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Educating physicians on OSHA bloodborne pathogens

Training physicians in your practice is not only a requirement; it can be a challenge, too

The sense of fear and intimidation in the voice was impossible to ignore. It was a call to HCPro's OSHA consultation hotline. In barely a whisper, so that nobody in her office could overhear her, the caller asked, "Do I really have to train my physicians in bloodborne pathogens? OSHA doesn't require them to undergo training like the rest of the practice's staff, does it?"

The answer—that OSHA does not exempt any employee, including a physician, who is exposed to bloodborne pathogens from the training requirements of the standard—did not sit well with her.

"Oh well, maybe I'll just have them sign the training sheet and leave it at that."

That may be an over-the-top example of the physician-dominant pecking order for OSHA compliance in medical and dental practices, but it does illustrate a common safety officer observation—complaint, even—that getting physicians to comply with the initial, and especially annual, training requirements of the Bloodborne Pathogens standard can be a challenge.

Hiding behind the employer label

A common misunderstanding is that physicians who are owners of a practice are not subject to OSHA requirements. That may be true for a Marcus Welby-type solo practitioner situation, but not for most practices organized as a professional corporation.

Although physicians know that their practices are subject to some form of OSHA regulation, they are not clear on the specifics, especially regarding their own training under the standard, says **Kathy Rooker**, who advises medical practices on clinical laboratory and OSHA compliance as owner of Columbus Healthcare & Safety Consultants in Canal Winchester, OH.

"You are dealing with very professional people; you have to tell them more than just 'you have to do it.' You have to explain why."

—Bruce Cunha

Operating as the safety officer to her client practices, Rooker will often spend one-on-one time with physicians who own a share of the practice explaining that they, as both employer and employee, are subject to OSHA regulations just as other staff members are.

Understanding the overlap, however, is no guarantee that physicians will jump at the opportunity to attend a bloodborne pathogens training session.

"I don't need training in bloodborne pathogens; I learned that in medical school" is a common response, says Rooker. Watching how the physician uses, or better yet, misuses personal

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OSHA bloodborne pathogens

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protective equipment in an incision and drainage procedure, for example, is a good opportunity to show physicians that bloodborne pathogens training is not a total waste of their time, she says.

Use exemplars and leverage

Although the requirement for OSHA training is the same for all staff members occupationally exposed to bloodborne pathogens, the approach to training physicians need not be.

“You are dealing with very professional people; you have to tell them more than just ‘you have to do it.’ You have to explain why,” says **Bruce Cunha**, manager of employee health and safety at the Marshfield (WI) Clinic. The roughly 900 physicians at Marshfield all have an ownership stake and all receive OSHA initial and annual training, says Cunha.

In addition to keeping Marshfield’s computer-based bloodborne pathogens training interactive as required by OSHA, while introducing new content with annual training, Cunha recommends appealing to the safety culture that the organization maintains when dealing with physician OSHA training. That, and making sure you have physicians act as safety champions, he adds.

“Involve physicians directly in developing training. Find a champion on the medical staff, especially one in a leadership position, to help make it knowledge-based and as easy as possible to get through while still giving them new information to take away,” says Cunha.

But appealing to the safety culture doesn’t mean you never leverage compliance by referencing fines. At Marshfield, OSHA fines for noncompliance that are within the control of practitioners are charged at the department level. Cunha gives the example of not engaging the safety device before disposing in the sharps container. This is an easy fault for an OSHA inspector to find.

“First, make the point that nobody in the organization needs to be injured or exposed due to noncompliance to OSHA. Next, hit them with the financial implications,” says Cunha.

Engage for effective training

When engaging physicians for bloodborne pathogens training, think of yourself as a facilitator, not a lecturer, advises **Sarah Alholm, MAS**, who provides safety-related healthcare consulting services and training in Asheville, NC, and is the author of HCPro’s *OSHA Training Handbook for Healthcare Facilities*. Alholm’s book uses the case study method, one that she feels can especially appeal to initial and annual bloodborne

OSHA responds to the physician employer/employee question

Medical Environment Update asked OSHA how the Bloodborne Pathogens standard training relates to physicians. Here are the e-mail responses from OSHA’s standards specialists. Use this information in case you get pushback from your medical staff.

