Volume 1, Issue 5

The Business of Medicine Newsletter

"Leave the Business of Medicine to Us"

Inside DoctorsManagement: Message from the President

Will the ACA Impact Your Business (Medical Practice)?

You likely know the Affordable Care Act (ACA) is here to stay. You also know that the cost of healthcare in this country during the last two decades has gotten out of hand and that reimbursements have not kept pace with the costs associated with providing patient care. With this in mind, the government hopes the ACA is the best way to counter these costs.

One big debate in Congress is on the impact of the ACA on small business. These regulations mandate that businesses with at least 50 full-time employees provide insurance coverage or face financial penalties. This might pose a significant financial problem for businesses right near that 50-worker mark. Many small business owners are already feeling the pinch of running their business, and adding a large mandated cost is yet another hurdle to clear.

We know that health insurance is already a large cost associated with running a small business and it might get bigger. According to the National Conference of State Legislatures, small businesses in the past paid on average about 18 percent more than larger firms for the same health insurance plan. It is often the case that small businesses face a larger burden when it comes to purchasing insurance for their employees. The good news for our practices is that under the ACA most patients will now have coverage, while many businesses are struggling with the added costs of providing that coverage.

It might be important to understand how the government defines the various types of employees. A full-time employee is anyone who works at least 30 hours a week. Part-time workers can also count towards the total number of full-time workers. Their hours are added up and then divided by a 40-hour workweek. So a couple of part-timers who work 20 hours a week add up to a full-time employee. If you have a mix of part-time and full-time workers, you could easily be pushed over the 50-employee mark into the employer mandate zone without even knowing it.

With each passing change in healthcare reform, we are called to prepare ourselves for what lies ahead. One way small businesses can be more successful in light of the ACA is to work on their organizational structure as well as budgeting as they approach the 50 employee mark. DoctorsManagement would recommend that your practice work on this and other issues related to the ACA, such as coding, billing and reimbursement, and OSHA, and be compliant by the October 2013 implementation date. Let's all do the best we can with this new program.

Yours in Success,

Paul L. King
President
DoctorsManagement, LLC

OSHA News

On March 26, 2012, OSHA released its new Hazard Communications Standard with significant changes to be phased in over several years. The HazCom Standard is now aligned with the Globally Harmonized System of Classification and Labeling of Chemicals (GHS).

OSHA requires manufacturers to classify the hazards in the chemicals they produce, to comply with new labeling requirements, and to create Safety Data Sheets to replace the current Material Safety Data Sheets. Employers are required to maintain a current, comprehensive list of hazardous chemicals; to obtain Safety Data Sheets (SDSs) for each chemical on the list; to develop a written hazard control plan; to ensure labeling for worksite containers; and to train employees.

The first deadline is for the new employee training requirements, with a compliance date of December 1, 2013. Employers must prepare employees to understand the new SDSs and the new labeling system in anticipation that employees will begin seeing these even before manufacturers are required to use them.

Next is the deadline for the new Safety Data Sheets, which must be provided by the manufacturer or importer by June 1, 2015. The employers must obtain the new SDSs and make them available to employees. They will be in a specified 16-section format with improved information needed by employers and employees. For example, chemical identification must be in Section 1 and first aid information must be in Section 4.

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Special Features

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

Inside this issue:

OSHA News, continued

Manufacturers, distributors, and importers must use compliant labels by December 1, 2015. The new labeling system requires the chemical identification; a signal word, either "Warning" or "Danger," with "Danger" indicating a more hazardous chemical; a hazard statement; and pictograms. Pictograms include a black graphic on a white background surrounded by a red diamond. See the examples below:

Flame

- **Flammables**
- **Pyrophorics**
- **Self-Heating**
- **Emits Flammable Gas**
- **Self-Reactives**
- **Organic Peroxides**

Flame Over Circle

- **Oxidizers**

The final change requires employers to update their alternative workplace labeling and hazard communication program as necessary and to provide additional employee training for newly identified physical or health hazards by June 1, 2016. OSHA will allow employers to continue using the labeling system already in place, but the information on the labels must be sufficient to provide employees with the information needed and to connect the chemical with the Safety Data Sheets and the information on the manufacturers' labels.

Ann Bachman, CPC (AMT), MT (ASCP)
Director of OSHA/CLIA/HIPAA Dept.
Partner, DoctorsManagement, LLC

Cloning of Medical Records

It's hard to blame providers for wanting to find shortcuts or ways to be more efficient when it comes to documenting levels of evaluation and management services. However, cutting and pasting or carrying forward is not the way to achieve this.

