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HUMAN RESOURCES

What you need to know about sexual harassment

Sexual harassment accusations are just about everywhere on media today! We see high profile individuals in many professions under scrutiny and some losing their jobs. Whether it is an employer, school, or government, it is paramount to strive to prevent sexual harassment and address it when brought to light. Let's talk about this from an employer's perspective.

Employers must be committed to providing a professional work environment. In keeping with this commitment, they must strive to maintain a policy prohibiting unlawful harassment. This includes sexual harassment, and any conduct that has for the purpose or effect of interfering with an individual's work performance or creating an intimidating, hostile, or offensive work environment, when based upon a person's protected status, such as race, color, religion, sex, national origin, age, disability, veteran status, genetic information, marital status, sexual orientation, gender identification or expression, or other protected group status as provided by law. The policy should apply to all employees including supervisory and non-supervisory employees, and conduct between male/female, female/male, and members of the same sex. It should prohibit harassment in any form including verbal, visual, and physical harassment. This includes, but not limited to, means of communication like e-mail, texting, faxes, handouts, and voice-mail, etc.

Sexual harassment is a behavior, which undermines the integrity of the employment relationship. All employees must be allowed to work in an environment free from unsolicited and unwelcome sexual overtures, sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature. Sexual harassment does not refer to occasional sincere compliments. It refers to behavior, which is not welcome, is personally offensive, reduces morale, and unreasonably interferes with employee effectiveness and work performance.

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Generally, two categories of sexual harassment exist. The first, **"quid pro quo"** (something for something) may be defined as an exchange of sexual favors for improvement in an employee's working condition and/or compensation. The second category, **"hostile work environment,"** can be described as unwelcome conduct that has the purpose or effect of creating an intimidating, hostile or offensive work environment or unreasonably interfering with an individual's work performance.

Examples of sexual harassment include, but are not limited to, offensive or unwelcome physical contact, lewd or sexually suggestive comments, sexual propositions, sexually oriented teasing or kidding, jokes of a sexual nature, or any display of sexually explicit pictures, photos, cartoons, books, magazines, greeting cards, or other objects. **What one employee considers funny, interesting, unique or amusing may be offensive to another employee.**

All employees must respect the rights of one another and should refrain from any behavior or conduct toward any other employee that could be interpreted as sexual harassment.

Any employee or supervisor who believes they have been harassed and/or intimidated by a co-worker, supervisor, or any other person has the responsibility to promptly report the facts of the incident or incidents and the names of the individuals involved to management. An employee should not have to complain to the offending person -- contact another manager or physician with whom he or she would feel comfortable. Employees are encouraged to report harassment to management before it becomes severe or pervasive. All concerns brought to management's attention should be kept confidential as far as is possible and practical. Any investigation may include interviewing the individual charged, and/or witnesses. No employee should purposely provide or make an untrue statement of fact regarding a complaint of harassment or in an investigation. Retaliation against anyone who complains of harassment or who participates in an investigation should be strictly prohibited.

An employer's aim is to investigate all incidents and have prompt resolutions with appropriate management personnel involved. If the employer determines that harassment did occur, appropriate disciplinary action must be taken against the offending employee, up to and including termination. If the individual who harassed the employee is not employed by the company, it should take corrective action to the extent practical and possible. However, if the investigation determines that the complaint is not bona fide and that the employee has willfully given false information regarding the complaint, disciplinary action may be considered against the individual who filed the complaint and gave false information. Such matters may need the assistance of an experienced attorney in discrimination.

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MEDICARE RULES

MIPS survival guide for 2018: How to avoid a negative adjustment

January marks the start of the second year of Medicare's Merit-based Incentive Payment System (MIPS) – but the end of the transition year. That means tougher minimum reporting requirements just to avoid a negative payment adjust in 2020, although next year will also make MIPS easier in other ways thanks to the Quality Payment Program (QPP) final rule for 2018.

