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Doctor Perspectives

How to Reward Your Employees for a Job Well Done - Without Going Broke

How can you show your employees that you appreciate them without breaking the bank? Good question.

First, be sure you reward only exceptional, not regular, performance. Reward employees who "go the extra mile" (stay late, take on extra duties, etc.), show initiative or bring new ideas to the practice management team, take pride and ownership in their duties, are "team players" who motivate other staff members, and, most important, give patients outstanding customer service. Consider these when designing an employee recognition system:

♦ Entering fee tickets for one month without any errors;

♦ Collecting 90-95% of all patient cost-sharing for one month;

♦ Obtaining all referrals needed in a given month;

♦ Perfect attendance for an entire quarter or year;

♦ Exceeding collection goals set by administrator;

♦ Positive feedback from patients.

Financial incentives do not have to be large amounts. Even small bonuses show your appreciation and can go a long way to motivate your employees. Try some of these:

1. "Employee of the Quarter Award". Give this employee a $50.00 gift certificate for dinner or passes to a movie chain. Employees appreciate both personal gifts and those that they can enjoy with their families.

2. Give a one-time merit bonus based on performance and overall achievement, not an annual cost of

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Pecos Is More Than a River

On April 5, 2010, new CMS rules regarding Medicare Provider Enrollment, Chain and Ownership System (PECOS) enrollment will create a very negative situation for those who are caught unaware, as, beginning on that date, no Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) provider will be reimbursed by CMS if the prescribing practitioner is not PECOS enrolled.

Thus, patients who cannot get their devices due to this change at CMS will target their prescribing doctors, as well as the DMEPOS provider, with their dissatisfaction at having to pay out of pocket, do without, or waiting until the prescribing practitioner enrolls. It takes a minimum of about 60 days to enroll, thus the state of urgency.

Who is affected by PECOS? Ordering/referring providers include: doctor of medicine or osteopathy, dental medicine, dental surgery, podiatric medicine, optometry, chiropractic medicine, physician assistant, certified clinical nurse specialist, nurse practitioner, clinical psychologist, certified nurse midwife, clinical social worker.

I just obtained my Medicare number 3 years ago; am I affected? If ordering/referring providers have either obtained their Medicare numbers in the past 5 years or updated their information in that time, then they should already be in the PECOS system. Getting an NPI number does not automatically transfer to PECOS.

How does status of my PECOS

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CMS releases "meaningful use" rules, financial incentive details announced

The Centers for Medicare & Medicaid Services (CMS) just released a notice of proposed rulemaking (NPRM) and the Office of the National Coordinator for Health Information Technology (ONC) has released an interim final rule regarding the electronic health record (EHR) incentive program mandated as part of the American Recovery and Reinvestment Act of 2009 (ARRA). The regulations are part of a comprehensive program authorized by ARRA to create a nationwide, interoperable, secure and private electronic health information system.

The CMS proposed rule outlines the complex provisions related to the requirement that professionals must be "meaningful users" of "certified" EHRs. Beginning in 2011, those qualifying professionals are eligible for up to $44,000 in Medicare incentives or up to $63,750 in Medicaid incentives. The ONC interim final rule details the initial standards, implementation specifications and certification criteria for EHR technology. Through these incentives, CMS hopes to expand the meaningful use of certified EHR technology and improve health care quality, efficiency and patient safety.

CMS proposes a phased approach to achieving meaningful use by eligible professionals between 2011 and 2015, with each of the three stages requiring escalating requirements. The meaningful use criteria proposed for stage one predominately focuses on electronically capturing health information in a coded format; using that information to track key clinical conditions and communicating that information for care coordination purposes; implementing clinical decision support tools to facilitate disease and medication management; and reporting clinical quality measures and public health information. CMS intends to update the stage two and three criteria through future rulemaking.

