Hall, Kistler & Company LLP

Doctor Perspectives

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Conflict in the Healthcare Arena: What Physicians Can Do About It

Do you and your partners frequently have difficulty working through strategic planning issues? (Is there internal strife between your office manager and the lead nurse?) Is the hospital committee you serve on a source of confusion and ambiguity rather than a source of professional pride?

Conflict is an incompatibility of interests, goals or perspectives. It is a natural occurrence in daily life and human interaction. It is an expression of differences. If it is managed correctly it can be the source of growth, strength and positive change. If not, it can mushroom into a host of damaging adverse results.

Conflict in the healthcare arena

Research demonstrates that unmanaged conflict has numerous costly impacts and widespread implications on the healthcare system and its stakeholders. There are numerous types of conflicts that can occur. They can be categorized by either the identity of the parties or the nature of the issues. Disputes include workplace issues, such as employee management concerns, organizational disputes, which relate to governance, power, structure and authority, bioethics disputes, facility vendor conflicts and patient care disputes. They can lead to poor outcomes and even patient death.

Regardless of the nature or severity of the conflict the adverse impacts include direct costs such as low patient satisfaction, litigation payouts, quality and safety issues, high staff turnover rates, decreased efficiency and reduced productivity. Indirect costs include bad press and public relations.

Complexity and diversity of roles in healthcare make conflict more likely. Physicians are in a unique role with respect to the healthcare system and the patients it serves. Depending on the nature and duration of this relationship there is potential for misunderstanding. Varying perceptions and expectations surrounding physicians roles also can give rise to disputes. In addition, the diverse set of actors in the healthcare system, such as nurses, and administrators whose perceived role with regard to specific issues, such as scope of practice often are at odds with each other, or at a minimum a potential source of confusion which can lead to conflict. Compounding these difficulties is the hierarchical top down power structure which does not encourage expression of diverse views which may be at the root of the conflict.

Conflict management is a leadership issue

In 2009, the Joint Commission established a new leadership standard on conflict management (LD 02.04.01). This standard requires that the hospital manages conflict between leadership groups to protect the quality and safety of patient care.

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Conflict in the Healthcare Arena...(continued from pg 1)

It took ten years after the Commission on Health Care Dispute Resolutions issued their report encouraging use of alternative dispute resolution for resolving these disputes for this new standard to be issued. Previously, standards were put into place about disruptive physicians. Now, with this new Joint Commission standard the importance of properly managed conflict is on the front burner for hospital administration.

Conflict management skills are now recognized as a critical leadership skill. Successful physician leaders don't shy away from conflict; rather, they take it on with a spirit of open communication, full involvement of all stakeholders and respect for every viewpoint. They initiate a conflict resolution process to get to the root cause and fully resolve the issues. Unresolved conflict is like a festering wound, it only gets worse.

What physicians can do to manage conflict

- Recognize it in your organization
- Learn your inherent conflict handling mode--do you avoid, compromise, compete, accommodate or collaborate in conflict situations?
- Acknowledge your emotional response to conflict
- Address the conflict early and privately
- Conduct regular meetings with your team to ferret out issues that may be swept under the rug
- Convene a committee to establish a conflict management policy
- Put systems in place to manage conflict proactively
- Use an outside neutral mediator or facilitator to help the parties resolve the conflict
- Create conditions and opportunities for problem resolution

What physician executives can do to implement the Joint Commission standard

- Gather a group of experienced clinicians especially those with a quality assurance background
- Establish an environment where all staff feel safe to report problems without fear of retribution
- Review existing contracts and agreements for dispute resolution language
- Designate a conflict resolution subcommittee to draft guidelines for early identification and resolution of problems

Engaging in conflict, rather than avoiding it, is fundamental to good organizational health, whether it be a small medical practice or a healthcare system.

What is PECOS?

PECOS stands for Provider Enrollment, Chain and Ownership System which is the database where CMS enrolls providers and stores all of their enrollment records. Currently, CMS is requiring that all ordering/referring providers have a *current* and *complete* enrollment record in PECOS. So, if your practice has changed locations, changed the practice's business or personal name, Tax ID, etc., you need to let CMS know so that you are *current* in PECOS.

Now, you may think that you are current in PECOS because you haven't changed anything in years, but your record may not be *complete* in PECOS, even though you are receiving payments. You see, CMS updated their system in 2003 and not all the records transferred over completely. It is very important that you check your enrollment in PECOS to be sure that your record is current and complete. If you are - great, no changes are necessary. If not, you should rectify that immediately by completing the appropriate 855 enrollment application. The final rule regarding the requirement that the ordering/referring physician must be current and complete in PECOS was effective July 1, 2010, however, CMS will not start to reject claims not meeting this requirement until January 3, 2011.