- » **MEU:** Must all the elements identified in the initial training—items 1910.1030(g)(2)(vii)(A)-(M)—be included in annual or refresher training?
- » **OSHA:** If participants in a particular training session have already been through the initial training, the annual training may consist of a review of previous training material. The more important function of annual training is to inform employees about new and emerging healthcare worker

issues, new technology, lessons learned, and what policies the employer has in place to address them.

- » **MEU:** For the annual and refresher training requirements for the Bloodborne Pathogens standard, are physicians exempt if they are employees of the healthcare facility?
- » **OSHA:** No, if they have potential exposure to bloodborne pathogens, they are required to have training.
- » **MEU:** In a professional corporation, if a physician with an ownership stake is also considered an employee for salary drawing purposes, would OSHA consider this physician an employee and subject to bloodborne pathogens training?
- » **OSHA:** Yes, if they have potential exposure to bloodborne pathogens, they are required to have training.

pathogens training because it involves analysis and decision-making, which helps give physicians the sense of directing the content of the sessions.

Of course, to do that effectively, you have to really know the content, Alholm adds.

Don't forget that for bloodborne pathogens, OSHA allows you to tailor the training program to the learner's job duties and background. You might not need to spend as much time on the routes, signs, and symptoms of hepatitis B, hepatitis C, and HIV with physicians as you would for other employees. "Touch on the requirements without getting too into the weeds," says Alholm.

Another pecking order

Before the physician training dilemma rears its head again, work on creating a positive pecking order. Consider the following tips:

- » Work toward creating a training program that provides knowledge-based content, uses an engaging method of delivery, and allows for one-on-one reinforcement

- » Remind physicians about maintaining a culture of safety and being a safety role model for nonphysician staff
- » Take time to explain the nuances of being a physician practice owner while at the same time being regarded as an employee subject to OSHA compliance
- » Caution that noncompliance as an owner and/or employee on initial and annual training could have financial consequences to the practice in the form of OSHA fines

Having accomplished all that, you can then make sure you have physician signatures on the bloodborne pathogens training sheet. ☒

Source

Adapted from *Medical Environment Update*, October 2010.

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Getting real with OSHA violation data

If you received a citation during an OSHA inspection in the past year, chances are the inspector found something wrong with your exposure control plan (ECP). If you didn't get inspected, chances are there is still something wrong with your ECP.

That's because bloodborne pathogens ECP citations—the requirement has been in effect since the promulgation of the standard in 1990—have again topped the list of OSHA violations for medical practices, according to a recent report from OSHA.

The overview

Every year, *Medical Environment Update* acquires a detailed report of citations by standard for medical (the category includes clinics, ambulatory surgery centers, and various outpatient settings) and dental practices from the OSHA Office of Management Systems. The data, which cover all federal and state citations from July 2009 through June 2010, showed 708 individual citations for medical practices,

an increase of 20% from the previous year, and 392 citations for dental practices, an increase of 30%.

Total fines increased by approximately the same proportion on the medical side, while decreasing on the dental side. The difference in the dental amount was due to an extraordinary fine of \$76,500 imposed on a Nashua, NH, dental practice for willful violations of the Bloodborne Pathogens standard in September 2008.

Common medical practice violations, chapter and verse

Of the top 10 most frequent OSHA violations in medical practices, seven apply to bloodborne pathogens. Of those violations, four are specific to the ECP. The most frequent violation was not having an ECP, resulting in an average fine of \$924. (All fines given are average initial fines, not the final adjusted fine.) Failure to update the ECP annually (\$770) and not documenting consideration of safety devices every year (\$166) also made the top 10 list.

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OSHA violation data

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A newcomer to the top 10 list was failure to solicit or document input from frontline workers on engineering and work practices to prevent exposure from contaminated needles and sharps. Although the average fine of \$227 was modest, its appearance shows that OSHA inspectors are beginning to look specifically for compliance in this area.

Other frequent bloodborne pathogens violations included not using safety devices (\$1,009); failing to provide training free of charge and during working hours (\$848); and not having signed documentation for employees declining the hepatitis B vaccination (\$421), another newcomer to the top 10 list.