The Medical Group Management Association (MGMA) voiced these objections:

- ⇒Unreasonable thresholds for some of the meaningful use criteria (i.e., computerized prescription order entry, electronic claim submission, electronic insurance eligibility verification, and others);
- ⇒Potentially difficult meaningful use attestation after the first year; and
- ⇒A requirement that physician offices provide patients and others with electronic copies of medical records.

"We were pleased to see that the CMS and ONC rules include some flexibility, especially in the areas of escalating stages of meaningful use requirements, straightforward first year attestation and reasonable 90-day reporting windows," said William F. Jessee, MD, FACMPE, MGMA president and CEO. "However, we firmly believe that the government should make additional changes to achieve wide-spread adoption by professionals in all types of clinical settings."

The press release from CMS announcing the interim final rules can be found at http://www.hhs.gov/news/press/2009pres/12/20091230a.html .

It is not the strongest of species that survive, nor the most intelligent, but the one most responsive to change.

--Charles Darwin

Stricter Enforcement of Signature Requirements

In the Executive Summary issued in November 2009, CMS directed the CERT contractor to more strictly adhere to its policy on signatures contained in the submitted medical record. For medical review purposes, Medicare requires that services provided/ordered be authenticated by a legible identifier and stamp signatures are not acceptable. In the past, if the provider's signature was missing or illegible, and there were no other reasons for denial of the claim, the CERT contractor did not deny the claim. After consultation with the OIG, CMS issued instructions to the CERT contractor directing them to strictly adhere to the CMS policy requiring a legible identifier.

Even clearer, the Medicare Program Integrity Manual Medicare requires a legible identifier for services provided/ordered: "The method used shall be hand written or an electronic signature (stamp signatures are not acceptable) to sign an order or other medical record documentation for medical review purposes."

Rewarding Your Employees

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living increase or a generic year-end or holiday bonus. These bonuses should be tied to formal, written evaluations and be based on pre-defined job descriptions and expected performance goals. An outstanding employee should not be given the same increase as an employee who is just performing his duties adequately.

3. A popular reward program is to take $200 and divide it into segments - two $50 bills, four $20 bills and two $10 bills. Place each bill into a separate envelope and place the envelopes in a candy jar. *Each week pick the person who has done an outstanding job for your practice and invite them to pick an envelope from the candy jar.* This turns the reward program into a game in which the entire office can participate.

Use the candy jar idea from above but instead of (or in addition to) cash, try a week of free parking; an extra 1/2-hour for lunch; leave one hour early on Friday.

Non-monetary rewards may be only small tokens of appreciation but can still mean a lot to an employee. Just some simple words could make the difference in an employee giving 75% and 150%. Words of gratitude can go a long way and can actually make employees work even harder: "Thanks for doing a great job this week!"; Thanks for helping out while Jane was out sick!"; "The doctors and I appreciate you staying late to help out with those extra patients."; "The doctors and I have noticed that you have been working long hours, and your dedication is greatly appreciated."; "You did a great job in handling that difficult situation."

Some other ideas that will not cost the practice much: Write little notes of "thank you" or "for a job well done" and place them on an employee's workstation when they have done something well. You can also mention employee accomplishments in a staff meeting.

In our tight employment market, showing your staff that you appreciate them is vital. The most common comment heard from medical office staff is that they feel the doctors do not appreciate their work. Physicians, especially, should make a conscious effort to address employees by name, say "Good Morning," or thank them at the end of the day. When physicians show these simple gestures of gratitude, the staff will be more likely to treat patients with the same respect and courtesy, and both staff and patients will remain much more loyal to your practice.

Is there any good news in the CPT®/CMS consult conflict? Yep: AMA has announced that, as of January 1, 2011, its CPT® code structure will eliminate all consult codes, bringing its E/M codes back in consonance with CMS. Come on '11!!!

↑ FCA = ↑ Group Practice Liability

Recently signed legislation known as the Fraud Enforcement Recovery Act (FERA) has amplified the scope of the Fraudulent Claims Act (FCA). FERA makes failure to return an overpayment actionable under FCA, so a group or practitioner can be fined not only for the false claim itself but also for the separate offense of not repaying the overage. FERA also extends the statute of limitation in which to make accusations, expands the government's authority to investigate, and covers agents and contractors under the same anti-retaliation which covers the FCA.