Meaningful Use Update

Congress passed and President Barack Obama signed the American Recovery & Reinvestment Act (ARRA) in February 2009. The healthcare IT component of the Bill is the HITECH (Health Information Technology for Economic and Clinical Health) Act, which appropriates $23 billion dollars to encourage healthcare organizations to adopt and effectively utilize Electronic Health Records (EHRs) and establish health information exchange networks at a regional level. Physicians can receive up to $44,000 under Medicare or $63,500 under Medicaid for installing and implementing a certified EHR and using it in a meaningful way.

The initial legislation empowered the Office of the National Coordinator (ONC), which is part of Health and Human Services (HHS), to interpret the law and develop programs and policies to carry it out. After an extensive process, which involved several rounds of rulemaking and comments from interested third parties, the final rules and regulations were published in July 2010.

In order to be eligible to receive payments, each provider will have to register with HHS. The registration will occur online starting January 1, 2011. In order to receive payments, providers will have to prove that they are meaningful users. For 2011 and 2012, providers will attest to this fact via a secure, online portal that is currently in development. In addition to attestation, providers will have to identify the certified EHR technology they are using, as well as submit reports on product use and clinical metrics. Many of these reports should come from and be a feature of your certified EHR. Providers are expected to keep copies of these records for six years.

The final criteria for Stage 1 Meaningful Use are broken down into two sets. There are 15 Core Set Objectives/Measures that every provider is required to comply with. There are 10 Menu Set Objectives/Measures; each provider gets to choose 5 Menu Set measures to report on. Each provider must report on a total of 20 measures; however, the number of measures reported on can be reduced if a provider attests that a given measure is irrelevant to the practice (for instance, it may be irrelevant for a psychiatrist to record vital sign measurements for his patients).

Core Set Measures

1. Use CPOE (Computerized Physician Order Entry) to order medications for more than 30% of all unique patients with at least one medication in their medication list.
2. Enable drug-drug and drug-allergy interaction check functionality on the EHR for the entire reporting period.*
3. Maintain an up-to-date problem list of current diagnoses for 80% of all patients. If there are no problems, indicate no problems are known.
4. Maintain an up-to-date list of active medications for 80% of all patients.
5. Maintain an up-to-date problem list of medication allergies for 80% of all patients.
6. Generate and transmit prescriptions electronically for 40% of prescriptions written by the provider.
7. Record demographics for at least 50% of patients.*
8. Record and chart changes in vital signs for at least 50% of patients.*
9. Record smoking status for 50% of patients 13 and older.*
10. Report ambulatory clinical quality measures to CMS.*
11. Implement one clinical decision support rule relevant to the provider's specialty.
12. Provide at least 50% of patients with an electronic copy of their health information, upon request, within 3 business days.*
13. Provide at least 50% of patients with clinical summaries of their office visit within 3 business days.*
14. Perform at least one test of the certified EHR technology's capacity to electronically exchange key clinical information.*
15. For the EHR and its related IT network, conduct a security risk analysis and implement security updates as necessary; correct security deficiencies.*

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National News

Specialty News

End Stage Renal Disease Prospective Payment System and Consolidated Billing for Limited Part B Services, Effective January 1, 2011

The current method of reimbursing ESRD services will change January 1, 2011. Hospital based providers and ESRD facilities will be affected. All ESRD outpatient dialysis services will be covered under this new system, including supplies and equipment used in facilities and will also include patient's home services, drugs, biological, lab testing, training and support services.

This will be a four year transition that will initially blend the current and new payment systems. By January 1, 2014 the payments will be based solely on the new payment system. In an unusual move, providers may elect to skip the transition period and be paid completely under the new system.

As the new payment method goes into place, providers will need to make sure that they submit separate claims forms for dates of service in 2010 and 2011 to avoid delays in reimbursement.

For complete details and help in determining whether to choose to be paid under the transition payment method or skip directly to the new pricing system, go to http://www.cms.gov/MLNMattersArticles/downloads/MM7064.pdf

Audiology Policy Revisions

To assist providers of audiology services, CMS has released a MLN Matters article in an effort to clarify covered benefits and define who may provide services, including which services need to meet supervision requirements. The revised policies go into effect September 20, 2010. Details can be found at http://www.cms.gov/MLNMattersArticles/downloads/MM6447.pdf

Chiropractic Claims Under Scrutiny

One of the goals of Executive Order 13520, signed in November 2009, is to reduce improper payments and eliminate waste in Federal programs. The order requires Federal agencies to perform semiannual studies to identify areas of high risk while ensuring that warranted services are correctly paid. To that end, CMS is utilizing CERT to conduct these studies.