The hazard communication standard contributed three top 10 violations: not having a written plan (\$250); not

providing training at the time of assignment (\$62); and inaccessible material safety data sheet files (\$75).

Other frequent fines occurred in the electrical standard (insufficient space to safely operate and maintain electrical equipment), personal protective equipment (PPE) standard (not having a certified hazard assessment), and portable fire extinguishers standard (not training employees who are designated to use extinguishers, not visually inspecting extinguishers monthly, and not having an annual maintenance check).

Expensive fines; like working without a net


In addition to frequent violations, **Medical Environment Update** analyzed the data for expensive fines. One violation made both lists, failure to use safety devices, with \$1,009 average per fine. Be sure to document this requirement in the ECP and put it into practice to avoid this double-whammy-natured fine.

Other expensive but less frequent fines dealt with failure to follow universal precautions (\$1,500), not immediately removing PPE penetrated with blood or other potentially infectious materials (\$1,500), and failure to make hepatitis B vaccination or postexposure evaluation and follow-up at no cost to the employee (\$1,438).

Three non-bloodborne pathogens violations made the most expensive list this year, but they appear to be infractions in standards that are not usually associated with medical practices.

Having an untrained employee operate an aerial lift (\$2,000), not using a belt and lanyard when working from an aerial lift (\$1,500), and not protecting electrical conductors from abrasion (\$1,175) attracted expensive fines.

If your practice engages in work practices or has hazardous conditions similar to these, be sure to check for compliance.

To find those standards, click the Regulations/Standards link for General Industry on the OSHA home page at www.osha.gov. 

Source

Adapted from **Medical Environment Update**, September 2010.

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What about dental practices?

Fines for dental practices mostly followed form with medical practices, with one exception. In this case, it was the appearance of the hazard communication standard violation for not having a written plan as No. 1 on the most frequent list (\$303). All other most-frequent dental violations appeared in the medical practice list.

As for most expensive dental fines, not reviewing and updating the exposure control plan at least annually and whenever necessary to reflect new tasks and procedures topped the list (\$2,500), followed by not documenting the annual consideration and implementation of appropriate commercially available safety devices (\$2,045).

Noncompliance with the flammable and combustible liquids standard also proved to be expensive, with \$2,000 fines for using Class 1 liquids near an open flame and improperly drawing or transferring flammable or combustible liquids out of storage containers.

Be sure to check Tab 6 of the *OSHA Program Manual for Dental Facilities* for examples of flammable and combustible liquids found in dental practices and regulations for storage.

The last item of note was a \$2,000 fine for providing defective or unsafe personal protective equipment.

PRIVATE PRACTICE SUCCESS

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Hospitals responsible when independent physicians behave badly

Who is responsible when an independent physician discriminates against or harasses a hospital employee? The hospital? The medical staff?

Hospitals may try to hide behind the fact that they do not directly employ the offending physician. However, this is a thin defense, says **Michael McAuliffe Miller, Esq.**, an attorney at Eckert Seamans Cherin & Mellott, LLC, in Harrisburg, PA. Just because a hospital doesn't directly employ an independent physician doesn't mean the organization isn't liable for the doctor's behavior.

"You control the terms and conditions of employment for your employees, and if your employees are being harassed by a nonemployee, you are on the hook for that nonemployee's behavior because you have the ability to protect your employees," McAuliffe Miller says.

The fact that the physician is not an employee of the hospital will not insulate hospitals should a discrimination or harassment claim make it to court. "That obligation [to protect employees] is there whether it is the fellow that comes in to repair the Xerox® machine who says inappropriate things to the admins or whether it is a physician that has admitting privileges," says **Robert Wolff, Esq.**, a shareholder at Littler Mendelson in its Cleveland office.

Harassment or rude behavior?

Harassment and discrimination violate the Civil Rights Act, which protects against employment discrimination based on race, color, religion, sex, or national origin.

According to the Equal Employment Opportunity Commission (EEOC), discrimination is defined as treating someone unfavorably based on a personal trait, such as sex, religion, or race. Behavior is considered harassment (and therefore illegal) "when it is so frequent or severe that it

creates a hostile or offensive work environment or when it results in an adverse employment decision."