In this article we'll discuss the changes to MIPS from 2017 to 2018 as well as the steps needed to meet the minimum reporting requirements. In the next issue of *The Business of Medicine*, we will explore ways to maximize your MIPS composite score should your practice desire to earn MIPS bonus payments and a share of cash from the exceptional performance pool.

Check your eligibility, again: Some of your providers could be off the hook in 2018 because CMS has significantly expanded the "low-volume" threshold below which providers were exempt from having to participate in MIPS. For an individual provider, this threshold *was* set at $30,000 or less in total annual Part B charges or seeing 100 or fewer Medicare beneficiaries per year. This threshold is increasing substantially for 2018: A provider who bills $90,000 or less in Part B charges a year, or who sees 200 or fewer beneficiaries per year, will be exempt from MIPS. You can visit this CMS website and enter each provider's national provider identifier (NPI) to see if he or she is required to participate in MIPS for 2018.

2018 MIPS: Getting by with the bare minimum

To avoid a 5% negative payment adjustment in 2020, providers who are eligible for MIPS must earn a MIPS composite score of at least 15 points. **Remember:** MIPS is composed of four categories, each of which – while weighted differently – contributes points to a single composite score. The composite score is used to determine payments and penalties.

Achieving the 15-point minimum score is much tougher in 2018 (the minimum score was only 3 points in 2017). However, it can be achieved in a few ways:

- Full participation in the Improvement Activities category such as, submitting one high-weighted activity and two medium-weighted activities for small practices or, two high-weighted activities, four medium-weighted activities, or a combination of both;
- Completing the Advancing Care Information (ACI) base score and one quality measure meeting the measure threshold or data completeness requirement, but not benchmarks;

Final GOP tax bill eliminates health insurance mandate

A major Republican effort to reform existing tax law is nearing success as this issue of *The Business of Medicine* goes to press, with the House and Senate reconciling most of their legislative differences. One provision has remained intact in what appears to be the final version of the bill: A repeal of the individual insurance mandate required by the Affordable Care Act (ACA).

GOP links health insurance to taxes

The most significant development in the tax reform process has been the Republican introduction of a provision to eliminate the current ACA requirement that individuals must purchase health insurance or be subject to a tax penalty. Both the Senate and House bills contain a provision that repeals this individual mandate, which hasn't been popular with much of the public, but is needed to pay for the ACA's health insurance exchanges.

The emerging consensus bill between the Senate and House includes this provision, even though the non-partisan Congressional Budget Office (CBO) has estimated that eliminating the individual mandate would result in approximately 13 million more uninsured persons nationwide while also causing insurers to increase premiums by as much as 10% each year. While the CBO acknowledges such projections are difficult because it's hard to predict the behavior of those individuals who stand to lose insurance, it stands by its prediction of the overall impact. "Despite the uncertainty, some effects of this policy are clear," the CBO writes in its report. "For instance, the federal deficit would be many billions of dollars lower than under current law, and the number of uninsured people would be millions higher."

Consensus bill takes shape

GOP leaders in the Senate and House said they have reached an agreement on a final bill, and it appears that this legislation will be more similar to the Senate bill than the House bill. Below are a list of provisions that are expected to be in the final legislation to be signed by President Donald J. Trump:

- **Corporate tax rate reduced to 21%**; this is up slightly from the 20% rate in the Senate and House bills, but far below the current rate of 35%.
- **Lower top individual tax rate of 37%**, down from the current 39.6%.
- **Eliminate the tax penalty** associated with the ACA's individual health insurance mandate.
- **Preserve the alternative minimum tax** for individuals, applying to individual with an income of $500,000 or more and couples with an income of at least $1 million or more.
- **Individuals can choose how to use the state and local tax deduction**. Individuals may be able to deduct up to $10,000 in property taxes, income or sales taxes paid, or a combination of these taxes.

Republicans are pushing hard to have a final bill on Mr. Trump's desk before Congress leaves for its holiday break.

- Reporting the required base measures for the ACI category and one medium-weighted improvement activity; or
- Reporting six quality measures to meet data completeness, but not measure benchmarks.