And remember, FCA penalties are $5500 to $11,000 for each claim (and each failure to repay), plus treble the amount of the actual damage to the government. Furthermore, if a "whistleblower" or qui tam relator, under FCA the practitioner or group, brought the action is also liable for that individual's costs & legal fees.

Now, for the bad news. A group practice or employing hospital can be charged for the fraudulent activities of its individual practitioners or other contracted/associated entities, even if the facility or practice has no knowledge of the preparation or submission of a false claim. This includes the circumstances in which the group or facility acts "in reckless disregard of the truth." Additionally, the hospital or group practice cannot seek redress of its defense or subsequent penalties from the erring practitioner.

So, what can you do to protect yourself and your partners? The same fore-action that safeguards against RAC, CERT, CCI, and private carrier scrutiny: be sure the all the members of your group are regularly audited for billing & documentation compliance, correct any systemic errors, and voluntarily report & repay any claims paid erroneously.

This can really hit home in light of the efforts almost all groups have to make to retrench in the current strenuous economic climate. Practitioners are pressured to produce even more, to code aggressively, and to minimize expenses. This could lead to staff salary and benefit cuts, or even reductions in staff. A disgruntled employee or ex-employee makes a great *qui tam* relator, and even if the accusation is eventually dismissed, there will still be lost productivity and defense costs.

Cuts in practitioner education, audits, compliance programs, and restitution to make ends meet could prove to be "penny wise and pound foolish", since exposure to the practice and you as an individual physician increases as billing and coding errors go undetected, or as you and your partners fail to keep abreast of the rapid changes in regulation and guidelines.

As Michael Miscoe, JD stated in the January 2010 issue of *Coding Edge*, an effective audit program "will not only identify errors before they get out of hand, but will demonstrate the entity's efforts at compliance, thereby mitigating the potential that recklessness or deliberate ignorance can be shown." The documented steps your groups takes to demonstrate its intent to comply with the rules, guidelines, and regulations is sufficient to protect you from accusations of "reckless disregard" and may stand between you and repayments and fines levied for fraudulent claims activities of which you are not even aware.

For further information about implementation and exercise of a defensible compliance and audit plan, contact Mary Ann Lucas, CPC, 901-761-2720, x453 or mlucas@wucpas.com .

It is better to light a candle than curse the darkness.

--Chinese proverb

U.S. Savings Bond Redemptions

Many taxpayers may be holding matured, unredeemed savings bonds at home or in their safe-deposit boxes. If you are one of those taxpayers, you should cash them, as they are no longer earning interest and the redemption proceeds could be applied to other more profitable investments. Currently, the following savings bonds are no longer earning interest: all Series H bonds; many Series E bonds; some Series EE bonds; and some Series HH bonds. After June of this year, all Series E bonds will no longer earn interest. When redeeming the bonds, you will have to pay federal income tax on the interest earned, but not state income tax. If your bond holdings and accrued interest amounts are substantial, you may want to spread the redemptions over several years to soften the tax impact. We can assist in developing a strategy that fits your specific situation.

Before cashing bonds that are still earning interest (*i.e.*, not matured), be sure to check when the interest accrues or you may lose as much as six months' interest. Older bonds tend to accrue interest every six months, while newer bonds accrue interest monthly. Also, in some cases, cashing a bond that has not been held for at least five years may result in a penalty of three months' interest.

Savings bonds may be redeemed through most banks and credit unions, or by mailing them to the U.S. Department of Treasury (after having your signature verified at a financial institution), or online. On the web, go to TreasuryDirect.gov, click on Individuals, Research Center, Products in Depth, and select the relevant bond. In the Tools section, you can calculate the amount of interest that has accrued on the bonds to be redeemed.

