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# The Business of Medicine

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HUMAN RESOURCES

## Prepare for overtime law to debut in December

There will be no stopping the federal overtime law, and the many businesses that opposed its passage can now only prepare for its Dec. 1, 2016 effective date. The U.S. Department of Labor (DoL) issued the final version of the long-anticipated overtime rule on May 18. While the final rule reduced the overtime exemption threshold from $50,440 to $47,476, this figure is still more than double the current threshold of $23,660.

**Remember:** The threshold represents the salary below which overtime (at least 150% of hourly wage) must be paid by the employer when employees work more than 40 hours in a work week. Starting Dec. 1, any employee making less than $47,476 will be eligible for overtime pay.

Currently, an employee only gets overtime if he or she has a salary of $23,660 or less, a threshold that means relatively few medical practice employees are eligible for overtime pay. The final overtime rule will make millions of currently exempt employees eligible for overtime, and the new threshold of $47,476 will cover a wide array of medical practice positions such front desk staff, coders, billers, and medical assistants. You must begin preparations now, and it's not simply a matter of budgeting for potentially much more overhead – you must also develop methods to track overtime and determine which employees will become eligible.

Aside from the slight reduction to the salary threshold, the only other piece of good news is that employers have more time to prepare. The proposed rule offered only 60 days to comply while the final rule sets Dec. 1 as the deadline.

### Threshold to automatically increase

The impact of the overtime rule will escalate in coming years; the final rule includes a provision that will increase the minimum salary

(continued on pg. 3)

threshold every three years. Employers will have to continuously monitor the minimum acceptable salary level for exempt classification, identify affected employees, and assess whether to reclassify those employees or restructure jobs. Based on current projections, the salary threshold is expected to exceed $51,000 in its first three-year update on Jan. 1, 2020.

Depending on the timing of the increases, employers may need to restructure their review and compensation cycles to better align with this new regulatory scheme and train managers to account for overtime changes when they are making decisions on merit raises and bonuses. In addition, some employers will need to take a long, hard look three years ahead to decide whether continued salary increases are sustainable or whether certain positions should simply be reclassified at the time of the review.

## Duties tests and highly compensated employees

The final overtime rule made no changes to the duties test. However, it did raise the salary threshold for highly compensated employees from $100,000 to $134,004, or the 90th percentile of full-time salaried workers nationally. Like the standard exemption threshold, the highly compensated employee exemption threshold will increase every three years beginning Jan. 1, 2020.

**Note:** The rule can also indirectly affect employee benefits. Some exempt employees enjoy additional benefits or perks that they may lose when reclassified as nonexempt (and thus eligible for overtime).

## Steps to take now

The final overtime rule will have wide-ranging effects on your practice and you need to take steps now so you will be compliant on Dec. 1. Below is a list of suggested steps to take now:

- Assess the costs of reclassification vs. salary increases. Determine if it's feasible to raise salaries to retain the exempt status of employees with salaries very close to the new threshold. Reclassify those who fall under the new threshold and determine their pay structure – salaried plus half time, hourly plus time-and-a-half, bonus and commission changes. Nondiscretionary bonuses and commissions are included in the calculation of the exempt salary threshold up to 10% of the required salary level, as long as employers pay those amounts on a quarterly or more frequent basis.
- Implement and communicate the compliant approach to affected employees and managers. Determine whether you will communicate the rule's changes via one-on-one meetings, small group meetings, large group meetings, memos or a combination of these approaches.
- Train supervisors on managing nonexempt employees.
- Check whether state wage notification laws require a pay period or 30 days' notice of any change in pay and send out notices accordingly, if required.
- Determine effects on benefits as a result of reclassification.

Educate your managers on how to:

- Train nonexempt employees to track and report overtime.
- Avoid encouraging after-hours work, especially if it leads to efforts to game the system (i.e. by being less productive during working hours to create more overtime hours).
- Watch employee morale in the event of reclassification. Reclassified employees may view the change as a demotion. Communications with employees should emphasize that reclassification is purely the result of regulatory changes. Employers should note that any reclassification is not a reflection of the value of an employee's contributions to the organization and that the company will work with affected employees to make a successful transition.

