The Business of Medicine Newsletter

"Leave the Business of Medicine to Us"

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

Inside DoctorsManagement: Message from the President

Compliance and Profitability

Welcome to 2014! This may be the year your practice faces compliance head-on. Compliance may not be sexy or even something that is appealing to all but it can be the glue the holds your practice together and can make the difference between success and failure.

DoctorsManagement ended 2013 being viewed throughout the industry as one of the premier compliance organizations. Our compliance team handled more than 150 audit and overpayment appeals for clients across the country with a success rate matched by none in the industry. You might be wondering what makes us so successful. We believe it is our team of professionals who carry with them the most recognized credentials in the industry and have an average of 12 years of real-world industry experience. This team includes one of the most sought after compliance officers and lecturers

on compliance and profitability in the entire industry. In addition to our already outstanding roster of individuals, our most recent hire to the team is a former RAC auditor.

Compliance isn't just another buzz word. Auditing by the payors is not going to slow down or go away; it's just the opposite. We encourage your practice to not only ensure that you've done your part but also to go beyond that to demonstrate your compliance with all payors. Failure to do so could potentially result in extensive overpayment demands, exclusion from participation with payors and worst case prosecution by the United States Attorney's Office which might seek criminal, civil, and/or monetary fines.

To combat the potential threats in the industry, DoctorsManagement is developing a suite of compliance products, forming strategic partnerships with some of the most respected software and publication com-

panies and developing models to bring the highest level of compliance education to you, our valued customers. This is just another way Doctors-Management allows you to "Leave the business of medicine to us!"

Yours in Success,

Paul L. King
President
DoctorsManagement, LLC

CFOs and Practice Managers – Do the ROI Thing and the Right Thing

The Case for Making Interventions to Improve Retirement Plan Outcomes

If you only plan to be the CFO or practice manager at your company for a few years, then this article really isn't for you. On the other hand, if you take a long-term view of your company's financial strategy, this article may cause you to add "Improve Retirement Plan Outcomes" to your list of finance strategies. A recent study published by Mass Mutual reveals that under many circumstances, a company's qualified retirement plan can often yield a positive ROI by helping the company's employees retire sooner and on their own terms.

Qualified retirement plans have often been viewed as the "right thing" to do. They are necessary because "HR says we must have a good plan." Or perhaps, "we have to offer a retirement plan to all employees so we can offer one to executives as well." Retirement plans are important to recruit and retain talent. These benefits all come at a cost. And, these benefits are often esoteric and theoretical, which makes it difficult to assign a financial value to them.

Retirement plans in America have undergone a fundamental shift with companies taking ownership for less and less of their employees' futures. This isn't to suggest that all compa-

nies have behaved in the same way, but the general trend has been in the direction of reduced company commitment and involvement in the retirement plans of their employees.

In the 1950s, 60s, 70s and 80s, the trend in company retirement plans was to offer defined benefit plans, often known as pensions. These provided an immediate win for companies by engendering great loyalty in employees. However, they came at a cost to the company's future. The companies received immediate benefits with their pension plans and gambled the future financial health of their companies by obligating them to legacy costs. *Cont. on page 4*

Initial Hospital Care—When Documentation Doesn't Add Up

No matter how seasoned an auditor you may be, there is one scenario that still leaves many of us scratching our heads. What should we do when auditing initial hospital care services (CPT codes 99221-99223) if the documentation available to review does not satisfy any of these CPT codes? You see, initial hospital care codes require that all three "key" components (history, examination and medical decision making) be demonstrated to qualify for a given level of service. In other words, if a documented level of history and/or physical examination do not support even the lowest level of initial hospital care (CPT code 99221), we would not be permitted to credit an initial hospital care code, right? Remember, the one "key" component that resides in the lowest overall level would ultimately determine accurate code selection (see chart below):

CPT CODE Key Components Required	99221 (3/3)	99222 (3/3)	99223 (3/3)	99231 2/3	99232 (2/3)	99233 (2/3)
HISTORY	DET	COMP	COMP	PF	EPF	DET
EXAMINATION	DET	COMP	COMP	PF	EPF	DET
MEDICAL DECISION MAKING	STFD /LOW	MOD	HIGH	STFD /LOW	MOD	HIGH