For more definitions and information about harassment and discrimination, visit www.eeoc.gov/laws/types/index.cfm.

Given these definitions, it is important to understand that not all behavior is considered harassing or discriminatory.

"If the physician is being sufficiently disruptive and abusive, it could be something that the hospital is obligated to report to the [licensing] board, and it could be a basis to pull admitting privileges."

—Robert Wolff, Esq.

For example, if a physician snaps at a nurse once, that doesn't necessarily constitute discrimination.

"I often get calls from clients saying that person A is being discriminatory, but when we drill down into the issue, he is not being discriminatory—he is just not being nice," says McAuliffe Miller.

Inappropriate behavior can often be remedied with sensitivity training or a firm reminder from an HR representative or a medical staff leader that such behavior is not appropriate.

Occasional off-color remarks or isolated nonserious incidents, although they may be offensive, do not constitute harassment and are not covered by the Civil Rights Act. Be sure that the definition of harassment and discrimination in your organization's code of conduct policy distinguishes between inappropriate behavior requiring a physician to

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Hospitals responsible

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undergo sensitivity training and serious incidents of harassment or discrimination requiring more aggressive action.

One step beyond occasional poor behavior is bullying. Bullying that is not directed at any particular person (harassment) or any particular sex, religion, or race (discrimination) may not fall under the Civil Rights Act, but it is still a serious offense. In some states, such as Ohio, bullying is reportable to the state licensing board, says Wolff. “If the physician is being sufficiently disruptive and abusive, it could be something that the hospital is obligated to report to the [licensing] board, and it could be a basis to pull admitting privileges,” he says.

Although poor behavior doesn’t always fall under the jurisdiction of the Civil Rights Act, it is important to address. “Fires start somewhere,” says McAuliffe Miller. “Where I get worried is when hospitals say, ‘This doctor is notably difficult, but we aren’t going to deal with it because he is not an employee.’ You’re just whistling past the graveyard.”

The role of HR and the medical staff in addressing bad behavior

If a physician discriminates against or harasses a hospital employee—regardless of whether that employee is another physician, a nurse, or a food services staff member—and that employee files a claim with HR or even the EEOC, HR will most likely take the reins and interview the physician and other witnesses to determine whether discrimination or harassment actually occurred.

“The hospital must take action to investigate and, where necessary, remediate the issue even if it’s not their employee,” says McAuliffe Miller.

However, HR should not leave the medical staff in the dark. Rather, it should involve the medical staff as it collects

information about the physician’s behavior. HR may work with the medical staff to limit the independent physician’s contact with the complainant, when necessary, McAuliffe Miller adds. HR may also coordinate with the general counsel, the president of the organization, and/or the chair of the department during an investigation and any remedial action to ensure that appropriate measures are taken.

The medical staff’s actions will vary depending on the severity of the behavior. For minor cases, a medical staff leader, such as a department chair, may explain to the physician that the behavior is unacceptable and will not be tolerated. For more severe cases, the medical staff may report the physician to the state licensing agency.

“You always want to document regardless of what the final outcome is,” says Wolff. Medical staffs should document their steps, regardless of the severity of the behavior.

Wolff explains that in some states, disruptive behavior is considered a sentinel event and is reportable to the National Practitioner Data Bank (NPDB). The NPDB is the medical staff’s last line of defense in combating disruptive behavior.

In states where the medical staff bylaws are considered a contract between the independent physician and the medical staff, the medical staff may terminate the physician’s privileges for breach of contract.

“The contract may have a clause that says you must act in a collegial nature toward your colleagues and behave in a way that will engender respect,” says Wolff. If a physician can’t live up to the terms of the contract, he or she is not entitled to privileges.

Policies and training are the best defense

HR typically has one set of policies that govern the hospital’s employees, and the medical staff has another set that governs its members. Often, they are similar policies written for two different audiences.

Ideally, the hospital’s and the medical staff’s policies match, but if they don’t, the hospital’s employment policy prevails, says McAuliffe Miller. This is because, as previously stated, the hospital is responsible for the behavior of those employees and it has some control over the employees in the workplace.

