

The MAIN SHEET



MARINA MEDICAL™
BILLING SERVICE INC



Summer 2009

Converting Emergency Care Into Compensation

Inside This Issue:

- 1 The RAC's are Here!
- 2 Investing for Emergency Physicians
- 3 CMS Releases Proposed Medicare Payment Changes for 2010
- 4 DS&A 2009 Emergency Physician Salary and Benefit Survey Released

Upcoming Events:

July 12-15

Michigan Chapter of ACEP

September 13-15

Northern and Southern California HFMA Fall Conference

October 5-8

ACEP Scientific Assembly

November 15-17

HFMA Region 9 Annual Conference

The RAC's are Here!



Greer Contreras, CPC,
Marina Medical

The Medicare Modernization Act of 2003 established the Medicare Recovery Audit Contractor (RAC)

program as a demonstration program to detect and correct improper Medicare payments so CMS can implement actions that will prevent future improper payments. The RACs are responsible for identifying both overpayments and underpayments. The RACs (third party auditors) were paid on a contingency fee basis, receiving a percentage of the improper overpayments and underpayments they collect from providers.

Under the demonstration program which operated from March 2005-March 2008 in California, Florida, New York, South Carolina and Massachusetts, RACs could review the last four years of provider claims for the following types of services: hospital inpatient and outpatient, skilled nursing facility, **physician**, ambulance and laboratory, as well as durable medical equipment. The RACs used proprietary software programs to identify potential payment errors such as duplicate payments, fiscal intermediaries' mistakes, **medical necessity and coding**. In July 2008, CMS reported that the RACs had succeeded in correcting more than \$1.03 billion in Medicare improper payments. Approximately 96 percent (\$992.7 million) of the improper payments were overpayments collected from providers, while the remaining 4 percent (\$37.8 million) were underpayments repaid to providers.

The Tax Relief and Health Care Act of 2006 made the RAC program permanent and

authorized the Centers for Medicare & Medicaid Services (CMS) to expand the program to all 50 states by 2010. A nationwide rollout of the permanent RAC program is presently underway, with all states scheduled to come on board this year.

CMS recently announced their phase-in strategy which identifies a state by state timeline for the type of reviews to be performed (good news- medical necessity reviews are not anticipated until 2010), but as of early June, CMS also stated the RAC's have not sent any demand letters or record requests and the program is still in a provider outreach stage.

So... now you have the skinny on the who, what, and where regarding RAC's, but what does all this mean for emergency physicians? This is still somewhat of a "wait and see", but what we do know is they (RAC) will be reviewing evaluation and management services. With that said, CMS states "*medical necessity is the overarching criterion for payment*" and it's safe to assume this is an area that will be closely scrutinized. Now is the time to take a look at (and probably improve upon) your documentation of medical decision making, confirming that the documentation clearly establishes the medical necessity for the overall service. The challenge here is being able to quantify and qualify your thought process.

Remember to document the cognitive work involved during the encounter, clearly describe the nature of the patients presenting problem(s), and document your decisions, the clinical significance of abnormal test results, as well as any co-morbidities that have influenced your work. In this here-to-stay RAC environment "more is better"!

Investing for Emergency Physicians

According to Robert Sarnoff, former President of NBC and RCA, "Finance is the art of passing money from hand to hand until it finally disappears!" With the Dow down 29.5% over the past 12 months as of this writing, investors at times must have felt Sarnoff was pretty perceptive! But experienced investors – whose time horizon is 3-5 years or longer – know that buying



value and then reinvesting dividends through down cycles is the "returns accelerator" that greatly magnifies long term investment returns by having the dividends buy more shares when prices are down. As we've discussed in prior columns, successful investing requires identifying very high quality companies with steadily growing dividends, and reinvesting those dividends while mastering the natural emotion to want to sell during down markets.

People often ask for recommendations on what to buy, and for physicians especially, Johnson & Johnson is worthy of consideration. "JNJ" is a high quality 'blue chip' company and in fact is one of the components of the famous Dow Jones Industrial Average. With a superb balance sheet that contains only 16% debt, JNJ generates sales of \$60.6 billion through consumer products (25%) such as baby

care, Neutrogena, Tylenol, Sudafed and Splenda, non-prescription drugs, medical devices and diagnostics (41%) including wound closures, surgical instruments and orthopedics, and pharmaceuticals (34%) such as Remicade, Topamax, Procrit, Risperdal, Levaquin, Concerta and others. JNJ has huge free cash flow of about \$7 billion after capital expenditures and dividends, so it has ample cash for acquisitions, dividend increases and stock buybacks. The company is extremely profitable with a 24.5% return on capital and a 28.5% return on equity, and enjoys very high financial strength and quality ratings.

During the same period the Dow has been down 29.5%, JNJ is down 17.6% to \$54.62 a share. It's been adversely impacted by discussions in the media of U.S. healthcare changes, yet 49% of JNJ's business is overseas.