According to CPT instruction, both CPT codes 99222 and 99223 require a comprehensive history, comprehensive examination and a moderate _or_ high complexity of medical decision making, respectively. In order to qualify for the lowest level of initial hospital care (e.g., CPT code 99221), the provider is required to document, at a minimum, a detailed history, detailed examination, and a low or straightforward complexity of medical decision making. You may begin to see the potential problem. How is a provider to report an initial hospital care code when the levels of history and/or physical examination do not support even the lowest level of service? Should one report the lowest level of initial care and apply modifier -52 (reduced service)? Should the provider report unlisted E&M service (e.g., CPT code 99499)?

The answer to these questions is *NO*. Remember the most basic coding rule: *select the code(s) that most accurately describe the service(s) performed*. To this end, it would be necessary for the provider to select a subsequent hospital care code (CPR code 99231-99233) in cases where the lowest level of initial inpatient service is not supported. According to Novitas Medicare Solutions, *"Providers who recognize their documentation is deficient for an initial hospital service but find the documentation satisfies the medical necessity and key component work of a subsequent hospital service should report the subsequent hospital service."* So, when auditing initial inpatient hospital services, be aware that you may need to consider subsequent hospital care codes.

John Burns
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Focus on Proficiency Testing—Twelve Steps to Success

Proficiency testing is a primary focus during laboratory surveys, and certain mistakes can cost a laboratory its certificate.

Proficiency testing is another layer of quality control and is required for all non-waived (moderate or high) complexity laboratories. The laboratory must contract with an approved provider for all regulated analytes performed in-house and must treat proficiency testing specimens just as they treat patient specimens.

1. Enroll in proficiency testing for all non-waived regulated analytes, choosing a program that best suits the needs of your laboratory. You must remain in this program for the full calendar year. Keep the invoice or receipt to verify enrollment in case you are inspected before receiving your first challenge.
   - COLA requires their accredited labs to enroll in proficiency testing for all analytes, including waived tests.
2. Post the shipping schedule (available on the program's website) in the laboratory or transfer the shipping dates to the main laboratory calendar. Check these dates frequently to ensure that someone will be present to receive the shipment.
3. When the box arrives, open it immediately and date the package insert. Check for missing or damaged items and call immediately for replacements if needed. The company may run out of specimens if too many labs receive defective shipments. Read the entire set of instructions. Store specimens as directed and make a special note of the deadline.
4. Double check calibration and maintenance, supplies, and Levey-Jennings graphs. Take any indicated actions immediately. Check records from the previous challenge to see which testing personnel ran those tests and, if you have a large list, ask different individuals to run this challenge. *Everyone* involved in patient testing *must* take their turn at proficiency testing.
5. Designated testing personnel must read the mixing and handling instructions and follow them explicitly. Failure to mix and handle specimens carefully is a common cause of failure.
6. Run the specimens exactly as you run patient specimens. One person runs the test one time and documents it. DO NOT have more than one person run any specimen and DO NOT allow anyone to run a specimen more than once. DO NOT confer with another laboratory and DO NOT send any specimens to another lab.
   - Exception: If the operator gets a result that meets your criteria for a repeat of a patient test, then you may repeat the proficiency testing specimen. Example: If the hemoglobin is 2 or the glucose is more than 500, you may repeat the test.
7. If possible, save the specimens for retesting later. This would be part of your investigation if you miss something and they can, under certain circumstances, be used for teaching purposes, competency assessments, or even troubleshooting, but only AFTER you have gotten your graded report and the deadline has passed.
8. Use extreme caution when documenting results, whether you write them on a form or key them in. Clerical errors are the next most common cause of unacceptable results. Make sure you use the right test method code, that you enter results correctly, and that you put each result in the proper place. Reversing % and # on differentials is a common error.
   - Be sure that the director and all testing personnel sign the attestation statement and that you keep a copy of the form. Print out your results and keep that as well.
9. As soon as the graded report arrives, review and sign it and make sure the director does this as well. All participating operators should also read and sign the report.