...and what is your name, Doctor?

CMS's new place-of-service and date-of-service policy and guidelines for professional components may cause you to become disoriented to location and time. The new rules will be to report the *actual* place & date you read or interpret the test or image.

These interpretations were originally set to go into effect January 4, 2010, but protests from MGMA and the American College of Radiology, citing that additional time was needed for vendors of critical software (such as management, billing, & clearinghouse systems) to make required changes, gained delay of the date-of-service aspects of this change until July 1, 2010.*

A letter from these groups to CMS stated:

"Explanations to ordering and treating Physicians describing why two records are present in electronic medical records (EMR) for the same examination will not be understood easily nor well received and as such will negatively impact patient care. Moreover, billing the professional component on a date different from the technical component will cause patient confusion, increased processing costs for both payers and providers, and in some cases denial of legitimate claims for a variety of reasons."

For example, if a patient has a test or x-ray in your office on July 1 and you interpreted or read it at your home on July 4, the date of service on your professional component claim should read 7/4/2010, presuming there is no further delay of the effective date.

**The place of service change became effective on 1/4/2010 as originally announced.* In the example above, the place of service of your PC would be likely be 99 (other, in this case your home). Choices for place of (interpretive) service also include 11 (office) and 16 (temporary lodging, such as a hotel room). Incidentally, these locations should be reported even if the service is rendered over a wireless remote device.

CMS requires that the ZIP code of the location appear on the claim, though some management systems require the entire address. Interpretations made in locations outside the United States will not be reimbursed by Medicare.

The text of the policy announcement is at www.cms.hhs.gov/transmittals/downloads.R1873CP.pdf .

...But Wait! There's More: ZPIC Audits

Zone Program Integrity Contractors are a re-assembly of the old Program Safeguard Contractors (PSCs), awarded in 1997 after HIPAA gave CMS permission to hire outside contractors to do benefit integrity work. PSCs didn't work well: each had different type of claim (Part A, Part B DME, etc). Providers might have had to work with several PSCs at the same time. The approach of PSCs to fraud detection was fragmented; it left gaps and gave undue scrutiny to well-meaning providers while fraudulent ones evaded punishment.

The Medicare Modernization Act of 2003 provided for PSCs & Medicare Drug Integrity Contractors (MEDICs) to be re-organized together in geographical alignment with MACs (sort of). TN, MS, AR, LA, AL, GA, SC, NC, VA, & WV make up Region #5; the ZPIC contract for this region was let to Advanced Med, though currently this is under dispute by a losing bidder. (Does this sound familiar?) Region #3, including MO, KY, IL, etc., is not yet awarded.

ZPICs will cover Parts A, B, C, & D and Medicare/Medicaid data matches. ZPICs can look into provider cost reports and handle consent settlements. ZPICs can investigate soliciting/offering kickbacks and Stark violations. They can look for routine waiver of coinsurance or deductible, and for practitioners or staff on the federal ineligible list. ZPICs can conduct random checks of physician licensure and original Certificates of Medical Necessity. RACs can do none of these.

RACs may only review the CMS-approved issues reported on the RAC website. (There are currently 12 of these.) RACs may only go back 3 years. RACs have a restricted number of charts that can be requested within a certain period. ZPICs are not limited in any of these ways. ZPICs may interview beneficiaries and investigate onsite with little or no notice. ZPICs may review a provider's past audits, investigations or violations; RACs are prohibited from doing so.

ZPIC reviews may be triggered by outliers (high volumes of services or items, high cost services or items) or 3rd-party complaints. Additionally, "ZPICs are required immediately to advise the OIG of complaints by the provider's current or former employees."

Providers may be dealing with multiple federal audits (CERT, RAC, OIG, ZPICs) simultaneously. And ZPICs may employ the potentially devastating extrapolation of recoupment, just like RACs can.

What can or should you do to deal with this latest challenge? As with all other auditors, you should have a proactive, up-to-date, and enforced 7-point compliance program. Appeal protocols are the same as with other Medicare audits.