Having an organizationwide code of conduct policy, which is required under Joint Commission standard LD.03.01.01,

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isn't enough; the hospital needs to publish it. McAuliffe Miller suggests that HR e-mail the policy to employees and nonemployees with a read receipt and distribute it at meetings every two years. The medical staff should do the same with its behavior policy, which is located either in the medical staff bylaws or in separate accompanying documents.

It's also wise to provide training to employees and non-employees to ensure that they understand that poor behavior is unacceptable. If a harassment or discrimination claim makes it to court, the hospital will need to demonstrate that it had policies in place and that it presented training opportunities for all employees and independent physicians, says McAuliffe Miller.

Protect against retaliation

If a hospital employee claims that an independent physician discriminated against or harassed him or her, the physician may attempt to retaliate against the employee. Sometimes retaliation comes in the form of increased harassment or discriminatory behavior. Retaliation is just as serious an issue as the original discrimination or harassment, says McAuliffe Miller. Retaliation can happen even if the hospital and medical staff determine that the employee's original complaint did not constitute harassment or discriminatory behavior on the physician's part.

McAuliffe Miller says that some employees may mistake routine procedures as retaliation after filing a complaint. For example, contention between a nurse and physician may be

the result of poor communication. If HR and the medical staff determine that harassment or discrimination are not at play, they may choose to educate the nurse on appropriate communication techniques. The nurse may construe that additional education as retaliation. Or, on further investigation, the hospital may find that the nurse's performance is not up to par, and the organization may choose to fire the nurse. These actions do not constitute retaliation, says McAuliffe Miller.

Any action the hospital takes must be in relation to the employee's performance and not as a result of his or her claim of discrimination or harassment. According to the EEOC, "it is illegal for an employer to refuse to promote an employee because she filed a charge of discrimination with the EEOC, even if EEOC later determined no discrimination occurred."

The hospital's code of conduct policy and the medical staff's behavior policy should address retaliation to protect victims and to ensure that anyone who experiences harassment or discrimination is not afraid to come forward. ■

Source

Adapted from **Medical Staff Briefing**, October 2010.

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MGMA report links higher physician compensation to practice ownership

Hospital ownership can make a significant difference in both revenues and compensation, according to a report from the Medical Group Management Association (MGMA).

Physician group practices owned by a hospital or integrated delivery system (IDS) have lower per-physician revenues than do their counterparts at practices not owned by hospitals, MGMA's *Cost Survey for Integrated Delivery System Practices: 2010 Report Based on 2009 Data* finds.

Practice losses in groups owned by a hospital or IDS often arise from accounting systems that reallocate income and cost; thus, they tend to have lower revenue figures, according to MGMA.

"Hospital-based physicians' revenues are accounted for in the hospital (technical) revenue stream and not the physician (professional) revenue stream. The numbers are not a surprise. **The rationale and reasons stated are sound and appropriate.**"

—Beth Ward

The median total medical revenue for a multispecialty hospital-owned practice was \$448,597 per full-time-equivalent physician, \$350,011 lower than in non-hospital-owned groups (\$798,608).

Those findings make sense, says **Beth Ward**, executive vice president and CFO of Wellmont Health System. "Hospital-based physicians' revenues are accounted for in the hospital (technical) revenue stream and not the physician (professional) revenue stream. The numbers are not a surprise. The rationale and reasons stated are sound and appropriate."

The report also found differences in compensation between owned and non-owned practices.

Specialist physicians working in multispecialty hospital- or IDS-owned practices earned 19.85% less in total compensation than those in multispecialty practices not owned by a hospital or IDS-owned practice. Specialists in hospital- or

IDS-owned practices earned a median total compensation of \$294,984, compared to \$353,549 for those in practices that were not owned.


Primary care physicians working in multispecialty "owned" practices reported median total compensation of \$192,116. Those in multispecialty non-owned practices earned \$179,688 in median total compensation.

"The need for primary care coverage and referrals in a hospital- or an IDS-owned system may contribute to the overall difference in compensation," **Jeffrey B. Milburn, MBA, CMPE**, with MGMA's Health Care Consulting Group, said in a prepared statement. Those types of data will help practice managers striving to benchmark their financial performance, Milburn said.