## Expect aggressive enforcement

The top officials in the Obama administration charged with enforcing the rule are Secretary of Labor Thomas Perez and Wage and Hour Division Administrator David Weil. Both have indicated their commitment to increased enforcement and the new rule is expected to be policed aggressively.

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MEDICARE RULES

# Proposed MIPS rule tweaks meaningful use

Your practice's performance in terms of quality reporting and electronic health record (EHR) meaningful use will start to be recorded on Jan. 1, 2017 – less than six months from now – in order to determine your future Medicare payment adjustments under the new Merit-Based Incentive Payment System (MIPS). The first adjustment will hit in 2019.

In an earlier issue of *The Business of Medicine*, we addressed the highlights of the MIPS proposed rule, focusing on the changes to Medicare's quality reporting program. In this article, we'll look at changes to meaningful use as well as how the overall MIPS score is generated and how it results in positive or negative payment changes for you.

As promised by CMS, the meaningful use program will be replaced with something called the Advancing Care Information (ACI) category, which is one of the four components of the MIPS program. We will discuss the other components and the overall MIPS score in detail later.

## MIPS vs. stage 3 meaningful use

The biggest difference between the ACI category of MIPS and stage 3 of the existing meaningful use program is that ACI is not a pass/fail proposition, says Stanley Nachimson, a former Senior Technical Advisor for Health IT at CMS who is now CEO of Nachimson Advisors in Reisterstown, Md. "Eligible clinicians can get some credit, up to 50% [of the possible MIPS score] for using a certified EHR and performing some tasks," Nachimson explains. "They are not required to meet every single criteria, as they were in the meaningful use program."

A major strike against meaningful use is that when providers attest, if they aren't 100% successful they get no incentive payment. This goes away with MIPS, Nachimson says. The ACI category gives providers a score of up to 131 points based on the measures they report, all of which are adapted from existing stage 3 meaningful use criteria. Earning 100 points or more will give providers the maximum possible *category* score of 25 points. This 25-point maximum possible score represents the most credit providers can get for the ACI component of MIPS, which is added to the overall MIPS score.

## How MIPS score is calculated

Let's address the confusion, much of which is the result of CMS using the same term, "points," to grade providers within each MIPS category as well as for the final MIPS score itself. As mentioned earlier, MIPS consists of four components, also known as categories, each of which is scored and weighted individually, then combined to create a final value called the MIPS Composite Performance Score (CPS).

Weighting is crucial, because the quality reporting category (replacing the Physician Quality Reporting System or PQRS) accounts for 50% of the MIPS score. Meaningful use, now the ACI category, accounts for 25% of the CPS. The CPS is a value from 1 to 100 and it ultimately determines the payment adjustment. In 2019, the range runs from a negative 4% penalty to a positive 4% bonus. Your meaningful use performance can contribute at most 25 points to the CPS score, while your quality reporting can contribute at

most 50 points. Perfect scores in these two categories alone would yield a 2.5% positive payment adjustment in 2019.

### Final rule could change numbers

It's important to remember that all of these values and calculations are based on the proposed rule, Nachimson says. You can find the full text of the MIPS proposed rule here. The official public comment period ends June 27 and you may submit feedback to CMS until that date. Visit *The Federal Register* page for MIPS to view or submit comments.

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## ACCOUNTING

## Beware new IRS phone scam

"Hello, this is Agent Smith with the IRS, ID number 74930. You owe delinquent taxes and must pay immediately. Give us your bank or credit card information or we will send you to jail."

If you get a phone call that sounds like this, hang up immediately because it's a scam. Unfortunately, too many taxpayers learn this after they have given the caller access to their bank accounts or credit card information. The scenario outlined above topped the IRS "Dirty Dozen" list in 2016. The "Dirty Dozen" is a list published annually by the IRS that details recent tax scams and cons. The IRS recently released an updated bulletin to warn taxpayers about these types of ploys. The agency outlines several ways to distinguish between a real IRS agent and an imposter.

