COMPLIANCE

Use the summer to prepare for ICD-10

CMS has just announced ICD-10 mitigation provisions, including steps to reduce the chance of financial disruptions (see box on pg. 2), but the ICD-10 deadline is only three months away.

That Oct. 1 deadline seems as inevitable as ever, which means you have what’s left of the summer to get education, perform more testing, and depending on your practice and processes, begin actual software deployment tasks.

Even with CMS making the transition easier, commercial payers have no obligation to do so, which means there is no getting around having to use ICD-10 codes. While the road map to compliance differs widely based on practice size, specialty, IT capabilities, and provider readiness, implementation is guaranteed to significantly change the way you do business every day, which means that delaying preparation is a recipe for financial catastrophe once the summer ends.

ICD-10 overview

If you are truly a novice to the concepts of ICD-10, there is much work that lies ahead. Essentially, ICD-10 allows the reporting of medical diagnoses, signs, symptoms and disease states with more specificity and granularity than ever before. Only in America is this level of detail a new concept; the rest of the world has been using ICD-10 since as early as 1994. There are 21 chapters in ICD-10 since as early as 1994. There are 21 chapters in ICD-10-CM when compared to the 17 chapters in ICD-9-CM. ICD-10 also allows for the reporting of anatomical laterality.

Example: Under ICD 9, there’s one code for pain in the knee joint (719.16). Under ICD-10 there are three possibilities as listed below on page 2. The last digit is in bold to highlight how it indicates laterality.

See box on pg. 2
When you take this diversity in knee joint pain and apply it across the myriad body parts, conditions, and disease states that are possible, you can start to appreciate the massive change in scope that comes with ICD-10. **Remember:** You have a one-year cushion for finding the most specific codes. The CMS decision to pay for claims with ICD-10 codes as long as the codes are from the appropriate family means any of the knee codes above would be paid (during the year-period from Oct. 1, 2015 to Oct. 1, 2016).

We all know how important ICD-9 code assignments are in terms of proper claims processing and eventual remuneration. With ICD-10, we anticipate an even closer relationship between CPT and HCPCS II codes and the diagnoses which will result in payment. We are not saying that unspecified codes will automatically result in denial, but rather that specific code assignment and supporting documentation will yield payment far more reliably than using their unspecified counterparts.

**Specific practice considerations**

There are many variables that need to be considered before ICD-10 compliance can be achieved. Obviously the size of the practice should be your first consideration. The training and education needs of a one or two-provider group are lower than the needs of a large group with a dozen or more providers across multiple specialties and office locations. Next, considerations involving IT systems, practice management software and electronic medical records must be evaluated in addition to the services of billing companies, clearinghouses and other vendors.

ICD-10 compliance will require careful planning, implementation strategy, and open lines of communication with payers. We strongly suggest taking advantage of any testing platforms and opportunities various payers offer. This will maximize your chances for a smooth transition and

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**BREAKING NEWS**

**CMS moves to ease ICD-10 transition**

You can take a small sigh of relief about the looming Oct. 1 implementation deadline for ICD-10. There’s no delay coming, but for one year after Oct. 1, CMS will pay for all claims that don’t have the correct ICD-10 codes as long as the codes used are in the ballpark.

This is the biggest of several concessions CMS is making in light of the Oct. 1 deadline and the grave concerns providers have expressed with compliance. Here’s a breakdown on the specific terms CMS announced.

- **No claim denials.** For the first year of ICD-10, from Oct. 1, 2015 to Oct. 1, 2016, Medicare claims will not be denied if the only problem was the use of inaccurate diagnosis codes. Any claim with ICD-10 codes in the appropriate family will be accepted and paid. **Claims with ICD-9 codes will be not be accepted on or after Oct. 1, 2015.**

- **No ICD-10 audits.** Medicare claims will not be audited based on the accuracy of ICD-10 diagnosis codes as long as they are from the appropriate family of codes. The idea is to give providers time to become familiar with the ICD-10 codes they’ll use. CMS said. Both Medicare carriers and Recovery Audit Contractors (RACs) will abide by this rule.

- **No quality reporting penalties.** Like the change to claim denials, CMS won’t penalize physicians under the Physician Quality Reporting System (PQRS), the value-based payment modifier, or the meaningful use program based on the specificity of diagnosis codes as long as codes from the correct ICD-10 family of codes are used.