Big bonuses for complex patients and small practices

One final piece of the MIPS puzzle to remember is that under the 2018 QPP final rule, CMS is handing out free bonus points for treating complex patients and for small practices. Here's how they work.

Complex patients bonus will be based on your ICD-10 coding. You get up to 5 points toward your composite score. CMS will calculate this bonus automatically by crosswalking your patients' ICD-10 diagnoses to Hierarchical Condition Categories (HCC) to produce an average HCC risk score, which is then added to the dual eligible (patients eligible for Medicare and Medicaid) ratio and multiplying the result by 5. To maximize your chances of getting points for complex patients, make sure your providers select ICD-10 codes to the maximum level of specificity, and report any applicable secondary diagnoses to capture the full complexity of every patient visit.

Small practice bonus will be based on your ICD-10 coding. Like the complex patients bonus, the small practice bonus is worth up to 5 points toward the composite score, and it's calculated automatically by CMS. Any practice with 15 or fewer MIPS-eligible providers will get 5 points (either individually or as a group depending on how they report). What's more, small practice will receive no fewer than 3 points for any quality measure submitted. Even more significantly, small practices may claim a significant hardship for the ACI category. If the claim is approved by CMS, the ACI category weight will be redirected to the Quality category, making Quality account for a total of 85% of the MIPS composite score. The ACI hardship is available if a practice or provider has insufficient Internet connectivity, extreme and uncontrollable circumstances, or lack of control over the availability of certified EHR technology. Finally, small practices will get full credit in the Improvement Activities category by submitting one high-weighted activity.

The best thing about these two sources of bonus points is that they can count toward your 15-point minimum. If you are a small practice, you have 5 points to start with and your path to minimum reporting is already one-third complete. Look for a guide to maximizing your composite score and earning as much bonus payments as possible under MIPS in the upcoming January 2018 issue of *The Business of Medicine*.

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REVENUE CYCLE MANAGEMENT

Practices fight Blue Cross over growing modifier 25 cuts

It started with one Blue Cross plan in Pennsylvania, but eight other states across the country will start the New Year being subject to the same painful policy: A 50% reduction in reimbursement for all E/M services with modifier 25 appended.

On Jan. 1, Anthem Blue Cross Blue Shield (BCBS) will reduce the payment of all E/M services with modifier 25 attached by 50%, targeting those E/M services billed in the same encounter as minor procedures (CPT codes with a 0-day or 10-day post-operative period). The policy will affect all practices participating with Anthem in the following states:

- California
- Connecticut
- Kentucky
- Maine
- New Hampshire
- Nevada
- Ohio
- Wisconsin

The charge to slash payment for modifier 25 services was led by Independence Blue Cross (IBX) of Pennsylvania, which implemented the policy on Aug. 1 with little fanfare. IBX began issuing warnings about its impending modifier 25 policy in May, citing data that showed it was an "outlier in terms of cost of care and utilization."

Anthem provided less rationale for its adoption of the same policy, writing in its announcement that "there is duplication of the indirect practice expense when performing both a minor surgery and evaluation and management service on the same day by the same provider. The duplication of indirect practice expense may include, but is not limited to, scheduling the visits, staffing, obtaining vital signs, lighting, and supplying the examination room

for the same day medical visits. Therefore, when the E/M reported with minor surgery is eligible for separate reimbursement, the maximum fee schedule allowance for the reported E/M code will be reduced by 50%."

Anthem's rule actually goes farther than the IBX rule: In addition to all minor procedures, Anthem's language includes preventive services and wellness exams. This means that if a problem-oriented E/M code is billed with modifier 25 in the same session as preventive services such as Medicare's annual wellness visit (**G0438-G0439**) or commercially covered preventive visits (**99391-99397**), the problem-oriented E/M codes will be hit with the 50% reduction.

Affected practices push back

At Advanced ENT and Allergy, a 14-physician practice in Louisville, KY, the Anthem policy could cost up to $500,000 in annual revenue, estimates CEO Danielle Fife. "We are going to fight our toughest fight to get this policy changed regionally," she says.