"We continue to say if you are surprised to be hearing from us, then you're not hearing from us," IRS Commissioner John Koskinen states in the bulletin. All genuine IRS communications begin with a letter to the taxpayer, so a phone call out of the blue is an immediate indication that the IRS isn't actually involved.

Below is a list of five things the IRS **will never** do:

1. Call to demand immediate payment, or call about taxes owed without first having mailed you a physical bill.
2. Demand that you pay taxes without giving you the opportunity to question or appeal the amount they say you owe.
3. Require you to use a specific payment method for your taxes, such as a prepaid debit card.
4. Ask for credit or debit card numbers over the phone.
5. Threaten to involve local police or other law enforcement to have you arrested for not paying taxes owed.

If you do receive one of these phone calls, hang up and contact your tax professional immediately. They will be able to help you contact the IRS and confirm its authenticity. They can also verify whether you have any outstanding liability. You may also contact the IRS directly by taking one of the steps below:

- Contact TIGTA to report the suspicious call. Use their IRS Impersonation Scam Reporting site or call 800-366-4484.
- Report the incident to the Federal Trade Commission by visiting FTC.gov and clicking "File a Consumer Complaint." Include the remark "IRS telephone scam" in the notes.
- If you think you might owe taxes, call the IRS directly at 800-829-1040.

**Note:** It's important not to be intimidated by the scammers as they will try any tactic to separate you from your money. Various scammers have been known to target the elderly and immigrants who have a limited understanding of our tax system. Younger taxpayers and students in particular are a new target, Commissioner Koskinen says. "These scams and schemes continue to evolve nationwide, and now they're trying to trick students."

One of the most recent iterations of the scheme is targeting students by telling them they owe a "student tax." These particular scammers request that students pay with a prepaid debit card or iTunes gift card. The IRS will never request any such payment method. There is no "student tax."

Another recent tactic involves targeting human resources professionals. The HR specialist will receive an email that looks like it came from their boss, asking for personal employee information such as W-2 forms, Social Security Numbers, or home addresses. The scammer will then use the information to steal employees' identities. Below are sample scam emails taken from an IRS bulletin:

- "Kindly send me the individual 2015 W-2 (PDF) and earnings summary of all W-2 of our company staff for a quick review."
- "Can you send me the updated list of employees with full details (Name, Social Security Number, Date of Birth, Home Address, Salary)."
- "I want you to send me the list of W-2 copy of employees wage and tax statement for 2015, I need them in PDF file type, you can send it as an attachment. Kindly prepare the lists and email them to me ASAP."

No matter what the scam, the best response is to protect your personal information. If anyone purporting to be from the IRS contacts you with a request for information, investigate it before providing anything. You can never be too careful when it comes to your personal information.

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REVENUE CYCLE MANAGEMENT


## Look before you cross: A practical approach to revenue growth

In a perfect world, you would show up to work, see a patient, submit a claim, and be paid. Patients would always arrive on time for their scheduled appointments having their correct insurance, health questionnaire and family history information in hand, ready to go when they arrive at the front desk. Your charges for the services rendered would reasonably reflect not only the cost, but the true value of what you did, and you would actually be paid the amount you billed. It goes without saying that, unfortunately, this is not even close to the world we live in.

In our world, a huge amount of competition exists for the limited dollars available to pay for healthcare services, and with recent quality and outcome measures added to the mix alongside dwindling reimbursement, it's harder than ever for providers to simply stay in the black.

When presenting on this topic, we often begin by asking attendees: "What would you say is the most important responsibility of a medical practice?" The inevitable, nearly unanimous response (***which may have even crossed your mind while reading this***) is: "Provide quality care to our patients."

This is a noble objective and is definitely high on the list, but in our opinion, it's not achievable unless the *actual* most important obligation is met first: The obligation to maintain practice profitability. Unless you are a military or government-mandated practice, or some other form of deficit-funded facility, you'll reliably go out of business if you aren't profitable. If that happens, no one wins; your patients will no longer have access to the quality care you provide and you'll no longer be practicing the way you really want to. In short, to take good care of your patients, you must first take good care of your practice.

