covered diagnoses for a particular service and the appropriateness of conducting the service or procedure. You must establish the medical necessity of the service or procedure in the medical record before ordering or performing the specific service or procedure. Medical records should reflect how the service or procedure allowed you to provide a higher level of care to the patient. A diagnostic procedure performed should be necessary to your medical decision making, resulting in a better outcome for the patient.

Pay close attention to Medicare and other payer newsletters for notices as to when these policies are added or updated.

The claim is missing a modifier or has an inappropriate or invalid modifier.

Modifiers are necessary to process many claims correctly by providing such information as location, condition, or situation. The problem is that they are often either missing, inappropriate, or invalid for the specific procedure and diagnosis indicated on the claim form.

Know the proper use of the CPT modifiers that exist and that are appropriate to use for the specific condition or situation. The most commonly misused modifiers are 25, *Significant, separately identifiable evaluation and management (E/M) service by the same physician on the day of a procedure,* and 59, *Distinct Procedural Service identifies procedures/services not normally reported together, but appropriately billable under the circumstances.* The CPT modifiers are listed in their entirety in Appendix A of the current version of the CPT manual. You should also know that misuse and abuse of modifiers are under the scrutiny of the Office of Inspector General (OIG) and can result in significant penalties.

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Job Performance, *cont.*

Find out what others think and use that information to set some priorities of things that must be accomplished in your business. Most of all take care of yourself; without you and your business, DoctorsManagement would not exist.

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