Chiropractic claims have been identified by CMS because the Medicare program only pays for medically necessary *acute* chiropractic services and does not cover "maintenance" therapy. The OIG conducted a study recently that found there were reasons for concern in regard to chiropractic claims submitted that may have been for maintenance therapy. In addition, the 2009 Medicare FFS error rate substantiated this, noting there was a 31.7% error rate in chiropractic claims which could result in $174.1 million of improper payments.

In August CERT letters began going out to Chiropractors in regards to DOS (dates of service) rendered from April 2010 through June 2010, but requesting records not only for those DOS, but also for the prior 12 month period. CMS will focus on determining if services were for maintenance therapy with the intent of recouping any overpayments identified, while training and educating the provider in appropriate billings.

Physical Therapists the *First* Targets of Comparative Billing Reports

Another tool in the arsenal to identify improper payments and to educate providers, the Comparative Billing Report (CBR) is designed to compare individual providers to their peer groups, looking at specific procedures and services and how they were billed. The information provided will be compared with 2009 Medicare claim data. Safeguard Services, LLC was awarded the contract to produce the CBRs, and they will be distributed by Livanta LLC.

In August, as many as 5,000 independent physical therapists that provide outpatient physical therapy services were sent a CBR. The focus will be on the use of the KX modifier which indicates that the service was medically necessary, that the patient's condition required additional treatment and that the physical therapy cap was met. Once the review is complete, a report of the findings will be released to the physical therapists asked to complete the CBR.

As the title indicates, this is only the first, and new CBR's will be produced and sent out monthly. For more information go to http://www.safeguard-servicesllc.com/cbr/default.asp

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Bad Economy = Good Internal Controls

"Desperate times call for desperate measures." We've all heard this phrase. Unfortunately, during a bad economy, this phrase really does ring true. It should come as no surprise that when the economy is bad, the probability of employee theft increases. When faced with the financial and emotional stress of losing a home to foreclosure or the inability to pay bills or maintain a certain lifestyle, employees can become desperate enough to steal. Whereas once they thought they would never even consider stealing from an employer, some may now view it as a way to survive; and the consequences, if caught, seem minor in comparison. Having the appropriate internal controls in place will serve to greatly reduce or remove the opportunity for embezzlement.

Medical practices are an easy target for fraud. Usually very busy (and oftentimes understaffed), the front desk handles a lot of cash, resulting in the ideal environment for theft. Physicians are focused on patient care and in general spend very little of their time overseeing the 'business side' of the practice. Depending on your management team for such oversight is important; however, physicians must not completely remove themselves from this function. The combination of too much trust and too few internal controls and oversight can be a recipe for disaster.

The following summarizes some of the key areas of a medical practice that require good internal controls. Also listed are some simple ways to put safeguards in place to help prevent employee theft.

Front Desk Collections and Mail Deposits

- Each front desk employee should have their own payment log to record their daily over-the-counter collections. At the end of their shift, they are responsible for reconciling their own log to the payments they collected, which should be kept separate from the payments collected by other front desk employees. Logs should be totaled, initialed, and submitted with the payments to the person who creates the deposit slip.
- Numbered receipt books should be used for all cash payments. Each front desk employee should have their own cash receipt book.
- A change fund should be utilized at the front desk. Change should not be made from the daily collections or employees personal funds. Some offices have a change fund for each front desk employee. At the end of the day, the change fund(s) should be reconciled and replenished.
- The person who sorts and opens the mail should not be the same person who prepares the deposit.
- The person who prepares the deposit should not also be responsible for taking the deposit to the bank.

Accounts Payable

- Appropriate documentation (i.e., invoice, packing slips, check requests, etc.) should be attached to the checks awaiting signature. Documentation should be thoroughly reviewed prior to signing any checks.
- Invoices should be stamped and dated, once paid to avoid duplicate payments.

Bank Statements

- Bank statements should be mailed directly to the physician. Statements should be opened and reviewed by the physician in a timely manner prior to being forwarded to the person who reconciles the statement unless prepared by an outside firm.
- The physician should review and sign off on the bank reconciliation after it is complete.

Payroll

- The physician should conduct a periodic review of the summary payroll reports by employee. Careful attention should be paid to wage rates, overtime, and bonus payments.