The word "cloning" refers to documentation that is worded exactly like previous entries. This may also be referred to as **"cut and paste"** or **"carried forward."** Cloned documentation may be handwritten, but it generally occurs when using a preprinted template or an Electronic Health Record (EHR). While these methods of documenting are acceptable, it would not be expected that the same patient had the same exact problem and symptoms and required the exact same treatment or that the same patient had the same problem/situation on every encounter.

Cloned documentation does not meet medical necessity requirements for coverage of services. Identification of this type of documentation by a payor or carrier will lead to denial of services for lack of medical necessity and recoupment of all overpayments.

There are numerous examples out there of providers taking shortcuts and it coming back to haunt them. For example, a three-month-old baby failed her family physician's "oriented x3" test because the physician's computer-generated exam noted that the newborn was unable to state her name or answer other key questions doctors generally use to test mental acuity in elderly patients. There is another story out there about a doctor who repeatedly entered "arteriosclerosis" as a diagnosis for patients with chronic coronary artery disease because his electronic medical record "drop down" menu didn't list the specific condition he wanted to report. I am sure we can all relate to the specialist who routinely returns seven-page E/M notes to the primary care doctor filled with exam points that look like more than he/she actually would have performed and with an extensive history with no pertinence to the condition he's treating. These are the things that get providers in trouble. You may have chuckled about the examples of cloning listed above, but it is happening and I bet it is happening in your practice without even knowing it.

Items that could be linked to cloning:

- Op Reports that were obviously pre-populated templates and were identical in content even down to the Estimated Blood Loss.
- Gender errors resulting from a cut and paste function. A patient is "he" in one paragraph and a "she" in another paragraph.
- Documentation in the H&P indicating body system findings are Within Normal Limits (WNL), yet the same body system is the reason for the admission and is, in fact, not within normal limits.
- Protocols that are being used as standard orders and in most cases have not been adapted to the patient, resulting in many pages of orders.
- The use of pre-populated templates for H&Ps, Discharge Summaries and orders creates a huge medical record, but it is often repetitive and reimbursement is not based on the quantity of documentation but upon the quality of the documentation.
- The "cut and paste" option used when templates are not pre-populated creates less credible information because errors go unnoticed within the volume of the records.

DoctorsManagement suggests that all practices develop a specific policy related to cloning as part of their compliance efforts. As a matter of fact, you should be able to create your policy just based on the information contained within this article - we did!

Shannon DeConda
Partner, DoctorsManagement, LLC
President of NAMAS

Ophthalmology Diagnosis Coding—Are you ready for ICD-10?

Every specialist has their own set of worries in regards to the transition to ICD-10. In Ophthalmology, we too often find unspecified diagnosis codes in our documentation and on the claim forms. Understanding how ICD-9 and ICD-10 classify different conditions will help aid in syncing these terms to your documentation. Let's focus today on preparing our *current* medical records for ICD-10 selection.

Two main areas are common culprits for unspecified diagnosis codes: Glaucoma and Cataracts.

Glaucoma

Review of documentation often lists glaucoma as controlled or uncontrolled, but the available diagnosis codes in ICD-9, as well as their syncs to ICD-10, do not make such statements. Listed here are the main categories we work with in glaucoma:

TYPE	ICD-9	ICD-10
Borderline glaucoma	365.0x	H40.0xx
Open-angle glaucoma	365.1x	H40.1xx
Primary angle-closure glaucoma	365.2x	H40.2xx
Unspecified glaucoma	365.9	H40.9

Within most of these ICD-10 categories, we have specific codes for the glaucoma stage as well: mild, moderate, severe, unspecified and indeterminate. For example, H40.11X2 reports Primary open-angle glaucoma, moderate stage. In ICD-9 we would have to report 2 codes, 365.11 for POAG and 354.72 for glaucoma moderate stage.

If our documentation does not reference the specific type of glaucoma and its stage, we are forced to report H40.9 for unspecified. Our carriers will set policies to reduce or withhold payment of surgical procedures as well as office visits when the specific condition is not listed. Start clarifying glaucoma type, stage and specific eyes affected now so ICD-10 doesn't disrupt your documentation and coding process.