### Profitability is a simple equation

Profitability actually is a pretty simple algebraic equation: revenues divided by expenses. To increase profitability, you need to increase the numerator (revenues) or decrease the denominator (expenses), or do some combination of both. Let's examine each of these options in a little more detail.

First, let's look at expenses. You always have the option to reduce staff pay and benefits, but what happens when you lower these expenses to below market value? You end up with a high attrition rate (i.e., people quitting) or at the very least, a disgruntled staff. In either scenario, the quality, continuity of care, and office morale usually declines, resulting in a less-than-ideal situation for the practice.

This inadvisable option is further complicated by the recently finalized overtime law (see story, pg. 1), which effectively increases the number of employees who are eligible for overtime pay. Some practices turn to layoffs or reducing work hours in an attempt to control payroll expenses, but as many have discovered later, changing staffing levels without changing the way they do business ends up being more expensive in the long run because of mistakes, missed opportunities, and rework. Though it's important to monitor and control your payroll expense, it may be even more important to examine other factors that are likely impacting your profitability.

How about reducing volume? Well, because we have not yet figured out an efficient way to get paid based on outcomes, volume continues to rule with regard to revenue, so when

you reduce volume, you reduce revenue. The bottom line? Quality is expensive and volume is necessary.

If you can't do much to make a significant dent in your expenses, then shouldn't you just focus on increasing revenue via increased patient volume or charge amounts? Well, in theory, but as we mentioned earlier, that may be easier said than done. Unlike any other industry that comes to mind, healthcare is one of the few business models in the U.S. where, with the exception of concierge providers, the amount you charge bears little resemblance to the amount you're eventually paid. Even if you filed 100% clean claims, you'll inevitably be paid less than you should.

Here's why: You're scheduled to see a patient, but even before the office visit occurs, you have to verify the patient's insurance coverage and that it will pay for the visit or procedure in question. After all, patients rarely pay for their own care. Finally, you see the patient and nearly 1,600 decision points later, one or more procedure codes are selected from a possible list of 150 or so evaluation and management codes and possibly 15,000 other HCPCS codes. Add to this the 300 or so possible code modifiers and you end up with around 976 billion possible combinations from which to choose.

Your job, should you accept it, is to pick the right one. And to get paid, you need to correctly match these procedure codes with one or more of the 69,823 diagnostic ICD-10 codes. Once you make it through these murky waters, the claim goes to a payer with a charge that often seems irrelevant because the payer has a predetermined payment amount. It derived this amount from one fee schedule out of a thousand that it has distributed between different markets and products. When the claim either goes unpaid or underpaid, there is a set of codes that comes from a list of five group codes, 250 reason codes, and 650 remark codes. This means there are 976 billion possible reasons for your claim to be unpaid or underpaid, and you are responsible for knowing which one is the right one. And if you didn't do this in the beginning of the process, you likely will have some portion to collect from the patient, who must make a choice between paying you and taking the kids to Disney World. In the most recent National Health Insurer Report Card (created by the American Medical Association or AMA), it was reported that the payer ends up paying nothing for nearly one out of every five claims filed. Of the remaining four claims that are paid, approximately 80% are paid incorrectly.

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COMPLIANCE

# 6 tips to handle Medicare enrollment and revalidation

CMS has recently beefed up its efforts to conduct random site visits to ensure that enrolled providers and suppliers aren't actually storefronts engaged in fraudulent billing. Unfortunately, many practices and providers have gotten caught up in these efforts, making the already unforgiving enrollment and revalidation process even more punishing when mistakes happen.

Even so, CMS needs to do more to combat Medicare fraud, according to a report by the Government Accountability Office (GAO). "The GAO analysis identified areas for improvement in our Provider Enrollment Chain and Ownership System (PECOS) regarding verification of provider and supplier practice locations and physician licensure statuses," CMS writes in a Feb. 22 press release. "The GAO's findings supported CMS' efforts to further enhance provider and supplier screening activities. CMS has begun increasing site visits to Medicare-enrolled providers and suppliers, enhancing and improving IT systems and implementing continuous data monitoring practices to help make sure practice location data is accurate and in compliance with enrollment requirements."