Her practice is in touch with the state medical society and will soon participate in a meeting with Anthem representatives and other practice stakeholders to discuss the policy. "It's not going to improve quality for their members, and that's what our stance is going to be," Fife says.

Under Trump, CMS reverses course on mandatory bundled payment

CMS has finalized a proposal to cancel the Episode Payment Models (EPM) program, which would have included the mandatory hip fracture bundled payment model. The cancellation rule also makes changes to the Comprehensive Care for Joint Replacement (CJR) model, reducing the number of geographic areas that must participate in CJR from 67 metropolitan statistical areas (MSAs) to just 34.

Medicare's bundled payment programs had been criticized by former Congressman Tom Price (R-Ga.), who served briefly as HHS secretary in the Trump administration. As HHS secretary, Price said that while he did not oppose bundled payment models in principle, he did object to mandatory programs such as CJR and EPM.

Here's a list of the highlights in the final cancellation rule:

- Hip fracture bundled payment program, originally scheduled to begin on Jan. 1, 2018, will be cancelled. The cardiac bundled payment program is also cancelled.

- Mandatory participation in the CJR program is limited to 34 MSAs in 2018; an updated list of these areas can be found on the CJR website. In the remaining 33 MSAs, participation in CJR will be voluntary.

- A participation election window from Jan. 1 to Jan. 31, 2018, will be held for hospitals in the voluntary MSAs to indicate that they wish to participate voluntarily.

- Hospitals with a low volume of total joint replacements (20 or fewer CJR episodes over three years of data) will be also be exempt from mandatory participation regardless of their MSA. They may also elect to participate voluntarily in January.

The reduction in mandatory participation isn't necessarily a bad thing for bundled payments as an overall reimbursement and care model, says Matt Civili, senior director of program management for Signature Medical Group in St. Louis, Mo. "From a public standpoint it might look like a step back, but our view is that the future of value-based payment should be focused on getting voluntary bundled payment programs to work before making them mandatory."

Signature acts as a convener, or facilitating entity, for 50 orthopaedic groups participating in Medicare's voluntary Bundled Payments for Care Improvement (BPCI) program, which is set to conclude next September, but is likely to be reborn with a new voluntary program, tentatively known as BPCI Advanced, Civili says.

CMS stated that its goal was not to target bundled payment programs, but the mandatory nature of some of these programs. In fact, CMS anticipates announcing new voluntary bundled payment programs soon, said Seema Verma, the agency's administrator, in a statement. Verma did not elaborate further, but all indications are that another voluntary bundled payment program, most likely BPCI Advanced, will be announced before the end of the year, Civili says.

The stakes are high: Anthem represents as much as 27% of her practice's payer mix and can't simply be dismissed, though Fife suggests that affected practices, including hers, could consider negotiating with Anthem to receive a carve-out exemption from the modifier 25 policy.

While there is no indication that Anthem would be likely to grant either a practice-specific or regional exception, Fife considers the fact that the meeting is happening at all to be a positive development. *The Business of Medicine* will continue to cover this story as Anthem meets with stakeholder practices.

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PRACTICE MANAGEMENT

How to reduce occupational exposure to hazardous drugs

Medical practices must often handle hazardous drugs (HDs) and contaminated materials, and there are a slew of federal, state, and local laws that must be complied with. Any discarded HDs greater than residue amounts should be evaluated as to whether they are a hazardous waste under federal U.S. EPA regulations and if so, be disposed of in accordance with 40 CFR part 261 (EPA, 1991a and b). In addition, any discarded antineoplastic HDs should be managed as hazardous waste as a best practice and as required by some states. Since the EPA's lists of hazardous wastes have not been updated since the 1980s, EPA's Office of Inspector General has strongly recommended that EPA conduct a review of drugs that have entered the market since that time, particularly chemotherapy agents, to determine which drugs should be managed as hazardous waste in order to protect human health and the environment (EPA OIG, 2012).