- **Payment disruptions.** If Medicare carriers have trouble processing claims because of the ICD-10 transition, CMS will allow advance payments to physicians.

- **More communication.** To stay on top of ICD-10 transition issues, CMS will create a special communications center to track problems during and after the run-up to October. A specific “ICD-10 ombudsman” will be named to sort through physician provider concerns and problems. — Grant Huang, CPC, CPMA (ghuang@drsmgmt.com).
minimize the likelihood of financial bottlenecks in October 2015 and beyond.

Auditing for ICD-10 success

Everyone knows how important compliance audits are, so why wait to begin auditing your providers and coders on their knowledge of ICD-10 codes? A great exercise would be to incorporate ICD-10 into your existing audits and offer extra training and education to providers and coders who don’t perform well. This will allow your providers a safe opportunity to make the clinical documentation improvements necessary to comply with the more specific coding conventions that ICD-10 requires, including anatomical laterality, episodes of care, external causes, places of occurrence, etc.

By incorporating ICD-10 in the auditing and educational processes now, you are preparing your providers for the sea change in your daily workflow that awaits at the end of summer. One final suggestion is to review your Local Coverage Determinations (LCDs) and National Coverage Determinations (NCDs) to ensure minimal disruption in your revenue cycle come October.

**Tip:** CMS maintains a compendium of coverage determinations specific to ICD-10 on its website. The link is [www.cms.gov/Medicare/Coverage/CoverageGenInfo/ICD10.html](http://www.cms.gov/Medicare/Coverage/CoverageGenInfo/ICD10.html).

— John Burns, CPC, CPC-I, CEMC, CPMA (jburns@drsmgmt.com). The author is a Senior Consultant, NAMAS Instructor, and AHIMA-Approved ICD-10 Trainer at DoctorsManagement.

**MEDICARE RULES**

**Supreme Court decision means more patients**

The latest decision by the Supreme Court ensures that the Affordable Care Act (ACA) will continue generating new patients and new regulations long after President Obama leaves office. The ruling, released June 25, marks the second time the high court has acted in favor of the biggest change to the healthcare system since the creation of the Medicare program.

The case revolved around insurance subsidies being provided in states that currently rely on Healthcare.gov, the insurance exchange established by the federal government. The Supreme Court upheld the federal government’s position that the ACA allows it to subsidize health insurance for eligible individuals in states that don’t have their own exchanges.

**A little clarity on the law**

The ACA established state-based insurance exchanges, which are online marketplaces where patients can purchase coverage plans and thus fulfill their obligation to be covered under the ACAs individual mandate. However, if any state is unwilling or unable to establish its own exchange, the responsibility to create the exchange defaults to the federal government. This in itself is not controversial, but the federal government also interpreted the law to mean that if states are unwilling to subsidize insurance purchased via the exchanges, it may use federal dollars to do so.

Many states, particularly those with Republican governors and legislatures, have refused to establish exchanges in an effort to reject the ACA. If the federal government could assume responsibility in these states, it would effectively outflank state-level resistance to ACA implementation. This was at the heart of the *King v. Burwell* case.

**Reactions and impact**

Sone healthcare providers, particularly hospitals and large networks, were pleased with the decision as it ensures payment for services rendered to low and middle-income patients – some 6.4 million across the 34 states that rely on Healthcare.gov instead of their own exchanges. "In the short time the subsidies have been available, hard-working people who are sick, need care for chronic conditions, or want preventive care have been able to seek care more easily," said Rich Umbdenstock, president and CEO of the American Hospital Association in a statement.

Groups that oppose the ACA lamented the ruling, because it represents another failed attempt at repealing the law by targeting its specific provisions. This decision, combined with the landmark 2012 decision by the Supreme Court upholding the legality of the ACAs individual mandate, means that two precedents in favor of the ACA have been set at the highest level of the American judicial system. It seems increasingly unlikely that the ACA can be repealed in the courts. Instead, an act of Congress with the support of a new presidential
administration seems like the only plausible way for a wholesale repeal of the ACA.

