Managing Your Dermatology Practice

Why You Need a Time Clock

Every medical office, even the smallest, should have a time clock, but a surprisingly large percentage of them do not. Although it is hardly a new innovation—the first commercial time clocks were built in the early 20th century by the company that later became IBM—the medical profession has been slow to adapt to this basic business practice.

There are two very good reasons why you should have a time clock. The first is obvious: to punch your employees' time cards. This is essential even if all your employees are paid weekly or semiweekly rather than by the hour.

BY JOSEPH S. EASTERN, M.D.

The other (and possibly more important) reason, which we will come back to, is to punch in your patients.

In most states, any employee who works more than 40 hours in a given week must be paid overtime wages. Employees know this, and disgruntled ones have been known to file complaints stating that they worked hundreds of hours of unpaid overtime.

This may be completely untrue, but labor boards almost invariably side with employees in such disputes, unless the employer can produce time records that disprove the claim. A time clock is cheap insurance against a large, unexpected, and possibly unjustified payment to a former employee.

For part-time, hourly-wage employees, time records are even more important, as you obviously want to pay them only for the hours they work. If you are paying your part-timers for the number of hours they should be working without documenting how many hours they actually work, you could be paying for a lot of nonwork. Employees have little incentive to arrive on time, or to stay the entire length of their shifts, if they know they are being paid for a set number of hours anyway. And they certainly will balk at staying late if they can't count on being paid for the extra time.

Time clocks also work to the advantage of your employees: Since they will be paid only for the time they work, they will be paid for *all* the time they work. If any employees object to your installing a clock, point out that they will be assured of payment for fractional time worked past their usual hours—time which might have gone unpaid before.

As for your patients, a time clock is a great tool in the endless struggle to run on time, as I mentioned in a column addressing that subject 3 years ago. (If you missed "How to Run on Time," go to www.skinandallergynews.com and click on "The Archive Collection" on the left-hand side.)

As each patient arrives, have your receptionist time stamp the encounter form that goes to the back with the patient's chart. As you take each chart off the door and enter the room, one glance at the time stamp will tell you exactly how long that patient has been waiting.

Now you no longer have to guess how far behind you are—and you'll have an answer for the curmudgeon who insists he's been sitting there for 2½ hours.

Time/attendance systems range from relatively simple to relatively complex.

My office has had an old-fashioned stamp-type time clock for 26 years, but nowadays you can get something far more sophisticated than that if you wish.

Many of the newer clocks will automatically calculate time between punches and add up total work time, and they can be configured for weekly, biweekly, semimonthly, or monthly pay periods. At least one will automatically deduct break time from the totals.

If you have a problem with "buddy punching" (employees punching in or out for each other), some clocks are equipped to recognize fingerprints or hand contours.

There are also electronic software systems, both Web based and in house, that can be deployed across a local computer network.They will print time sheets with employee hours and earnings calculated, and some will even interface with financial software such as QuickBooks and other third-party payroll services. (As always, I have no financial interest in any product or service discussed in this column.)

If you go the electronic route, make sure the software incorporates security measures to prevent time alterations by unauthorized employees. You can never be too careful.

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Hassles Continue in Second Year Of Medicare Drug Benefit

BY MARY ELLEN SCHNEIDER
New York Bureau

San Diego — In the second year of Medicare Part D implementation, physicians continue to struggle with prior authorization requests and other hassles, Dr. Kay M. Mitchell said at the annual meeting of the American College of Physicians.

Although some of the paperwork burden remains, the prescription drug program is generally easier to manage now because patients and physicians are more familiar with the rules, said Dr. Mitchell, a geriatrician and a professor in the department of community internal medicine at the Mayo Clinic in Jacksonville, Fla.

"It's still going to cost us time and money," Dr. Mitchell said. "It doesn't matter how much we've worked at it."

When you are faced with prior authorization, save time by having the patient collect the authorization forms and bring them into the office.

For example, physicians continue to see requests for prior authorization and step therapy, said Neil M. Kirschner, Ph.D., ACP's senior associate of insurer and regulatory affairs. In addition, in 2007, several drugs were approved under both Medicare Part B and Part D, which could create denials, he said.

Officials at the Centers for Medicare and Medicaid Services are working on this issue and recommend that physicians write the diagnosis and "Part D" on the prescription, Dr. Kirschner said.

Physicians might experience some relief in terms of prior authorization and exceptions if their patients haven't changed drug plans, Dr. Mitchell said. CMS officials announced that prior authorizations and exceptions approved by a drug plan in 2006 are expected to continue this year if the beneficiary remains in the same plan and the expiration date hasn't occurred by Dec. 31, 2006. However, if the beneficiary changes plans, physicians might have to go through the same process again. And even when patients remain in the same plan, some physicians have still received prior authorization requests, she said.

When you are faced with prior authorization, Dr. Mitchell suggested, save time by having the patient collect the authorization forms and bring them into the office. In her office, this saves office staff 20-35 minutes per prescription, she said.

Some physicians have decided to deal with the extra Part D paperwork by either hiring additional staff or designating staff to deal solely with Part D prior authorizations, denials, and appeals, Dr. Mitchell said. Some physicians use general office staff while others use nursing staff. Dr. Mitchell said she prefers to have one of her nurses work on Part D issues because she is already familiar with the patients and their medications.

Dr. Mitchell also recommended that staff members who are working on Part D issues attend continuing medical education meetings that focus on Part D.

During the course of Part D implementation, Dr. Mitchell also learned that insurers may ask for documentation justifying a switch in medications. To simplify that process, she recommends, keep a sheet in the front of the chart with information on medication changes and the reasons for the switch. ■

Proposed Clinical Trial Policy Change Would Effect Medicare Pay Eligibility

Clinical trials in the future may have to conform to several new procedural and reporting requirements in order for Medicare beneficiary participants to be eligible for reimbursement, if proposed revisions to the Clinical Trial Policy national coverage determination are implemented.

Changes proposed by the Centers for Medicare and Medicaid Services would include the following:

► Requiring all trials to be registered on the National Institutes of Health ClinicalTrials.gov Web site before enrollment begins.

► Requiring study investigators to publish their results.

► Adding Food and Drug Administration postapproval studies and coverage with evidence development (CED) to studies that would qualify under this policy.

► Paying for investigational clinical services if they are covered by Medicare outside the trial or required under CED through the national coverage determination (NCD) process.

► Expanding the agencies that can deem whether a trial has met the general policy standards to include all Department of Health and Human Services agencies, the Veterans Administration, and the Department of Defense.

The 30-day public commentary period began in April. The CMS is reviewing all public comments and suggestions and will incorporate them into the final published NCD, and the revised policy will be effective with that publication.

The Clinical Trial Policy (to be renamed the Clinical Research Policy) was first developed in 2000 to allow Medicare to pay for certain items and services for Medicare beneficiaries involved in clinical trials.

Further details are available from the CMS coverage Web site at www.cms.hhs.gov/mcd/viewdraftdecisionmemo.asp?id=186.

—Mark S. Lesney