A Burning New Employee Issue: E-Cigarettes

Eventually, one of your employees is going to "power up" an electronic cigarette in your practice. More commonly called "e-cigarettes," they are a type of computer-aided nicotine delivery system. They look very similar to regular cigarettes. When a user "lights" the e-cigarette, an electronic sensor activates a heating element in the device that releases the liquid in an aerosol form for inhalation. When users inhale, an LED at the end of the metal tube glows making the tip of the e-cigarette appear as if it were burning. A visible vapor is emitted that disappears within a few seconds. The process of using an e-cigarette is known as "vaping" or "e-smoking."

So, is this truly considered "smoking" and can you set a practice policy? According to some labor attorneys, there are no laws requiring an employer to allow e-smoking in the workplace. I would suggest that if state law allows for the prohibition of smoking in the workplace, you are free to ban these devices and should consider doing so.

Why would an employer consider banning such a product? Some reasons are because nicotine is addictive in any form; e-cigarettes look very similar to regular cigarettes (especially from a distance), making it harder for an employer to monitor employee cigarette use; and the vapor emitted from e-cigarettes could be an annoyance to non-smoking employees. Also, allowing employees to smoke e-cigarettes in a tobacco-free workplace may encourage non-smoking employees to try to smoke real cigarettes in the workplace or at least question why they cannot do so.

If you decide to stamp out "e-smoking" or "vaping" in your practice, revise your tobacco-free policy to indicate that smoking in any form using tobacco products (e.g., pipes, cigars and cigarettes) or "vaping" with e-cigarettes is prohibited.

You may wish to consider the following sample smoke-free workplace policy:

SMOKING, TOBACCO & E- PRODUCTS

[Your practice name] is committed to providing a safe and healthy environment in which to provide care to our patients and work. In light of this commitment, smoking in any form (tobacco or products like e-cigarettes) and the use of chewing tobacco are prohibited while working on practice property.

Tobacco breaks including e-breaks will not be allowed. If you must use tobacco or an e-product, restrict it to your lunchtime and do so off practice property. Tobacco products,

e-products, lighters and matches within sight, or the lingering smell of smoke on an employee or brought into the practice is strictly prohibited.

If an employee is found to be smoking in any form through the use of tobacco products (pipes, cigars and cigarettes) or "vaping" with e-products, using chewing tobacco products, or bringing the smell of smoke on to the premises, disciplinary action will be taken, up to and including termination.

If a patient or visitor is smoking, "vaping" or using other tobacco products, kindly inform them that this is a no smoking/tobacco-use facility and please refrain from its use.

Philip Dickey, MPH, PHR
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Focus on Proficiency Testing continued

Use "unacceptable" results as an educational opportunity! Read the entire report, looking for unacceptable results and tests that may have not been graded due to "lack of participant consensus" or technical problems.

10. Investigate any unacceptable result, checking first for clerical errors - yours and the proficiency testing program's. Then rerun any missed specimens. Generally this results in acceptable results. Sometimes, however, more extensive investigation is required. If you discover a problem with the test system, patient results must be evaluated and possibly even repeated on new specimens at no charge.

11. If you score less than 80% on any two out of three events for the same analyte, you must cease testing, obtain two "remedial" challenges and pass them prior to resuming patient testing for that analyte. No exceptions!

12. Keep all paperwork for a minimum of two years: package insert, instrument print-outs, handwritten results, attestation statement, results as reported to the proficiency testing company, the signed graded report, and the investigation report (also signed by the director).

Any suggestion of referring proficiency testing to another laboratory or even conferring with another laboratory is the single greatest reason for loss of CLIA certification. Achieving 100% on every challenge is not expected, and surveyors usually accept genuine efforts to investigate problems and implement corrective actions. Documentation is crucial. "If it wasn't documented, it wasn't done."

Need additional information? Contact Ann Bachman at abachman@drsmgmt.com. Good luck with your proficiency testing!

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CFOs and Practice Managers – Do the ROI Thing and the Right Thing—*continued from page 1*

This situation prompted legislators to pass the Employee Retirement Income Security Act (ERISA) of 1974. Promised pensions had to be funded with current dollars, not future dollars. This prompted the shift from defined benefit retirement plans to defined contribution plans. Companies began to disconnect from both their employees' futures and future obligations.