Cataracts

Medicare states that a cataract has to be visually significant to warrant removal. In documentation, typically this is all the information we're given: "Visually significant cataract." Like our situation with glaucoma, there are no current ICD-9 or ICD-10 codes to report a visually significant cataract. Instead, cataract diagnosis codes are broken down into the following types:

TYPE	ICD-9	ICD-10
Infantile, juvenile, presenile cataract	366.0x	H26.01x-H26.09
Senile cataract	366.1x	H25.0-H25.9
Traumatic cataract	366.2x	H26.10xx
Cataract 2nd to ocular disorder	366.3x	H26.21x – H26.23x
After-cataract	366.5x	H26.4xx

The most common diagnosis reported with cataract extraction surgery is 366.16, senile nuclear sclerosis cataract. This crosswalks to one of four new ICD-10 codes.

H25.10 Age-related nuclear cataract, unspecified eye

H25.11 Age-related nuclear cataract, right eye

H25.12 Age-nuclear cataract, left eye

H25.13 Age-related nuclear cataract, bilateral

If the only thing listed on the operative report is "visually significant cataract," we can only report 366.9, unspecified cataract. In ICD-10, this would be reported as H26.9, unspecified cataract. Your payers including Medicare will stop accepting these generic codes for payment on surgical procedures and diagnostic tests as they do not support the need for surgical intervention or certain testing procedures. Review the category classifications now and start including these definitions in your documentation today.

DoctorsManagement can review your current documentation and provide valuable feedback on ICD-10 readiness, for any specialty or subspecialty. Do not wait until ICD-10 implementation to find pitfalls in your documentation.

Regan Tyler
Senior Consultant
DoctorsManagement, LLC

Providers' Audit Tip of the Month

Compliance Motivation

Having trouble deciding if your practice is in need of a compliance audit?

Health and Human Services has proposed an increase in financial rewards given to individuals whose tips regarding suspected fraud lead to successful recovery efforts.

Previously the bounty paid was 10% of the recovery, up to $1,000.

Revised the bounty will increase to 15% of the recovery, up to $10 million.

This reward is not limited to just Medicare Beneficiaries but is open to anyone whose tip leads to the successful identification of fraud.

HHS proposed this change in late April 2013 in an effort to model their recovery efforts as those of the IRS, which they hope will lead to an increase in recoupments.

Performing an audit on billing, coding and documentation may help identify deficiencies and improvements to help avoid potential liabilities.

Shannon DeConda
Partner, DoctorsManagement, LLC
President of NAMAS

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

Notice to Employees of Health Insurance Marketplace Coverage Options

On May 8th, the U.S. Department of Labor (DOL) issued Technical Release 2013-02 to provide "temporary" guidance to employers regarding a new requirement, created by the Affordable Care Act (ACA), that employers provide a notice to employees of coverage options available through the Health Insurance Marketplace (referred to in the statute as the "Exchange") **by October 1, 2013**. This is the same notice, you might recall, that was postponed on January 24, 2013, for a March 1st distribution date --- moving the expected timing for distribution to late summer or fall of 2013, which would coordinate with the open enrollment period for the Marketplace.

Under the ACA, individuals will be able to purchase health coverage through state or federally facilitated Health Insurance Marketplaces. The Marketplace is touted to offer "one-stop shopping" to find and compare private health insurance options. Individuals will be able to enroll for coverage through the Marketplace beginning October 1, 2013, with initial coverage beginning effective January 1, 2014. The Technical Release provides needed guidance to employers regarding the notice requirement and provides Model Notices.

Employers Subject to the Notice Requirement

The Marketplace notice requirement applies to all employers that are subject to the Fair Labor Standards Act (FLSA). In general, the FLSA applies to employers with at least one employee and annual revenues equal to or greater than $500,000.

Providing Notice to Employees

Employers must provide the applicable Marketplace Notice to Employees of Coverage Options to all employees, regardless of their plan enrollment status or whether they are part-time or full-time. However, notices are not required for dependents or other individuals who are not employees.

Timing and Delivery of Notice

Employers must provide the Marketplace Notice in writing to all existing and new employees beginning October 1, 2013. For 2014, an employer will meet the notice obligation if it provides it within 14 days of an employee's start date.

The Notice can be furnished by First-Class Mail or electronically when done in a manner that meets the requirements of the DOL's electronic disclosure safe harbor rules.

There can be no charge to employees for the notice.

Notice Content and Format

The Technical Release includes two model Marketplace notices: one to be used by employers offering health coverage and one to be used by employers not offering coverage.

The notice must be understandable by the average employee and must include the following information:

1. A description of the services provided by the Health Insurance Marketplace and how to contact the Marketplace for assistance;
2. If the employer plan's share of the total allowed costs of benefits provided under the plan is less than 60 percent of such costs, the employee may be eligible for a premium tax credit under Section 36B of the Internal Revenue Code (the Code) if the employee purchases a qualified health plan through the Marketplace; and
3. If the employee purchases a qualified health plan through the Marketplace, the employee may lose any employer contribution (if any) to the employer-sponsored health plan, and all or a portion of such contribution may be excludable from income for federal income tax purposes.