For specialists, these new findings reflect ones issued in MGMA's larger compensation survey, *Physician Compensation and Production Survey: 2010 Report Based on 2009 Data*, issued this past year. That survey found that specialty care physicians in practices not owned by hospitals reported higher compensation than those in hospital-owned practices.

The median compensation for a specialty care physician in a non-hospital-owned practice was 25.5% greater. In addition, hospital-owned groups reported greater compensation per work relative value units. This suggests that the differences in compensation for these physicians may be the result of production, according to MGMA.

In contrast, practice ownership had little effect on primary care compensation, according to the 2010 physician compensation and production survey. It found that the difference was less than 0.4%.

The scope of the survey could account for the differences. MGMA's *Cost Survey for Integrated Delivery System Practices: 2010 Report Based on 2009 Data* contains data on 1,002 IDS practices. The *Physician Compensation and Production Survey: 2010 Report Based on 2009 Data* includes data on nearly 60,000 providers. 

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How to appeal denied claims: Have an organized strategy

Denied claims are just a part of doing business, but that doesn't mean you can write them off. You knew it was a legitimate claim when you submitted it, so you should be willing to fight for the money you are rightly owed.

But how do you successfully appeal a denied claim? What strategies work and when do you know it's time to cut your losses? For starters, look at the appeals process as a normal part of business and not an improvised response to an unexpected denial. After all, the denials aren't really unexpected.

Providers should consider the appeals process a routine part of managing the practice's revenues and have a standardized, formal plan for appealing denied claims, says **Shelly Cronin, CPC, CPMA, CANPC, CGSC, CGIC**, director of business and member development for the American Academy of Professional Coders in Salt Lake City. That means having at least one person in the office who understands the appeals process and is responsible for appealing claims quickly and effectively.

The provider also should have a policy that clearly states what your appeals process is, Cronin says. New staff can refer to the policy and existing staff can be held accountable to following the process outlined there, she says.

"One of the most common problems is not appealing in a timely fashion," Cronin says. "Once that claim is denied, you only have a certain amount of days to file your appeal and get it looked at again. A lot of people will let these denials stack up rather than addressing them quickly, and by the time they get around to them, they find out that the window has closed on some of the claims."

Cronin recommends following up on denied claims at least once per week, and possibly more often depending on the volume of claims and denials. The appeals process should include documenting the reasons for the denials and the eventual outcome, and then using that information to educate coders so you are not dealing with the same denial issues over and over again, she says.

Bundling similar denied claims and appealing them all at once can improve efficiency, Cronin says, but that strategy runs the risk of interfering with the required time frames.

"So you have to balance that effort to be efficient with meeting those deadlines. You haven't achieved anything if

your efficiency is offset by losing money on the claims that expired," she says.

Managed care companies have their own rules about how long you can wait before appealing, as well as their own preferences for how they want appeals submitted. It is to your benefit to know each insurer's timelines and processes, Cronin says. Keep a notebook that outlines each insurer's specifications and quirks for easy reference, she suggests.

"If you don't know what your payers are requiring for a timely appeals process, you are really taking another step back, setting yourself back even further than when you had the claim denied," she says.

Call the payer right away

Appealing improperly is almost as bad as not appealing in a timely fashion, Cronin says. Some providers have a stock appeal letter that they send out for all denied claims—that's a bad idea.

"If you're sending out these stock appeal letters, they're just going to be denied again because it is not pertinent to why the claim was denied in the first place," she says. "A lot of places use the stock appeal letters, and when it is denied again, the staff can say, 'Well, we tried,' and let it go. That's a waste of money that you are rightfully owed."

The first thing you should do when you receive a denial is call the insurer for more information, Cronin says. Ask why the claim was denied, even though the reason will be stated in the denial. By talking to someone about the claim, you often can glean more useful information that will help make your appeal letter more focused and convincing, she explains.

"In some cases, the problem may be something simple that can be resolved over the phone," Cronin says.

Send a proper letter with appeal

When submitting an appeal, make sure you get the details right and don't cut corners. Don't merely send the denial letter back with a note on it, Cronin says. Use a cover letter that states your reason for disagreeing with the denial, and provide any written backing for your position—any information that

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Denied claims

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demonstrates why you coded the claim the way you did and why the insurer should pay it. This could be information from the payer's own guidance, Medicare, or CPT coding guidelines, Cronin says.