Key 2010 Tax Amounts

As of January 1, 2010, the following rates and contribution limitations are in effect. The 2009 figures are provided for comparison and to aid in your income tax preparation for last year. For further information on tax preparation for either year, call 901-761-2720 and ask for Mark Lauber or Sherman Leong. They may also be reached at mlauber@wucpas.com or sleong@wucpas.com.

	2010	**2009**
Business mileage rates	50¢ per mile	55¢ per mile
Charitable mileage rates	14¢ per mile	14¢ per mile
Medical/moving mileage rates	16.5¢ per mile	24¢ per mile
Annual gift exclusion	$13,000	$13,000
IRA deductible contribution limit	$5,000; additional $1,000 for those 50 and older	$5,000; additional $1,000 for those 50 and older
Roth IRA non-deductible contribution limit	$5,000; additional $1,000 for those 50 and older	$5,000; additional $1,000 for those 50 and older
401(k) & 403(b) tax sheltered annuity	$16,500; additional $5,500 for those 50 and older (adjusted for inflation)	$16,500; additional $5,500 for those 50 and older (adjusted for inflation)

PECOS Is More Than a River

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enrollment affect my delivery of service on DMEPOS items? On April 5, 2010, if a DMEPOS provider accepts assignment and provides devices or supplies to a Medicare patient, which are not referred by a PECOS-enrolled referral source, the DMEPOS practice/supplier will not receive reimbursement from CMS. Furthermore, there is no appeal process. There is no mention of whether the patient can pay out of pocket.

Is there a database available where I can check my status as PECOS enrolled? Yes, but there is no guarantee that the complete PECOS-enrolled list of referral sources will be available on CMS site by April 5. That database is "under development". Check at https://pecos.cms.hhs.gov/pecos/login.do

How long does the process take and how does it work? The goal of CMS is to get ordering/referral providers' applications processed in 45 days. The process works like this:

a. If you are the provider, you can go online and fill out the application yourself. Then, you will print out the two signature page documents and mail them via the USPS within seven days. Signature documents must be received with an original signature, which cannot be done online. If it is post-marked later than 7 days after the online application was received, processing will be delayed.

b. If the ordering/referral provider wants to delegate the paperwork, a staffer in his/her office can be designated as the Authorizing Official (AO). However, there is an enrollment process to authorize an AO. CMS does not define how long those applications take to process but says it "can take up to several weeks".

Are there any exceptions to being able to enroll online? The materials to referring/ordering providers also mention some exceptions to the ability to enroll online, which would make it even more time consuming to get a PECOS identifier. The website identifies these exceptions.

What is the status of this? DMEPOS facilities are already getting warnings on CMS EOBs.

CMS always extends deadlines on this type of situation, is that going to be the case with PECOS? CMS has already delayed it from January 4, 2010.*Adapted from an article by Catherine Pruitt, the President of PrimeCare O&P Network, LLC. For more information, contact WUHCG's Mary Ann Lucas.*

Donate Sample Medicines: "1 in 3 for the CHC"

The Church Health Center is seeking doctors' offices who will donate one out of every three sample medications to the Center, so that CHC can then give it to their patients.

To donate sample medicines, phone the dispensary at **901-272-0010 ext. 1106.** Mallory Mulroy and her staff will arrange a pickup time convenient to you.

Your donation will help provide medicine for the uninsured and underserved population the CHC serves.

Watkins Uiberall Healthcare Consulting Group, LLC
1661 Aaron Brenner Drive, Suite 300
Memphis, Tennessee 38120

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Memphis Office
Bill Appling
1661 Aaron Brenner Drive
Suite 300
Memphis, TN 38120
(901) 761-2720
bappling@wucpas.com

Tupelo Office
Randy Gammill
499 Gloster Creek Village
Suite F-9
Tupelo, MS 38801
(662) 269-4014
rgammill@wucpas.com

www.wucpas.com

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