Meanwhile, the ACA has led to significantly fewer numbers of uninsured and significantly more new patients knocking on the doors of practices with new plans from Healthcare.gov or state exchanges. Whether this trend will produce better outcomes and more cost savings at a national level remains to be seen.

— Grant Huang, CPC, CPMA (ghuang@drsmgmt.com). The author is Director of Content at DoctorsManagement.

REVENUE CYCLE MANAGEMENT

Improve collections by improving patient behavior

The revenue cycle management (RCM) process is an area where most practices believe they have good controls in place only to discover during a crisis that the opposite is true. Even after such a revelation, many practices continue to repeat the same processes as if expecting a different result, behavior that meets the definition of insanity, to paraphrase Albert Einstein.

Early in my career, in the 1990s, I worked both the front office and back office at medical practices and learned that human psychology is a big part of RCM, particularly in the area of collections. Collections is both an art and a science because practices must struggle to deal with rule-heavy payers and unpredictable, emotional patients.

That said, let’s look at some key elements of a good collections policy that will maximize your chances of getting what patients owe you.

Identifying patients who won’t pay

Most practices have the same patient payment policy. It consists of a plaque on the wall that reads: “Payment is expected at the time services are rendered.” But this is too vague – what you need are policies designed to meet specific objectives.

Most patients are responsible, law-abiding individuals, but it only takes a small group of patients with an entitlement mentality to seriously disrupt your RCM process. Each month, the troublesome patients cost time and money while your staff scrambles to refer severely delinquent accounts to collection agencies. If the federal government could assume responsibility in these states, it would effectively outflank state-level resistance to ACA implementation. Our advice: Stop sending trouble patients regular statements because no matter how many you send, they won’t pay. Calling them can also be a waste of time because caller ID allows them to dodge your calls. By avoiding these steps, you save time and prevent your employees from feeling powerless, deflated, or nervous about being confronted by their supervisor or the physician owner who wants to know why accounts are so slow to pay.

Tip: Identify patients who repeatedly fail to pay on time, creating a list if necessary. The majority of accounts sent to collections are composed of these repeat offenders – patients who have been sent to collections multiple times yet continue to present for care. It’s rarely worth the effort to try and modify their behavior. Instead, consider discharging them from your practice (we’ll discuss this further on).

You must break the cycle and regain control of your practice. You can’t afford to allow a subset of patients to dictate how you run your practice. The continuing downward spiral in reimbursements, combined with the rise of uncertainty and regulatory complexity, many practices are at a crossroads and must take aggressive steps to ensure patients follow clear financial policies.

Creating norms for patients

To encourage good patient behavior, you must establish rules from the start and ensure your patients – customers – abide by them. If you live in a small town, I know it can be difficult to be strict about payment when physicians regularly run into patients outside of the office.

You have to run your practice like the for-profit business that it is, which means viewing physician services like an item at a supermarket. Patients are responsible for paying for healthcare in the same way they are responsible for buying their food. Our system does not grant healthcare as a free entitlement, and thus we must stop allowing patients to behave as if it is.

You need a policy that is firm but flexible, and you must get physician buy-in. Our advice: Send statements only to those patients with a balance large enough to outweigh the costs associated with sending up to three statements. The average cost of sending a statement is $10 per patient. If you send three statements to a patient who owes $10, then you no
longer have any return on investment. This is bad business, but unfortunately it’s also standard operating procedure for most practices. For patients who owe less than $40, I suggest sending one statement and then following up with two or three phone calls over a 90-day period. If they ignore the calls, 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 either to the office manager or person in charge of collections.

Once the patient has paid their amount outstanding, then they can be scheduled. Of course if you have a patient who owes hundreds or even thousands of dollars, you should work with them to create a realistic payment plan. **Tip:** Always allow the patient to first specify the amount they can pay. Each plan should be developed with patients so they can’t complain about arbitrary amounts.

**Tip:** Use a federal Truth-in-Lending form to outline the repayment terms and have the patient sign it. While you should work with the patient on the amount, obviously you should insist on a figure that will pay off the balance in a reasonable timeframe.

**Discharging patients and indigent care**

Many factors go into the decision to discharge a patient. **Our advice:** Once the patient becomes a repeat offender, then it’s appropriate to discharge him or her. It’s simply not a good practice to allow non-paying patients to fill time slots for paying patients who comply with your policies.