"Or have your physician write you a paragraph or a letter explaining why they wanted to use a certain procedure or take a certain action with the patient and why it was medically necessary," she says. "The more information you can add that is pertinent and fact-based, the better. You don't want to get emotional and demand that they pay this or criticize the process. Be polite and professional."

Don't resubmit a claim without explanation, says **Bill Gilbert**, president of AdvantEdge, a Warren, NJ-based company that provides billing services, practice management, and coding for specialty physicians and surgery centers. The carriers don't like that and will reject the claim again.

"It clears the paper off your desk, but you're just deceiving yourself. It doesn't accomplish anything and, in fact, it just further delays the resolution," Gilbert says.

Keep a paper trail on all denials and hold on to them for future reference. When you receive a similar denial in the

future, you can refer back to those earlier claims to see what worked in the appeals process with that insurer, Cronin says.

Watch for omissions, simple errors

The most common cause of denials is usually related to the insurance information submitted with the claim, explains Gilbert. For instance, the insurer may deny a claim by saying that the patient is not insured with that company. Instead of huffing and puffing about the insurer's error, look for clues as to why you got that response. "Often it's just because the insurance number was entered wrong somewhere. Maybe a couple of numbers were transposed and the insurer's computer kicked it out when it couldn't find that incorrect number in the system," Gilbert says. "If you can find that error, you can resubmit the claim with a letter explaining what the problem was and providing the correct information."

Sloppy errors account for a substantial number of denials, Gilbert says. Many claims are submitted to the wrong carrier, for instance. The problem is not just one insurer versus another, but also submitting a claim to a commercial carrier when it should have gone to the patient's workers' compensation insurer.

"It's fairly common to see claims denied on the first round because you simply didn't send it to the right place," Gilbert

Know when to cut your losses with appeals

Appealing denied claims requires tenacity, but when do you know enough is enough? If you are appealing a denied claim but getting nowhere with the payer, how long do you keep at it?

The answer will vary depending on each situation, but there definitely will come a point when further efforts are not justified, says **Shelly Cronin, CPC, CPMA, CANPC, CGSC, CGIC**, director of business and member development for the American Academy of Professional Coders in Salt Lake City.

"Every time you handle that claim, it costs you money," says Cronin. "If it's been touched so much that by the time you win the appeal you're not even covering the costs of the appeal, then it is really beyond the point where you should continue."

Providers often don't realize how much they are expending on the appeals process, says **Bill Gilbert**, president of AdvantEdge

in Warren, NJ. Gilbert's company has analyzed the cost of appealing a denied claim, including physician and staff time for researching the case and preparing the appeal. The figure came to an average of \$50–\$100 per appeal, he says.

To make the call, look at the claim for clues. Is this a high-dollar claim? The more money that is at stake, the harder and longer you should fight for payment, Cronin says. Is it a type of claim that you submit often? If so, it may be worthwhile to establish that the claim is valid so the insurer doesn't continue denying them later.

But if it is a claim for a relatively small amount of money, or a one-off procedure, the answer may be different.

"Sometimes those have to be put aside and you chalk it up to how the system works," Cronin says. "You lost that one but you'll win others."

says. “Accuracy in your billing office has to be a top priority because even if you eventually get the claim paid, bouncing it back and forth a few times before you get it right will cost you money.”

Many medical necessity denials also can be traced to incorrect or insufficient information, Gilbert says. He recently saw a claim for anterior cruciate ligament surgery that had been denied as medically unnecessary, but he found it was rejected because the claim did not outline all the previous steps that had been attempted in treating the patient’s shoulder injury.

“When an amended claim was resubmitted with updated information, the claim was paid,” he says.

Sometimes the reason for the denial is not clear. Gilbert recently addressed a problem in which a practice was seeing multiple denials for the same type of claim although virtually identical claims were being paid. “It turned out the ones that were being denied were all coming from the same claims processor in the carrier’s office,” he says. “That one person was denying the claims—incorrectly—and when we pointed out to the carrier that they were being inconsistent, they fixed it.”