Long term, JNJ has the ability to trade for approximately \$104 per share which together with its 3.5% dividend yield would provide an excellent 18% return. JNJ also has options, and a covered call strategy could be attractive in anything but a sharply rising market. At the current \$54.62 a share, the \$60 options expiring in Jan 2010 will net \$1.40 per share. Buying 100 shares would cost \$5,462 and will pay \$0.49 quarterly in dividends three times by January, plus receiving \$1,400 when selling the options. If JNJ goes over \$60 by January, the option will be exercised and the investor would receive \$60 + \$1.47 dividends + \$1.40 for the option = \$62.87, which is a 15.1% gain in just about 7 months or 25.9% annualized. A very nice trade with such a high quality company. If JNJ goes down, the investor has \$2.87 per share downside protection, or a 5.2% downside cushion before incurring a loss. And if the stock stays flat or goes up less than to \$60, or goes down, the Jan 2010 option will expire worthless and the investor can then sell another option and generate more cash.

In conclusion, buying an exceptionally high quality, dividend paying company like JNJ when it's off its highs as it is now, is a sound long term strategy. Returns can be further enhanced by using the conservative strategy of selling covered call options after having bought the stock.

Successful investing requires identifying very high quality companies with steadily growing dividends, and reinvesting those dividends while mastering the natural emotion to want to sell during down markets.



CMS Releases Proposed Medicare Payment Changes for 2010

On July 1, CMS released an outline of the proposed changes to Medicare reimbursement for 2010. Headlining the proposal is an overall reduction in payments to physicians of 21.5%. However, offsetting that for emergency medicine is an increase to the practice expense component by increasing practice expense RVU's 10-26% for the key E&M codes 99283-5 and 99291; this would have the impact of increasing total RVU's for these codes by 1.5% to 4.4%.

The overall reduction for physicians of 21.5% reflects the Sustainable Growth Rate ("SGR") formula originated in the Balanced Budget Act of 1997. However, Congress has regularly taken action to mitigate this formulaic result. Moreover, in the midst of



the unprecedented federal budget deficits currently expected, with greater deficits possible if certain proposed government programs such as health care reform are enacted, coupled with a number of States facing their own budget and Medicaid payment issues, CMS' proposals this year are likely to be especially impacted by the broader national politics and budget considerations.

Other CMS proposals include:

- elimination of payments for consultation codes;
- removal of physician-administered drugs from the definition of "physician services";
- increasing the payment for Initial Preventive Physical Exams ("IPPE");
- changing how professional liability insurance costs are recognized in Medicare payments;
- reducing payments for certain imaging equipment such as CT, MRI and PET, the growth of which has exceeded the government's expectations; and,
- revisions to the PQRI program enabling qualifying physicians to receive up to 2% of total allowable charges.

CMS will receive comments to their proposal through Aug 31, 2009 and expects to issue the final rule by Nov 1, 2009. At such time as more data is available in the Fall from CMS, Marina will compile the specific impact on each of its clients' expected 2010 revenues.

The CMS announcement is available at www.federalregister.gov/inspection.aspx#special

Headlining the proposal is an overall reduction in payments to physicians of 21.5%.

DS&A 2009 Emergency Physician Salary and Benefit Survey Released

The 2009 Daniel Stern and Associates *Emergency Physician Salary & Benefit Survey* has been released. Drawing from data provided by 1,009 physicians from all 50 states, the report is a comprehensive survey of compensation levels and methodologies. Among the key findings are:

- Partners at the 50th percentile earned base compensation of \$230,000 and total compensation of \$301,274
- Total compensation at the 25th percentile of \$259,500
- \$370,190 at the 75th percentile
- Employees at the 50th percentile earned only slightly less at \$220,000, but significantly less total compensation of \$252,690

Compensation methodologies varied significantly, with 66% reporting an hourly rate, 39% having a bonus plan, 27% reported an annual salary, 25% using an RVU-based compensation system, and 24% reporting some other kind of productivity-based system.

ED Directors at the 50th percentile reported base compensation of \$230,000 but total compensation of \$368,373, indicating that ED Directors are typically compensated with an additional \$67,000 for their services.

California (despite its budget problems), Florida, Colorado and Texas led all respondents as the favorite states in which to practice.

The 27 page report may be accessed at www.acep.org, and then search for "Stern".

Inside This Issue:

- 1 The RAC's are Here!
- 2 Investing for Emergency Physicians
- 3 CMS Releases Proposed Medicare Payment Changes for 2010
- 4 DS&A 2009 Emergency Physician Salary and Benefit Survey Released

Inside This Issue



MARINA MEDICAL™
BILLING SERVICE INC

18000 Studebaker Road, Fourth Floor
Cerritos, CA 90703

(866) 675-9441
Fax (562) 402-2755
www.marinamedicalbilling.com

For Additional Information,
Please Contact:

Marsha Besley, President
(562) 809-3501
mbsley@marinabilling.com

Michael Connellan, CEO
(562) 809-3500
michael.connellan@yahoo.com

PRSR STD
U.S. Postage
PAID
Fullerton, CA
permit #664