Model Notices

The Model Notices provided by the DOL feature general information in Part A, including the required information noted above. Part B advises the employee of information he or she will need to gather in order to apply for coverage through a Health Insurance Marketplace, including:

- Employer name and Federal Employer Identification Number
- Employer address and phone number
- The name, phone number and email address of an employer contact who can discuss employee health coverage with Marketplace officials

This additional information will be required from employers who offer a health plan to some or all employees:

- Information about any health coverage offered by the employer, including whether health coverage is offered to some or all employees, eligibility criteria, and availability of dependent coverage.
- Does the employer coverage meet the minimum value standard, and does the cost of the coverage to the employee meet the affordability tests?

Employers are permitted to modify the Model Notices, provided that they meet the content requirements described above.

For the DOL Technical Release 2013-02 and model notices go to:

*www.**dol**.gov/ebsa/pdf/FLSAwithplans.pdf*
for an *employer offering a health plan*

*www.**dol**.gov/ebsa/pdf/FLSAwithoutplans.pdf*
for an e*mployer not offering a health plan*

Reliance

The DOL issued this "temporary" guidance and model notice in advance of the expected timeframe due to requests from several employers. The "temporary" guidance contained in Technical Release 2013-02 may be relied upon and will remain in effect until the DOL issues new regulations or other guidance. Future regulations or other guidance on these issues are expected to provide adequate time to comply with any additional or modified requirements.

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

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

Differentiating Your Practice

Fifty years ago, a doctor could open the practice doors and patients would come. This is no longer the case. Medical practice competition continues to grow with retailers like Walmart and CVS opening clinics to having several specialists in the same town. Patients now have choices for seeking medical care.

Some practices believe a special procedure or skill set is enough to differentiate themselves from completion. At any time, another practice could open its doors and offer the same procedure or hold the same skills.

The most effective way to differentiate your practice is through customer service and professional image. The delivery of customer service and professional image not only sets your practice apart from your competition but also sets the tone for the entire experience.

With social media sites like Facebook and Twitter, one poor comment about a patient experience can dramatically affect the image of a practice. For example, a patient can tweet that they had a horrible experience at their recent visit to the doctor, now making all of the followers aware of the level of service received at this one practice.

The professional image can make or break a practice. For example, you could be the most skilled practice in the area but if you have a negative image, you are not the most skilled practice in the area - you are the practice with the bad reputation.

Your professional image is compiled of several components including how your entire staff behaves and looks as well as the aesthetics of the office. Walking into an office where the staff is behaving inappropriately leads the patients to believe the treatment will also be unprofessional. The same is true if your office appears old. Patients begin to question whether the treatment is going to be behind the times.

By going the extra mile with service and image, you now have the ability to easily differentiate your practice from your competition.

Lauren King,
Director of Customer Service & Leadership
DoctorsManagement, LLC

New DoctorsManagement Clients

Hospital Health System—Ft. Lauderdale, FL
Ophthalmology Practice—Jacksonville, FL
Cardiovascular Clinic—Orlando, FL
Eye Clinic—Griffin, GA
Cardiology Practice—Thomasville, GA
Hospital Health System—Homer, LA
Hospital Health System—Cincinnati, OH
Family Practice—Mt. Pleasant, SC
Orthopaedic Practice—Kingsport, TN
Laboratory Services Center—El Paso,TX
Rheumatology Practice—Allen, TX
Podiatry Practice—Miami Beach, FL
General Surgery Practice—Ocala, FL
Sports Medicine & Orthopedic Practice—Fort Wayne, IN

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King's Corner

During the month of April, the Power Buying division within DoctorsManagement made a significant impact on the finances of one of our clients. The savings for the practice was almost $60,000 and they had to do nothing more than become a member of one of our GPO partners! We connected a cardiology group in South Georgia to the Triad Isotopes contract through our GPO partner and saved them a little over $59,000 per year on their Sestamibi purchases. This client was already using Triad Isotopes, but they were not connected to any GPO contracts— so literally nothing changed for them except their pricing!

This is just one small piece of the savings we can provide our customers by simply becoming a member of our Power Buying program. To learn more about this program and what we can do for you, contact Craig King at cking@drsmgmt.com.

Craig King
Partner, PowerBuying Department Director
DoctorsManagement, LLC

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