It's easy to view employee participation in a company's defined contribution qualified retirement plan as "their decision." Hence, the trend has been toward continued disengagement. Companies offer plans, but don't necessarily feel obligated to promote their retirement plans.

The recent study by Mass Mutual suggests the time is right for companies to take a more active role in the retirement preparations of their employees. This does not mean that companies should offer defined benefit plans with future obligations. However, CFOs and practice managers should consider coming alongside employees and even incentivizing them to lay up treasure for the future.

With the economic downturn in 2008, more and more workers in American are planning or fully expect to delay retirement. Consider a study by The Conference Board Consumer Confidence Survey (March 2010) that indicated 42% of workers age 45-54 and 44% of workers age 55-64 planned to delay retirement due to the 2008 financial crisis. As more workers delay retirement, there will be a measurable cost impact on companies caused by an aging workforce. In industries where productivity is directly tied to the experience of the workforce, this trend may actually be positive for businesses. However, in industries and fields where a younger worker with modest training can essentially match the output of an older worker, the advent of an aging workforce could pose significant and growing challenges.

First, as workers age, their ability to work typically decreases. The Sloan Institute performed a National Health Interview Survey in 2005 that demonstrated the degree to which age impacts ability to work. Their study focused on the percent of workers who were A) unable to work or B) only able to do limited work. For 18-44 year-olds, 2.9% were unable to work and 1.9% were only able to do limited work. For 45-64 year-olds, the numbers increase to 8.9% and 4.4% respectively. And, by the time workers reach 65-69 years old, the number unable to work reaches 10.9% and those classified as able to do limited work reaches 8.2%. Almost

20% of workers age 65-69 are limited in their ability to work.

Second, as employees age, healthcare and disability insurance premiums rise. Employer healthcare premiums for the average 20-30 year-old worker cost $2,560 per employee. This assumes a 50/50 female to male ratio. This number rises slightly during the employees' 30s and 40s, and then climbs steadily. For workers over 60 years old, employer healthcare premiums cost $9,230 per employee. This same pattern holds true for employer disability income premiums. On average, companies pay $32 per year for disability income premiums for 20-30 year-old employees. The average annual premium cost jumps to $532 for workers over 60.

Third, as workers age, worker's compensation medical payments and benefit payments increase significantly. NCCI Holdings performed a study in 2012 titled Workers Compensation and the Aging Workforce. The study found that workers age 20-34 had an average cost of medical payments of $5,073 and average cost of benefit payments of $2,227. For workers age 45-64, these costs balloon to $3,485 and $7,649 respectively. These figures represent an increase of over 50%.

So, what can be done to lessen the impact of an aging workforce on your company's bottom line? CFOs and practice managers looking for a short-term fix will be hard-pressed to find one. However, companies that are committed to developing and implementing long-term solutions will be able to navigate these challenging workforce trends.

Step one, return to the ancient path. Return to the ancient path in principle, not in execution. Really, the path isn't so ancient. It is the path that was followed by most U.S. companies in the 50s, 60s, 70s and 80s when companies promised pensions to employees. For the most part, employees retired on their terms. They exited the workforce, clearing the way for younger contemporaries to step in. The principle is for companies to help workers retire on their own terms or, at least, on good terms.

Step two, avoid the ancient path in execution. Develop a better path. This article is not advocating a return to defined benefit (also known as pension) retirement plans. These plans were fraught with issues and saddled employers with future obligations. However, companies can spur employees to save more by putting more company "skin in the game." Numerous studies have shown that auto enrollment and employer matching contributions significantly boost employee contributions to their company retire-

ment plans.

In fact, a recent study by Mass Mutual suggests that relatively small changes in retirement contributions by employers and employees can drastically decrease lifetime employee cost. For 30-year-old employees, a savings rate increase of 3% will reduce lifetime employee cost by 20%. For 40-year-old employees, a savings rate increase of 4% will reduce lifetime employee cost by 24%. For a 50- year-old employee, a savings rate increase of 5% will reduce lifetime employee cost by 23%. Finally, for a 60-year-old employee, a savings rate increase of 10% will reduce lifetime employee cost by 47%.