If a claim or set of claims are important enough, you usually have the option of suing the carrier, says **Eileen Parsons, JD**, an attorney with Ver Ploeg & Lumpkin in Miami. Going to court is a big step, but it sometimes is worth it when the potential revenue is high enough, Parsons says.

Making that decision, however, can be difficult.

“That’s what still puts payers in such a terrific position,” says Parsons. “Their goal is to keep your money and force you to

sue, knowing that it is only 1% of 1% that are in a position to do that and make it all the way through. I have providers who say that their denied claims are a significant part of their business—\$100,000 or \$200,000—but the price of going through the legal process to collect it is so high.”

To get the most bang for your buck when appealing, Parsons recommends grouping claims into categories and appealing them in batches. Don’t wait for a number of claims to stack up. Rather, group your denials into categories that can be covered with one appeal to the payer. You still have to be careful not to let claims sit so long that you miss the deadline, she says, but for high-volume practices, this type of grouping can be more efficient than appealing them one at a time.

“If you have many claims that were rejected for the same reason, and you’re going to appeal each one with the same explanation or additional information, you can group them,” Parsons says. “This doesn’t mean just putting off your appeals until the stack gets too big to ignore, but rather it’s a matter of making the most of your time and resources.” ■

Source

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Avoid denials by reading the contract carefully

Many denials can be avoided by knowing the payer’s payment policies well, says **Eileen Parsons, JD**, an attorney with Ver Ploeg & Lumpkin in Miami. You should study the payer’s policies before signing the contract, particularly if your practice provides a certain type of treatment or procedure that is new or different or otherwise might be denied, Parsons says.

“This is particularly important when this care makes up a large part of your practice and your revenue stream,” she says. “You don’t want to get into this contract and then realize down the road that they are going to deny all of those claims.

At that point you could be forced to appeal claims all the time, when it could have been avoided with a careful reading of the contract.”

Contracts also should be scrutinized for language that restricts your ability to renegotiate or void the contract if the payer substantially changes payment policies, Parsons says. If the payer changes the way it reimburses you for a type of care that is key to your business, you need the ability to renegotiate or terminate your contract. “At least understand up front what the requirements are going to be for the claims that matter most to you,” she says.

The Breakroom

Litigation expenses to cost taxpayers \$1 billion

by Cheryl Clark

A reversal of federal policy that lets trial lawyers use litigation expenses as tax deductions would result in more frivolous lawsuits, add to America's healthcare bill, and result in lawyers' conflict of interest, says a coalition of 90 medical groups including the AMA.

"We would object in the strongest possible terms to any change in federal tax policy that could increase meritless claims and add unnecessary costs to our healthcare system," says the coalition's recent letter to Treasury Secretary Timothy Geithner.

The groups, which include numerous state medical societies and specialty organizations, say that if attorneys are allowed the proposed special tax deduction—for gross fee contingency contracts—it would pose a "conflict with long-standing state ethics rules against trial attorneys providing financial assistance to clients without the expectation of being paid back upon the successful conclusion of the case."

The Treasury Department is considering reversing its policy that court and other litigation expenses advanced by trial attorneys are not deductible as business expenses.

"This change would encourage trial lawyers to file more lawsuits," says immediate AMA past president **J. James Rohack, MD**. Even now, "many physicians are forced to practice defensive medicine to protect themselves from

meritless lawsuits. The U.S. government estimates the cost of defensive medicine to be between \$70 billion and \$126 billion per year," Rohack says.

The physicians' group letter makes several other arguments, including:

- » The change would cost taxpayers more than \$1.5 billion and could act as a financial incentive for trial attorneys to file less meritorious lawsuits against providers. The average cost per case would increase—money that could be used to expand coverage.
- » The IRS in 1997 said litigation expenses advanced by trial lawyers are not deductible regardless of whether a trial attorney uses a gross fee or net fee contract with clients.
- » Proposed legislation now in the House and Senate "has failed to attract enough support to hold hearings on the issue, let alone be considered by either chamber."

The groups support a national cap on pain and suffering awards, similar to that in California and Texas, which does not exceed \$250,000.

"The Congressional Budget Office found that medical liability reforms that include a quarter-million dollar cap on non-economic damages would reduce the federal budget deficit by about \$54 billion over 10 years," the coalition's letter said.

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