Though certainly not exhaustive, these are some relatively simple ways to safeguard against employee theft. Though difficult for smaller practices, it is important to segregate duties to the extent possible. The internal controls that are in place should be periodically reviewed and changed, as needed. Finally, having a strong oversight function will help to ensure that proper attention is paid to all areas of the practice that might be susceptible to theft.

Please give us a call if you would like to discuss an Internal Controls Review for your practice.

Did you know that we have staff certified in Fraud Examination? Please give us a call for more details 330-453-7633.

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Recession Staff Raises – Maybe Not?? Staff Evaluations – Absolutely!!

During these uncertain economic times, especially in the healthcare reimbursement area, many practices are choosing to forego salary increases for their staff, even cost of living increases. Most practices perform evaluations of their staff at the same time they do annual raises. Because many practices are not giving raises they are deciding not to do evaluations as well. In our opinion, this is a terrible mistake and an opportunity lost!

Evaluations are a time to connect with your employees, whether that connection be to tell an employee they are doing a great job or are not performing up to standard. Evaluations are also a great time to touch base with your superstars and to find out from them what they love about their job and which areas they feel they would like additional challenges. Without this annual feedback, you could be missing out on an opportunity to stay in tune with your employees, maintain and enhance your relationships with employees and keep them on track in meeting your expectations.

We believe that once the economy begins to recover, employees who feel like they are not valued and have not received any recognition including raises, will begin looking for other work.

Now is the time for you to seize the moment and get your annual evaluation process started! Here are some tips to make your process a valuable tool for the practice and the employees alike.

- If you do not have standardized evaluation forms, this would be a good time to get those developed. This will allow you to have a baseline to evaluate your employees for years to come.
- If you do not have written job descriptions, this is a perfect opportunity to undertake that process as well. Have your employees help write their own job descriptions by writing down everything they do for a two week period. You may be surprised by how much they do that you are not aware of.
- Consider allowing your employees to choose one or two people in the office who they would like to evaluate them. Then you can add these to the evaluations you or their direct supervisors complete.
- Consider having your employees do a self evaluation. It is valuable information for you to have their own impression of their work to make sure there are no disconnects in communication and self awareness and allows them to set personal goals.
- Address the fact that the practice is not able to give raises head on. Ask the employee what else you can do for them to reward them for their excellent service. Sometimes very small things mean a lot to them. Just asking gets you some brownie points!
- If you can, try to explain the financial situation to them and let them know that as soon as the practice can afford to give increases it will be done.

For most companies, the annual employee appraisal period is a stressful time – for both owners and management as well as for the employees. If you approach it differently this year, it can actually be a great team building experience and a time for lots of professional development opportunity.

On-Line Resources

Carrier websites continue to improve upon the on-line resources available to providers. In addition to checking on claims status, eligibility, and benefits information, practices can also inquire about and submit pre-certifications. Though functionality varies by carrier, most carriers readily offer training to office staff in utilizing the tools available on their websites.

Cigna and UHC also have cost of care estimators available online that can assist in determining patient financial responsibility prior to the rendering of services. This information can be shared with the patient at the time of the visit and used to collect the payment due. Up front patient collections are becoming increasingly important with the popularity of HSAs/HRAs and high deductible health plans. Regular use of these estimators will increase the accuracy and efficiency of patient collections.

2010 Year-End Planning Issues/Tips

2010 year-end planning is going to be a bit different than in years past. The following list includes issues that you will want to pay attention to as you meet with your advisors to plan your end of year planning and disbursements.

1. With the Medicare Rate Freeze expiring on November 30, 2010, it will be important to watch the updates from the government on this carefully. If past history is any indication, it is possible that the legislators will not act on this until the last minute which could cause CMS to stop processing payments for 2-3 weeks. This may wreak havoc on your year-end planning estimates, especially in the case where the monies are not ultimately paid by year-end, or if all of your late November and December payments are electronically posted to your bank account the last week of the year. Our suggestion is to make sure you have a line of credit in place with your bank so that you can pay additional expenses or year-end bonuses using that money and then pay back your line when the Medicare money ultimately comes in.
2. For 2011, employers will be required to report on employees' W-2 forms the amount they have paid for health insurance premiums on an employee's behalf. Please contact your payroll vendor now to see how this new requirement will be handled so you can isolate that information as of 1/1/11 to report. For now, this reporting is for informational purposes only, but may be used in another way by the government in the future.
3. Small Employer Tax Credit for Health Benefits – If your practice has less than 25 Full Time Equivalent employees and the average wages for those employees is less than $50,000 per year you may be eligible for a tax credit for health benefits paid. The measurement does not include owners, their family members or seasonal employees. To qualify for this credit you must pay at least 50% of the employees' premiums. Check with your tax advisor.
4. Hire Tax Credit – Your practice may also be eligible for a tax credit for 2010 if you hired a worker who had been unemployed for at least 60 days prior to coming to work for you. To qualify, the employee must have worked no more than 40 hours over the last 60 day period. This credit could be worth 6.2% of the employee's wages for 2010 and the credit is claimed on your payroll tax returns.