Let me be clear about the unique nature of healthcare: No one wants to be sick and health is one of the most basic of all needs. I fully encourage physicians to provide compassionate or indigent care for those in need. I know of practices that have created a process where, if all the owners and/or physicians agree, a patient or family may be removed from the collection process for up to 12 months, giving them time to reduce or eliminate their debt based on temporary hardship or extraordinary medical needs. This is part of being flexible, and should be combined with all the strict measures outlined earlier.

**Collection agencies**

Don’t forget that your collections policy should ensure your collection agencies are doing a good job. Typically you get a very small share of what an agency collects. Look for an agency with a rate less than 35% commissions (typically rates run between 35% and 50%) but is able to collect at a rate higher than the national average of around 30%.

**Remember:** Collecting at the time of service is your best opportunity to capture the revenue you’re entitled to. Just remember Medicare beneficiaries must have a claim submitted to Medicare first before any collection efforts can be made. In my experience, it’s rare to have collection

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**James Sands joins DoctorsManagement as RCM director**

DoctorsManagement is pleased to welcome James Sands as its new Director of Revenue Cycle Management. With more than 12 years of healthcare industry experience, James is a natural problem solver who applies his expertise to carefully evaluate clients’ revenue cycles, providing operations and process improvements that increase current and future revenue.

James and the RCM team integrate billing technology and workflow solutions along with the best practices in coding to help clients maintain their most optimal level of profitability and revenue cycle efficiency.

James provides clarity in an area of healthcare management that is often full of complexities and confusion. He embraces growth through learning and keeps his finger on the pulse of the latest developments in order to ensure that the RCM department delivers the highest level of service to clients.

James received his Bachelor of Science in business with a minor in healthcare management and is currently pursuing a Master in Business Administration degree from Colorado Technical University. He is also a certified coder. A native of Knoxville, Tenn., James enjoys spending time with family and friends, preferably near a lake or the beach.
problems with Medicare-age patients; younger patients are the ones who tend to be sent to collections.

Ultimately, your patients will take the business side of medicine seriously when you do, by creating clear, strict, and flexible payment policies. A healthy practice, operated like the business it is, will ensure healthier patients in the long run.

— Sean M. Weiss, CPC, CPC-P, CPMA, CCP-P, ACS-EM (sweiss@drsmgmt.com). The author is a Partner, Vice President and Chief Compliance Officer at DoctorsManagement.

ACCOUNTING

For physicians: The world’s simplest budget

In private practice, many physicians will have inconsistent income throughout the year. In some specialties, more income is earned toward the end of the year while for others, the summer will be more lucrative. Without proper planning, this can create considerable stress not only in the office but also at home. Doctors, just like everyone else, have bills to pay, and not knowing how much money is coming in can result in sleepless nights. In this article, we go over the world’s simplest budget, but be warned: it does require self-control.

There are a million different budgeting systems and websites out there. For some people, these work very well. For others (99% of the population), the time commitment and restrictions just do not work. Yes, you can track every dime you spend, but the law of diminishing returns comes in to play quickly. Instead of tracking every small item, track the large items. Know, for example, that your mortgage is $5,000 per month and you spend $10,000 per month on your credit cards for other items. Once you have an idea of your top five to 10 items (mortgage, car payment, credit cards, insurance), you know 90% of your budget. There’s no need to track how much was spent at the grocery store, you just know that the American Express bill should not exceed $10,000.

Now that you have an understanding of those big items, the next step is simple to understand but the most difficult one to follow: Spend less than you make. The problem is, many physicians are taught to spend all (or more) than they make. Doctors are known to be high-income earners and therefore face social pressures to spend heavily. Driving a nice car, belonging to a country club, and owning a home three times the size of your family are all easy traps to fall into. If you can consistently spend 75% to 80% of what you make (after taxes) on the top 10 items, most other budgeting is unnecessary. This does not mean that you have to do without, but it may mean that you should delay some purchases. Someone living below their means can still drive a very nice car and live in a very nice house, but these items may need to be delayed a couple of years.