Overtly contaminated materials, such as may occur during a spill or the cleanup of a spill, should also be managed as hazardous waste (EPA, 2008). Trace contaminated materials used in the preparation and administration of HDs, such as gloves, gowns, syringes and vials, also present a hazard to clinical support and housekeeping staff. These items should be disposed of in properly labeled, covered, and sealed disposal containers and handled by trained and protected personnel. Since sharps and potentially infectious materials may also be included in the trace contaminated materials, such containers should be managed as biohazardous waste under the Bloodborne Pathogens Standard. OSHA rules actually allow medical facilities, including private practices, to autoclave biomedical waste themselves. Autoclaving, if done according to the manufacturer's instructions, will not cause aerosolization. Spills involving HDs can also represent a hazard, and employers should ensure that all employees are familiar with appropriate spill procedures as outlined in the Chemotherapy Safety Standards issued by the American Society of Clinical Oncology/Oncology Nursing Society.

Disposal of dental carpules

Expired medications should always be handled as "pharmaceutical" or "chemical" waste. Many communities periodically provide opportunities to turn these products in to designated facilities at no cost. If that is not an option, work with the medical waste disposal company to properly dispose of expired dental carpules.

Unbroken carpules with no residual chemical and no visible blood technically would not be considered medical waste and could be discarded into the regular trash. However, considering that these carpules *could* break when compressed, it is better to discard them into sharps containers.

- Carpules with visible aspirated blood should go into sharps containers.
- Carpules with residual liquid but no visible blood should be placed in separate containers labeled "pharmaceutical waste" or "chemical waste."

Medical waste is autoclaved to destroy pathogens; chemicals are not affected. Chemical waste is usually incinerated.

Disposal of controlled substances

The federal government enforces regulations covering the disposal of controlled substances by registrants and ultimate users. Individual states, agencies or municipalities may have stricter rules that must be obeyed. This is not covered by OSHA.

Registrants are persons or entities that handle (i.e., manufacture, distribute, import, export, engage in research, or conduct instructional activities) or propose to handle controlled substances and that are required to register with the Drug Enforcement Administration (DEA) at each principle place of business or professional practice. These include authorized:

- Manufacturers
- Distributors
- Reverse distributors
- Narcotic treatment programs
- Hospitals/clinics with onsite pharmacies
- Retail pharmacies

Registrants must follow strict documentation regulations, such as frequent inventories and security measures. Ultimate users are persons who legally obtain and/or possess controlled substances for personal use by themselves or a member of the household, or for their animals.

Registrants have the following options for handling unused, unwanted, or expired controlled substances:

1. Onsite destruction – Rendering the controlled substances "non-retrievable" by permanently altering the controlled substance's physical or chemical state to make it unusable. This is meant to prevent the controlled substance from being diverted for illicit purposes.

2. Delivering to a reverse distributor.

3. Recall or return – Transferring to the registered person or manufacturer from whom it was obtained or another registrant authorized by the manufacturer to accept recalls or returns.

Ultimate users have the following options:

1. Participate in take-back events. These are usually conducted periodically by law enforcement agencies within designated communities.

2. Mail back programs are also conducted by law enforcement agencies.

3. Collection receptacles located inside law enforcement's physical address.

In each case, the law enforcement agency receiving these items is under strict regulations. The purpose of these regulations is to prevent controlled substances from polluting the environment or from being diverted for illegal purposes. The regulations do not specify destruction methods. These disposal methods can be used for the disposal of all unused or expired drugs, including personal use medications.

Which drugs are considered hazardous?

The National Institute of Occupational Safety and Health (NIOSH) created a list of hazardous drugs in 2004 and has updated it periodically since, most recently in 2016. The list is too long to print here and may be found in its entirety in the publication *NIOSH List of Antineoplastic and Other Hazardous Drugs in Healthcare Settings* from the CDC website.

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Compliance group	Speaking engagement – HIPAA webinar