Helping employees prepare to retire on their own terms makes good sense for employees as well as companies. CFOs and practice managers can do both the "ROI Thing" and the "Right Thing."

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How Can Auditors Get Ready for ICD-10?

The ICD-9 codes that have been used on claim forms since the late 1970s will cease to exist as of October 1, 2014. Medical auditors have grown accustomed to documentation and claims with codes that, by comparison, tend to be much simpler than ICD-10. Health care providers will need to learn to document for codes that did not exist in the old code set. Coders and billers will need to enhance their understanding of anatomy and pathology in order to be able to navigate ICD-10. Auditors, however, will need to do it all.

It seems that some health care professionals may bury their heads in the sand. They may have heard a rumor that ICD-10 will be delayed. As a result they do not intend to become familiar with the new code set until the future is more certain. The truth is that there are major changes coming in how claims will be reviewed and adjudicated. Professionals must devote time and energy to understanding ICD-10 codes in order to stay in business. This is especially true for the auditors who come along after the patient encounter to try to understand what happened and identify deficiencies.

What's Wrong With the Current System?
Anything that has been around since the 1970s can now be classified as "old." ICD-9 was released in 1979 and it just can't keep up with changes in healthcare. There are new technologies and science has a better understanding of the nature of many diseases. The codes set are finite - limited to the numbers 001 to 999 (plus E and V codes). Some sections have run out of room for expansion. But, perhaps most importantly, ICD-9 codes lack detail. Providers often select "unspecified" codes because they are the only option. In terms of healthcare, this is not ideal. Detail is better.

ICD-10 improves the capture of information. It is so detailed that payers should need to request a copy of the medical records to adjudicate claims much less frequently. According to the American Academy of Professional Coders, this better data is expected to lead to improved patient safety, improved quality of care, and improved public health and bio-terrorism monitoring.

ICD-10 provides more specific information, contains five times as many codes, and clinical descriptions that are much clearer. For example, ICD-9 does not include codes to differentiate between sides of the body. Since the 70s, scientists learned something very important: there are two of many body parts. ICD-10 includes details such as one code for the right eye and a different code for the left eye. Most would agree that this is a necessary improvement. See the table in the next column for other changes.

How Does This Affect Auditors?
It is hard to say which ICD-10 codes will be selected as medically necessary by third-party

Feature	ICD-9-CM	ICD-10-CM
Number of Codes	About 14,000	About 68,000
Number of Characters	3-5 characters in length Some are numeric Some start with "E" or "V" Decimal is used after 3 characters	3-7 characters in length Character 1 is alpha Character 2 is numeric Characters 3-7 are either Decimal is used after 3 characters Some codes use "x" for characters 4-6 Character 7 used in certain chapters
Number of Chapters	17 plus E and V chapters	21 chapters
Start Date	1975, 1979 in US	1994, 2014 in US
Expansion	Very limited	Has significant ability to expand without a structural change
Detail	Lacks detail	Very specific
Laterality	Lacks laterality	Includes laterality when appropriate
Encounters	Initial and subsequent encounters are not defined	Initial and subsequent encounters are defined
Combination Codes	Combination codes are limited	Combination codes are frequent

can provide consulting help. ICD-10 is a bit like eating an elephant. The best way to do it is one bite at a time. A simple plan that includes a few minutes each week should make most auditors experts in the time that remains. Regardless, procrastination is not the answer.

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References
AAPC.com/ICD10
http://www.cms.gov/eHealth/ListServ_ICD10_AHealthCarePriority.html

know until the last possible minute. As the implementation date approaches, more information may come forward and better guesses can be made. It is rumored that Medicare will release ICD-10 based coverage determination some time ahead of the October 1, 2014, implementation date. However, the question remains: Which codes will payers require and recognize? The payers must rewrite their guidelines around the new codes. Selection of the correct codes ultimately depends upon the whim of the payer, not simple ICD-9 to ICD-10 mapping. Since 95% of the ICD-10 codes do not map one-to-one, the new list will look very different. For now auditors must simply do their best to get familiar with the new system and make calculated guesses.

Auditors who want to be ready to transition to ICD-10 need to start training now. Seminars, webinars, and books are becoming more available as the date approaches. Several agencies offer credentials for trainers who

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