Meet DoctorsManagement

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<td>“Behind the Scenes of an Audit: How to Prepare and Respond,” webinar – Sean Weiss</td>
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So how can you achieve these things if you have inconsistent earnings? **Our advice:** Spend 75% of what you made last year and adjust monthly. Let’s say you are a fairly high wage earner and your after-tax earnings last year were $480,000. That means you have $40,000 to spend each month. So for the next year, you should plan on spending no more than $30,000 per month ($40,000 x 75%). If one month is lower, adjust down. If one month is higher, do nothing. If you live below your means and only adjust up on an annual basis, then you will have to delay satisfaction, but take it from me – your stress levels will plummet.

— Blake King, CPC, MAcc, CVA (ttking@drsmgmt.com). The author is Partner, Director of Accounting, and Chief Financial Officer at DoctorsManagement.

**FINANCIAL MANAGEMENT**

**Litigation alert:** **Tibble v. Edison**

On May 18, the Supreme Court of the United States released its opinion in *Tibble v. Edison International*. The ruling is expected to have far reaching implications to retirement plans, plan sponsors and the committees that oversee them and reinforces the need to continually monitor a retirement plan’s investment lineup.

**Factual and procedural background**

In 2007, participants and beneficiaries of the Edison 401(k) Savings Plan sued Edison International (“Edison”), along with the investment committee, the secretary of the committee, the vice president of human resources and the manager of the HR service center. The complaint alleged a breach of fiduciary duty of prudence in offering six available investment options that were retail-class mutual funds in the defined contribution plan instead of the lower priced institutional-class mutual funds. Of the six funds, three were added in 1999, and three were added in 2002.

Under ERISA § 1113, any breach of fiduciary duty claim must be filed within six years of “the date of the last action which constitutes a part of the breach or violation” or “in the case of an omission the latest date on which the fiduciary could have cured the breach or violation.” The District Court held that there was no issue of law concerning the 2002 fund additions and that Edison had not provided “any credible explanation” for the inclusion of the higher-priced mutual funds.

However, with the 1999 fund additions, the District Court held, and the Ninth Circuit affirmed on appeal, that any claim from 1999 was barred due to this statute of limitation having run by the time the complaint was filed in 2007. The Ninth Circuit, in its opinion, stated that to find liability for an investment option added to the plan more than six years prior would render the statute of limitations meaningless and could even expose current fiduciaries to liability for decisions made decades ago. The Ninth Circuit concluded by saying that only a significant change in circumstances could engender a new breach of a fiduciary duty.

The Supreme Court granted certiorari and oral arguments were made on Feb. 24, 2015. The ultimate question for the Court was whether a fiduciary’s alleged imprudent retention of an investment is an “action” or “omission” that triggers the running of the six-year limitations period.

**Holding**

The Supreme Court, in a unanimous decision, vacated and remanded the lower court opinion. A fiduciary, the Supreme Court reiterated, must discharge their duties “with the care, skill, prudence, and diligence” that a prudent person “acting in
a like capacity and familiar with such matters” would use. This concept, the Court notes, is derived from the common law of trusts and therefore, the Court looked to the trust law.

1 ERISA § 1104(a)(1).

The Court noted (as specifically mentioned in treatises, case law, Restatement [Third] of Trusts and the Uniform Prudent Investor Act) under trust law there are two separate and distinct duties:

1. The duty of prudence in selecting investments at the outset, and,

2. The continuing duty for reasonable monitoring and review of all trust investments at regular intervals; and to remove imprudent ones.

Therefore, the six-year statute of limitations is not properly applied only at the outset, when an investment is added to the lineup. In other words, you cannot “set it and forget it.” Instead, a suit will be considered timely so long as the alleged breach of the continuing duty occurred within six years of the suit.

Upon remand, it is possible the Ninth Circuit could find that Edison either conducted the necessary level of review or that the participants did not incur any damages. This is unlikely given the District Court’s review of the 2002 fund changes.

Summary

This case is an excellent reminder of the duties plan fiduciaries must consider on a continued basis. Not only must the plan sponsor, but each member of the investment committee, must act as a prudent expert in initially selecting an investment lineup. And that duty also requires you to meet on a regular basis to monitor the investments in the plan. Working with a qualified registered investment advisor can help you establish a process to help mitigate this expanded risk.

— Ryan Manaker (rmanaker@sageviewadvisory.com).

The author is a Principal with SageView Advisory Group.

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