The release listed four specific steps CMS is currently taking in response to the GAO report that will crack down on Medicare fraud with respect to enrollment and billing:

- **Increasing site visits** to providers and suppliers already enrolled in Medicare (including those needing revalidation), using its site visit contractor (visits performed by individuals employed by a private firm).
- **Using its online PECOS system** to "better detect vacant or invalid addresses or commercial mail reporting agencies."
- **Analyzing enrollment data** to identify and deactivate providers or suppliers "meeting specific criteria that have not billed Medicare in the last 13 months."
- **Monitoring addresses** of enrolled, enrolling, and revalidating providers and suppliers each month, checking against U.S. Postal Service databases to weed out invalid addresses.

To help you with these complex processes, *The Business of Medicine* spoke to several orthopaedic groups who have recently undergone new provider enrollments and revalidations.

## New provider enrollment

Having plenty of lead time is crucial, says Don Schreiner, MBA, CEO of OrthoIllinois in Rockford, Ill. He regularly tells all new hires that it "may take up to 120 days" to get them to their start date – a habit that he finally took to heart after his credentialing staff trained him repeatedly, Schreiner jokes.

**1. Lead time and documentation.** New providers without national provider identifiers (NPIs) must first apply for an NPI, a process that can take up to four weeks, and requires the individual's diploma, state licensure documentation, and even school transcripts to expedite, says Leslie Elmer, CPCS, credentialing coordinator at OrthoIllinois.

**2. Use online PECOS for more speed.** Medicare offers a web-based system for managing new provider enrollments, existing revalidations, reassignments, and any other enrollment information called PECOS – the Provider Enrollment Chain Ownership System mentioned above in the press release. When Elmer switched from paper CMS-855 application forms to online PECOS, she noticed every process ran faster, often by a week or more.

**3. Don't be afraid to call, and be persistent.** Despite her preparations and lead time, Elmer does run into problems with individual applications, and her advice is to call whenever you find yourself in that situation. "You have to be your own best advocate and call CMS, wait if you have to, but call and explain the details to a live person," she says. **Tip:** It's best to call your specific CMS carrier rather than your CMS regional office, which will typically refer you to your carrier unless you've already spoken to them and need to escalate.

**4. Retroactive billing is always an option.** In the worst-case scenario, you have a provider starting work without billing privileges, but that doesn't mean he or she simply sits around. You can retroactively bill back to the application date on a successful Medicare enrollment application, and suffer no negative consequences other than a slight delay in payment.

## Revalidations

Durable medical equipment (DME) suppliers have the hardest time with revalidation since CMS has classified them as a high-risk provider type.

**5. Get the address right.** In one case, revalidation letters were sent to a provider's old address – to a physician's address when she was still a fellow, says Christy Owen, revenue cycle manager at Advanced Orthopaedics Sports Medicine in Houston. In another case, a P.O. box was left off of the DME application, which resulted in frozen payments and $15,000 held up, Owen says. These were both situations that required escalating to CMS. Having the address correct, down to the most precise punctuation of names, is crucial since corrections restart the waiting process for a response.

**6. Signage at office locations.** CMS on-site inspectors visited a satellite office of Alabama Orthopaedic Specialists PA, but visited the wrong address, resulting in revocation of billing privileges, says Ron O'Neal, MPH, FACHE, administrator. He had to send photos of the correct office to get CMS to repeat the site visit, at which point the inspectors informed him that his signage required correction. It didn't say that the location was "by appointment only," so this had to be added. It's important your signage is totally clear about office hours, O'Neal says.

Satellite offices that have variable hours have proven to be a very tough nut to crack when it comes to random site visits, O'Neal says. CMS doesn't want to call ahead since this would make the visit not random. There's no easy answer for this, but it may require escalation to your CMS regional office.

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