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CMS

Medical Record Retention Guidelines

CMS recently released an informational MLN Matters article to provide practices with some guidelines on retaining medical records. While the article notes that State laws usually regulate how long medical records should be retained, the strictest regulation would prevail. Access this article at: http://www.cms.gov/MLNMattersArticles/downloads/SE1022.pdf

October 1st Brings Changes & Updates

CMS has released their quarterly and annual updates. Details on the following updates can be found at:

- ASC Payment System http://www.cms.gov/MLNMattersArticles/downloads/MM7147.pdf
- Annual HCPCS Codes for SNFs http://www.cms.gov/MLNMattersArticles/downloads/MM7159.pdf
- NCCI Edits http://www.cms.gov/MLNMattersArticles/downloads/MM7081.pdf
- New Waived Tests http://www.cms.gov/MLNMattersArticles/downloads/MM7084.pdf
- Hospice Payment Rates, Hospice Cap, Hospice Wage Index and the Hospice Pricer FY 2011 http://www.cms.gov/MLNMattersArticles/downloads/MM7077.pdf
- Quarterly Update to DME Fee Schedule http://www.cms.gov/MLNMattersArticles/downloads/MM7070pdf
- Quarterly Average Sales Price for Medicare Part B Drug Pricing
- http://www.cms.gov/MLNMattersArticles/downloads/MM7007.pdf

A reminder that the 2011 ICD-9 codes go into effect October 1, 2010. If you have not yet updated your ICD-9 books and reviewed it for changes, now is the time to do so.

CMS Clarifies JW Modifier Use

CMS has left it to the discretion of the Medicare carrier to determine if the use of the JW modifier will be required when billing for unused portions of a drug or biological agent. They urge providers to check with their local carriers to see if the JW modifier is to be used, and to obtain clear instructions on when and how it should be used. For additional information, go to http://www.cms.gov/MLNMattersArticles/downloads/MM7007.pdf

Meaningful Use Update (continued from pg 3)

Menu Set Measures

1. Enable drug-formulary checking functionality and have access to a formulary for the EHR reporting period.*
2. Incorporate clinical lab-test results into the EHR as structured data for at least 40% of all lab test results.*
3. Generate at least one report listing patients with a specific condition.*
4. Send reminders to 20% of all patients, 65 years or older, per patient preference for follow-up care.*
5. Provide at least 10% of all unique patients timely access to health information within 4 business days of the information being available to the provider.*
6. Provide patient-specific education resources to at least 10% of all unique patients.*
7. Perform medication reconciliation at least 50% of the time for patients transitioned from another setting of care.
8. Provide a summary care record for at least 50% of patients for patients being transitioned to another setting of care.
9. Perform at least one test of the certified EHR's capability to submit electronic data to immunization registries.*
10. Perform at least one test of the certified EHR's capability to submit syndromic surveillance data to public health agencies.*

**These functions may be performed by nursing, administrative or IT staff*

It is expected that EHR vendors will provide the capability to generate much of the above mentioned information within their software, and they will also assist physicians in conducting data exchange testing.

Physicians will receive HITECH funds based on being a meaningful user during an EHR reporting period. For the first EHR reporting period, physicians must "meaningfully use" the EHR for 90 continuous days. To receive maximum HITECH funds, the first EHR reporting period must be in 2011 or 2012.

The second and subsequent reporting periods must conform to a calendar year. For instance, if a physician first qualifies based on a period of July 1 – September 30, 2011, the second reporting period will be the calendar year 2012. In order to qualify for payment, at least 50% of a physician's patient encounters must use a certified EHR.

There will be a single, consolidated annual incentive payment. Payments will be made on a rolling basis, as soon as a physician has demonstrated meaningful use for the applicable reporting period and has reached the threshold for maximum payment (or the calendar year has ended). Payments will be made based on NPI (National Provider Identifier), and a payment can be reassigned to an employer. Note that you ***can*** receive both PQRI payments and HITECH payments.

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